ABBVIE CORPORATION

Permanent full time employees, Permanent part-time employees, Employees on temporary long-term assignment

Group no. 91311

LIST OF BENEFITS

Revised: January 2018

GENERAL INFORMATION

This booklet is aimed at giving you a description of the flex group insurance plan offered by the policyholder of the contract, ***ABBVIE Corporation*** and underwritten by ***Medavie Blue Cross***.

NOTICE CONCERNING CONFIDENTIAL INFORMATION

When you apply for coverage under the group insurance plan, ***Medavie Blue Cross*** sets up a file with personal information relevant to your coverage.

Your file is kept in the Insurer's office. Employees have access to this information when required for insurance purposes.

You have certain rights of access and correction with respect to the information in your file. A request for access or correction must be in writing and may be sent to the Insurer's office.

This notice is provided in accordance with any applicable legislation respecting the protection of personal information in the private sector.

NOTICE CONCERNING THE QUEBEC ACT RESPECTING PRESCRIPTION DRUG INSURANCE

Please note that the three levels of health insurance coverage offered in the group insurance plan comply with the minimum requirements of the Quebec Act Respecting Prescription Drug Insurance.

When you subscribe to the plan, you must choose between the three levels of health insurance offered, unless you are covered for drugs under another group insurance (for example, that of your spouse).

The plan administrator must issue, once a year, a confirmation of coverage which must be joined to your return of income. To that effect, it is paramount that we have your most recent address on file.

NOTICE CONCERNING YOUR BENEFIT SUMMARY

The Benefit Summary that follows must be read together with the benefit provisions described in the different sections of this booklet.

This booklet describes the group insurance plan in force as of January 1, 2013. This program is a flex plan offering options in most benefits. For a confirmation of the coverage you have selected and its effective date, please refer to your identification card.

BENEFIT SUMMARY

Employee eligibility:	In order to be eligible for all benefits under this contract, an employee must actively* work for the employer and belong to one of the following categories: 1. Permanent full time employees 2. Permanent part-time employees 3. Employees on temporary long-term assignment A category 1 or category 2 employee is eligible for coverage at the expiration of the plan waiting period. A category 3 employee is eligible for coverage on the 1st day of the month following expiration of the plan waiting period. All employee applications should be completed and submitted to the Insurer within 31 days of the start of the eligibility period.
Plan waiting period:	
➢ **Category 1**	None: you are eligible on your first day of employment.
➢ **Category 2**	None: you are eligible on your first day of employment provided you regularly work a minimum of 1,131 hours per year, including vacations and holidays.
➢ **Category 3**	Period during which you have completed at least 2 years of continuous service for the employer and have worked a minimum of 1,131 hours each of the 2 years, including vacations and holidays, based on the employment anniversary date or on the previous 2 calendar years.
Maintaining coverage :	To maintain coverage, a category 2 or category 3 employee must have worked a minimum of 1,131 hours in the previous calendar year (January 1st to December 31st).
Termination of benefits:	The benefits provided herein terminate at the earlier of retirement, termination of employment, or the age specified in each benefit, if any.

* *If you are not actively at work (i.e. maternity or parental leave, leave without pay, etc.), please contact your employer for details on the provisions applicable to your situation.*

STANDARD COVERAGE

Basic Life Insurance	
Amount of insurance for the Participant	1 times the annual salary rounded to the next higher $500
• **Maximum without proof of insurability**	$500,000 (including the Maximum without proof of insurability of the Participant's Extended Life Insurance)
• **Maximum with proof of insurability**	$1,500,000 * (including the Participant's Extended Life Insurance)
Amount of insurance for the spouse	none
Amount of insurance for children	none
Termination of benefit	termination of employment or retirement

EXTENDED COVERAGE

Extended Life Insurance	
Amount of insurance for the Participant	units of $10,000
• **Maximum without proof of insurability**	$50,000 (included in the Maximum without proof of insurability of the Participant's Basic Life Insurance)
• **Maximum with proof of insurability**	$1,500,000 * (including the Basic Life Insurance)
Amount of insurance for the spouse	units of $10,000
• **Maximum with proof of insurability**	$750,000
Amount of insurance for the children	units of $5,000
• **Maximum (No more proof of insurability is required)**	$50,000
Termination of benefit	termination of employment, retirement or age 65 (age of Participant or spouse)

* ***If the Participant wishes to subscribe an amount exceeding $1,000,000, this amount can be granted subject to acceptance by the Insurer of the required evidence of insurability and provided that the total amount of Life Insurance does not exceed 10 times his annual salary.***

STANDARD COVERAGE

Accidental Death and Dismemberment Insurance
(underwritten by AIG Canada, please refer to the Appendix for the coverage provisions)

EXTENDED COVERAGE

Optional Accidental Death and Dismemberment Insurance
(underwritten by AIG Canada, please refer to the Appendix for the coverage provisions)

STANDARD COVERAGE

Short-term Disability **see APPENDIX** ***(not underwritten by Medavie Blue Cross, provided by the employer)***	
Coverage	100% of regular salary
Maximum duration of benefits	26 weeks

STANDARD COVERAGE

Long Term Disability Insurance	
Amount of insurance	60 % of monthly salary, rounded to the next dollar
• **Maximum without proof of insurability**	$9,000
• **Maximum with proof of insurability**	$15,000
Elimination period	26 weeks
Maximum duration of benefits	to age 65
Definition of disability	
➢ **own occupation**	first 24 months following the elimination period
➢ **any occupation**	subsequently
Tax status of benefits	not taxable
Indexation	none
Termination of benefit	termination of employment, retirement or age 65

EXTENDED COVERAGE

Long Term Disability Insurance	
Amount of insurance	60 % of monthly salary, rounded to the next dollar
• **Maximum without proof of insurability**	$9,000
• **Maximum with proof of insurability**	$15,000
Elimination period	26 weeks
Maximum duration of benefits	To age 65
Definition of disability	
➢ **own occupation**	first 24 months following the elimination period
➢ **any occupation**	subsequently
Tax status of benefits	not taxable
Indexation	CPI, up to 3% per year
Termination of benefit	termination of employment, retirement or age 65

HEALTH INSURANCE

BASIC COVERAGE

Drug Insurance	
Percentage of reimbursement	100%
Deductible*	$500 for the Participant and dependent children and $500 for the spouse, per plan year
Method of payment	direct payment card
Survivor benefit	24 months, without payment of premiums
Termination of benefit	termination of employment or retirement

Accident/sickness Insurance	
Percentage of reimbursement	**hospital: 100%** **all other expenses: 100%**
Hospitalization expenses	no deductible
➢ **short term**	semi-private or private, up to $120 per day
➢ **convalescent or chronic**	semi-private, 180 days per disability
Medical and paramedical expenses, no deductible	
☛ **Ambulance**	unlimited, no deductible
☛ **Private nursing care**	maximum of $10,000 per Insured, per plan year, no deductible
☛ **Other eligible expenses**	deductible* of $500 for the Participant and dependent children and $500 for the spouse, per plan year
Survivor benefit	24 months, without payment of premiums
Termination of benefit	termination of employment or retirement

* Only one deductible is to be satisfied for Drug Insurance and Accident/Sickness Insurance

STANDARD COVERAGE

Drug Insurance	
Percentage of reimbursement	• 80% * of the first $2,500 of eligible expenses incurred per plan year by the Participant and dependent children and 100% afterwards • 80% * of the first $2,500 of eligible expenses incurred per plan year by the spouse and 100% afterwards *** 100% for lancet devices and test strips for the control of diabetes produced by Abbott Laboratories, Limited, and for all drugs produced by AbbVie Coporation**
Deductible	none
Method of payment	direct payment card
Survivor benefit	24 months, without payment of premiums
Termination of benefit	termination of employment or retirement

Accident/sickness Insurance	
Percentage of reimbursement	**hospital: 100%** **all other expenses: 100%**
Hospitalization expenses	no deductible
➢ **short term**	semi-private or private, up to $120 per day
➢ **convalescent or chronic**	semi-private, 180 days per disability
Medical and paramedical expenses	
☛ **Ambulance**	unlimited, no deductible
☛ **Private nursing care**	maximum of $10,000 per Insured, per plan year, no deductible
☛ **Vision care:**	no deductible
- **eyeglasses, contact lenses and laser eye surgery**	overall maximum of $200 per period of 24 months
- **eye examination**	maximum of $40 per period of 24 months
☛ **Other eligible expenses**	deductible of $100 for the Participant and dependent children and $100 for the spouse, per plan year
➢ **Health professionals : acupuncturist, audiologist, chiropodist, chiropractor, dietician, homeopath, massotherapist, naturopath, occupational therapist, osteopath, physiotherapist (or rehabilitation technician or athletic therapist), podiatrist, psychologist, psychotherapist and speech therapist**	maximum of $800 per Insured, per plan year, for all professionals combined
➢ **Hearing aids**	$500 per period of 3 years
➢ **Orthopaedic shoes and podiatric ortheses**	1 pair of each per plan year
Survivor benefit	24 months, without payment of premiums
Termination of benefit	termination of employment or retirement

EXTENDED COVERAGE

Drug Insurance	
Percentage of reimbursement	100%
Deductible	none
Method of payment	direct payment card
Survivor benefit	24 months, without payment of premiums
Termination of benefit	termination of employment or retirement

Accident/sickness Insurance	
Percentage of reimbursement	**hospital: 100%** **all other expenses: 100%**
Hospitalization expenses	
➢ **short term**	semi private or private, up to $120 per day
➢ **convalescent or chronic**	semi private, 180 days per disability
Medical and paramedical expenses	
☛ **Ambulance**	unlimited
☛ **Private nursing care**	maximum of $10,000 per Insured, per plan year
☛ **Vision care:**	
- **eyeglasses, contact lenses and laser eye surgery**	overall maximum of $400 per period of 24 months
- **eye examination**	maximum of $40 per period of 24 months
☛ **Other eligible expenses**	no deductible
➢ **Health professionals : acupuncturist, audiologist, chiropodist, chiropractor, dietician, homeopath, massotherapist, naturopath, occupational therapist, osteopath, physiotherapist (or rehabilitation technician or athletic therapist), podiatrist, psychologist, psychotherapist and speech therapist**	maximum of $1,500 per Insured, per plan year, for all professionals combined
➢ **Hearing aids**	$500 per period of 3 years
➢ **Orthopaedic shoes and podiatric ortheses**	2 pairs of each per plan year
Survivor benefit	24 months, without payment of premiums
Termination of benefit	termination of employment or retirement

THE BASIC, STANDARD AND EXTENDED HEALTH INSURANCE ALSO INCLUDE THE TRAVEL INSURANCE

Travel Insurance	
Percentage of reimbursement	100%
Hospital and Medical Travel Insurance	
☛ **Deductible**	none
☛ **Lifetime maximum per Insured**	$5,000,000
☛ **Maximum duration of coverage**	As long as the participant remains covered by RAMQ (total maximum of 180 days outside Canada in a calendar year)
Trip Cancellation and Interruption Insurance	$3,000 per insured risk, per Insured
Baggage Insurance	$500 per trip, per Insured
Survivor benefit	24 months, without payment of premiums
Termination of benefit	termination of employment, retirement or age 75

STANDARD COVERAGE

Dental Care Insurance	
Percentage of reimbursement	– Preventive treatment: 80% – Basic treatment : 80% – Major restorative treatment : 50%
Deductible	none
Maximum	
☛ **All treatments combined**	$2,000 per plan year, per Insured
Dental Fee Guide	current year
Termination of benefit	termination of employment or retirement

EXTENDED COVERAGE

Dental Care Insurance	
Percentage of reimbursement	– Preventive treatment : 90% – Basic treatment : 80% – Major restorative treatment : 80% – Orthodontics : 50%
Deductible	none
Maximum	
☛ **Orthodontics**	$3,000 lifetime, per Insured
☛ **All other combined treatments**	$3,000 per plan year, per Insured
Dental Fee Guide	Current year
Termination of benefit	termination of employment or retirement

At retirement, you become eligible under the group insurance plan applicable to retirees. A booklet describing that coverage is available at the Human Resources Department.

DEFINITIONS

Accident means a sudden, fortuitous and unforeseeable event inflicting directly and independently of all other causes, bodily injuries certified by a physician and due exclusively to an external cause of a violent nature and unintended by the Insured.

Actively at work means that an employee performs, during any workday, all the usual duties of his occupation with the employer and for the number of hours scheduled for said day.

Dependent means a spouse or child who meets the following definition.

a) **Spouse**
person legally married to the Participant, or the person the Participant designates as his spouse and with whom he has been cohabiting for a continuous period of not less than one year; this period does not apply if a child is born to the relationship. The spouse is named on the insurance application. At any one time, only one person may be covered as the Participant's spouse.

b) **Dependent child**
a child of the Participant or of his spouse, who has no spouse, who depends on the Participant or his spouse for financial support and who satisfies at least one of the following conditions:

- is under 21 years of age;
- is under 26 years of age and attends, as a duly registered full-time student, a secondary school, college or university;
- resides with the Participant and has become totally and permanently disabled while he was considered a dependent according to the above definition.

Employee means a person who is domiciled in Canada, is employed by the employer on a permanent or full-time or part-time basis or on temporary long term assignment and belongs to a category of Participants specified in the Benefit Summary. (Notwithstanding the above, as of May 1st, 2011, expatriate employees as identified by the Policyholder to the Insurer are covered under the life insurance benefits only).

Employer means ABBVIE Corporation.

Flex Dollars means the amount of money given to you by your employer, to purchase part or all of your group health insurance benefits including, if any, the Health Spending Account.

Hospital means an institution designated as such by law. It must be intended for the care and treatment of sick and injured individuals, have organized facilities for diagnosis and major surgeries and provide the services of physicians and registered nurses at all times.

The term « hospital » excludes psychiatric hospitals, tuberculosis hospitals, sanatoriums, community centres, rest homes, retirement homes, health spas, dispensaries, or any facility or part thereof set up to provide supervisory care or institutions used primarily for the confinement or treatment of alcoholism or drug addiction.

Illness means a deterioration of health or bodily disorder diagnosed by a physician, which requires regular, continuous and curative care. The Insurer must consider such medical care satisfactory.

Insured means each covered family member, as specified on the identification card issued to the Participant.

Participant means an employee who has subscribed to insurance hereunder.

Physician means a member of the medical profession who is licensed to practice medicine under the laws of the jurisdiction in which he practices.

Plan year means the period of time between October 1st of one year and the September 30th that follows.

Salary means the employee's regular rate of remuneration paid by the employer.

EFFECTIVE DATE OF INITIAL COVERAGE AND SUBSEQUENT AMENDMENTS

Participant's coverage

The effective date of your coverage is determined as follows:

- for any benefit not requiring proof of insurability : the date the Insurer receives your duly completed application; otherwise you will automatically be enrolled in the *default level coverage* from your date of eligibility
- if proof of insurability is required : the date the Insurer accept such proof.

Generally, if you are not actively at work on the day your coverage should take effect, coverage will begin on the date of your return to active full-time work. If you are not actively working (i.e. maternity and parental leave, leave without pay, etc.), please contact your employer for details on the provisions applicable to your situation.

Eligible spouse's coverage

The effective date of your spouse's coverage is determined as follows:

- for any benefit not requiring proof of insurability : the date the Insurer receives the application duly completed for the spouse
- if proof of insurability is required : the date the Insurer accepts such proof.

However, if the spouse is hospitalized on the day his coverage should take effect, coverage will begin following his discharge from the hospital, except for any benefit for which the above-mentioned proof is not required.

Dependent children's coverage

The effective date of a dependent child's coverage is determined as follows:

- for any benefit not requiring proof of insurability : the date the Insurer receives the application duly completed for the spouse
- if proof of insurability is required : the date the Insurer accepts such proof.

However, if the dependent child (except a newborn) is hospitalized on the day his coverage should take effect, coverage will begin following his discharge from the hospital.

Furthermore, for the Extended Life Insurance, the child must be at least 24 hours old.

If you already have employee/spouse, employee/children or employee/spouse/children coverage

The insurance for a new dependent child takes effect at the child's birth (except for the Extended Life Insurance which requires that the child be at least 24 hours old to be insured).

PARTICIPATION

Participation to the STANDARD COVERAGE in LIFE INSURANCE and in LONG TERM DISABILITY INSURANCE, and to the BASIC COVERAGE in HEALTH INSURANCE is compulsory.

However, an exemption right may be exercised with respect to the HEALTH INSURANCE BENEFIT, if you are insured under another group health insurance benefit plan. Supporting proof is then required.

DEFAULT LEVEL OF COVERAGE

If no option is chosen, the default level of coverage provided is as follows:

Benefit	Default coverage
Life Insurance :	Standard Coverage
Long Term Disability Insurance:	Standard Coverage
Health Insurance :	Individual Basic Coverage
Dental Care Insurance :	No coverage
Health Spending Account	Remaining Flex Dollars

PROOF OF INSURABILITY

You must submit proof of insurability to subscribe to the Extended Life Insurance if the combined amount of Standard Life and Extended Life Insurance exceeds the maximum without proof specified in the Benefit Summary or if you apply for any amount of Extended Life Insurance or increase thereof for your spouse or your dependent children.

For Long Term Disability Insurance, proof of insurability must be submitted if your coverage exceeds the maximum without proof specified in the Benefit Summary. However, for subsequent salary increases, proof of insurability will not be required if the increase is 10% or less.

MODIFICATION OF COVERAGE

Once your coverage has been chosen, you may modify your choices **every two years** on the renewal date of the plan, i.e., October 1st, provided you are not disabled. Your request must be forwarded within 31 days following that date.

The only exception to this rule is with respect to the Health Insurance: if you were exempt from the plan and you now wish to enroll, you can go directly to the standard coverage if you so desire.

Your coverage may be modified as follows:

Benefit	Coverage in force	Coverage requested
Life Insurance	Standard Coverage	Extended Coverage
	Extended Coverage	Standard Coverage
Long Term Disability Insurance	Standard Coverage	Extended Coverage
	Extended Coverage	Standard Coverage
Health Insurance	No coverage	Basic Coverage or Standard Coverage
	Basic Coverage	Standard Coverage
	Standard Coverage	Basic Coverage or Extended Coverage
	Extended Coverage	Standard Coverage
Dental Care	No coverage	Standard Coverage
	Standard Coverage	Extended Coverage or withdrawal from coverage
	Extended Coverage	Standard Coverage

Exception : the Participant can modify his options or request an addition of benefits within 31 days following one of the events mentioned below:

- marriage or eligibility of the common-law spouse,
- separation or divorce,
- birth or adoption of a first child,
- death of the spouse or of the last dependent child,
- the last dependent child is no longer eligible or a child over the age of 18 (but less than 26) is going back to school full time when there were not any eligible children left,
- the Participant involuntarily gains or loses access to coverage under the spouse's plan.

Once the 31 days are over, the Participant must wait for the next enrollment period to modify his choices and to cover a new dependent.

In Quebec, in accordance with the applicable legislation, the late Participant and his dependents are still granted health insurance coverage as provided in the contract.

If the Participant is unfit to work on the date the change should take effect, such change will become effective on the date he is able to return to work for a minimum of 21 hours per week.

Addition or increase of Extended Life Insurance amounts

These amounts of insurance may be increased at any time, for yourself and your dependents, subject to the required proof of insurability.

Note

If the Participant is disabled on the date the Extended Life Insurance increase should take effect, such increase will become effective on the date he is able to return to work for a minimum of 21 hours per week.

Modification of Long Term Disability Insurance

The Participant may modify the Long Term Disability Insurance Coverage from the Standard to the Extended Coverage at any time, subject to the Insurer's approval of the required proof of insurability.

TERMINATION OF COVERAGE

Participant's coverage

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

- the date the contract terminates;
- the date the Participant ceases to meet the definition of employee;
- the date his insurance premiums are no longer paid;
- at retirement;
- the date the Participant reaches the age set for each specific benefit, as specified in the Benefit Summary.

Dependents' coverage

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

- the date the insurance of the Participant, of whom you are a dependent, ends, with respect to each benefit;
- the date he ceases to meet the definition of dependent;
- the date his insurance premiums are no longer paid;
- if applicable, the date the dependent reaches the age limit for a specific benefit, as specified in the Benefit Summary.

PARTICIPANT'S BASIC LIFE INSURANCE

PURPOSE OF COVERAGE

In the event of your death while your insurance is in force, the Insurer will pay to your beneficiary the amount of life insurance you subscribed to, according to the Benefit Summary, and as specified on your identification card.

BENEFICIARY

The beneficiary is the one you have designated on your application and, subject to the provisions of the law, he may be changed by way of a written request signed by you and forwarded to the Insurer.

If you have not designated a beneficiary, the death benefit will be payable to your estate.

WAIVER OF PREMIUM IN CASE OF TOTAL DISABILITY

If you become **totally disabled** while you are covered under this benefit and before your 65th birthday, the insurance coverage is continued without payment of premium from the first day of the month coincident with or next following the date you become eligible for Long Term disability benefits. The amount of insurance that is subject to waiver is equal to the amount in force on the date your disability began.

The waiver terminates on the date the disability ends, without exceeding age 65.

CONVERSION PRIVILEGE

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

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

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

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

Life insurance amount that can be converted

1. If you reside in Quebec

The amount of Life insurance being converted for yourself must be at least **$10,000** and may not exceed **the lesser of the following amounts**:

a) your total Life insurance amount (including your Optional life insurance, if applicable) that terminates under your group insurance plan or

b) $400,000.

Your **Spouse** and D**ependent children** may also convert their group Life insurance to an individual insurance policy, within 31 days of your insurance termination for one of the above-listed reasons, or within 31 days of the date they cease to meet the definition of eligible Dependents under your group insurance plan.

The converted Life insurance amount per Dependent must be **at least $5,000** and may not exceed the lesser of the Dependent's total Life insurance amount that terminates, or $400,000.

2. If you reside outside Quebec

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

a) your total Life insurance amount (including your Optional life insurance, if applicable) that terminates under your group insurance plan or

b) $200,000.

Your **Spouse** may also convert his group Life insurance to an individual insurance policy, within 31 days of your insurance termination for one of the above-listed reasons, or within 31 days of the date he ceases to meet the definition of eligible Spouse under your group insurance plan.

The Spouse's converted Life insurance amount may not exceed the lesser of his total Life insurance amount that terminates, or $200,000.

The conversion option does not apply to your Dependent children's life insurance.

TERMINATION OF BENEFIT

The PARTICIPANT'S BASIC LIFE INSURANCE coverage ends on termination of your employment or at retirement, whichever occurs first.

PARTICIPANT'S EXTENDED LIFE INSURANCE

PURPOSE OF COVERAGE

In the event of your death while your insurance is in force, the Insurer will pay to your beneficiary the amount of Extended Life Insurance you subscribed to, according to the Benefit Summary, and as specified on your identification card.

PROOF OF INSURABILITY

You must submit proof of insurability if the amount of insurance exceeds the amount without proof specified in the Benefit Summary.

EXCLUSION

If you die as a result of **suicide** or an attempt at suicide within the first **two** years following the effective date of this benefit (including the months of insurance under a previous contract, if any), its reinstatement or any increase in the amount of benefit, whether you were of sound mind or otherwise at the time of suicide or attempt at suicide, the insurance or increase will be void and the Insurer's responsibility will be limited to refunding the premiums paid.

BENEFICIARY

The beneficiary is the one you have designated on your application and, subject to the provisions of the law, he may be changed by way of a written request signed by you and forwarded to the Insurer.

If you have not designated a beneficiary, the death benefit is payable to your estate.

WAIVER OF PREMIUM IN CASE OF TOTAL DISABILITY

The provisions of the PARTICIPANT'S BASIC LIFE INSURANCE pertaining to the waiver of premiums in case of total disability also apply to the PARTICIPANT'S EXTENDED LIFE INSURANCE in effect at the date of disability.

CONVERSION PRIVILEGE

The provisions of the PARTICIPANT'S BASIC LIFE INSURANCE pertaining to the conversion privilege also apply to the PARTICIPANT'S EXTENDED LIFE INSURANCE.

TERMINATION OF BENEFIT

The PARTICIPANT'S EXTENDED LIFE INSURANCE coverage ends on termination of your employment, at retirement or when you reach age 65, whichever occurs first.

SPOUSE'S EXTENDED LIFE INSURANCE

PURPOSE OF COVERAGE

In the event of your spouse's death while this insurance is in force, the Insurer will pay you the amount of Extended Life Insurance you subscribed for your spouse, according to the Benefit Summary, and as specified on your identification card.

PROOF OF INSURABILITY

As a prerequisite to eligibility under this benefit, the spouse must submit evidence of insurability deemed satisfactory by the Insurer.

EXCLUSION

If your spouse dies as a result of **suicide** or an attempt at suicide within the first **two** years following the effective date of this benefit (including the months of insurance under a previous contract, if any), its reinstatement or any increase in the amount of benefit, whether the spouse is of sound mind or otherwise at the time of suicide or attempt at suicide, the insurance or increase will be void and the Insurer's responsibility will be limited to refunding the premiums paid.

WAIVER OF PREMIUM IN CASE OF TOTAL DISABILITY

The provisions of the PARTICIPANT'S STANDARD LIFE INSURANCE pertaining to the waiver of premiums in case of total disability also apply to the SPOUSE'S EXTENDED LIFE INSURANCE in effect at the date of disability.

CONVERSION PRIVILEGE

Your spouse can exercise his conversion privilege, subject to the same conditions as those applicable to the Participant under the PARTICIPANT'S STANDARD LIFE INSURANCE BENEFIT.

Moreover, this privilege may be used by a spouse whose life insurance terminates following

a) the Participant's death, or

b) his exclusion from an eligible insurance category.

TERMINATION OF BENEFIT

The SPOUSE'S EXTENDED LIFE INSURANCE coverage ends on the earliest of the following:

- the date your spouse reaches age 65;
- the date the spouse no longer meets the definition of spouse indicated herein;
- termination of your employment, your retirement or when you reach age 65, whichever occurs the first.

DEPENDENT CHILDREN'S EXTENDED LIFE INSURANCE

PURPOSE OF COVERAGE

In the event of a dependent child's death while this insurance is in force, the Insurer will pay you the amount of Extended Life Insurance you subscribed for your child, according to the Benefit Summary, and as specified on your identification card.

EXCLUSION

If your dependent child dies as a result of **suicide** or an attempt at suicide within the first **two** years following the effective date of this benefit (including the months of insurance under a previous contract, if any), its reinstatement or any increase in the amount of benefit, whether the child is of sound mind or otherwise at the time of suicide or attempt at suicide, the insurance or increase will be void and the Insurer's responsibility will be limited to refunding the premiums paid.

WAIVER OF PREMIUM IN CASE OF TOTAL DISABILITY

The provisions of the PARTICIPANT'S STANDARD LIFE INSURANCE pertaining to the waiver of premiums in case of total disability also apply to the DEPENDENT CHILDREN'S EXTENDED LIFE INSURANCE in effect at the date of disability.

TERMINATION OF BENEFIT

The DEPENDENT CHILDREN'S EXTENDED LIFE INSURANCE coverage ends on the earliest of the following:

- the termination of your employment
- your retirement
- the date you reach age 65
- the date the dependent no longer meets the definition of dependent indicated herein.

LONG TERM DISABILITY INSURANCE

PURPOSE OF COVERAGE

If, due to an accident or an illness, you become **totally disabled** while your insurance is in force, the Insurer will pay you monthly benefits as specified in the Benefit Summary, provided you are under medical care. The elimination period and the maximum duration of payments are also specified in the Benefit Summary.

ADDITIONAL DEFINITION

Elimination period

The period consisting of the first consecutive days of total disability, for which no benefit is payable hereunder.

During the elimination period, successive periods of disability, imputed to the same cause or to related causes, are considered as a same period of disability, unless they are separated by at least two consecutive weeks of full-time work.

Total Disability

For the purpose of the LONG TERM DISABILITY INSURANCE, **total disability** means that you are under the care of a physician and that

- during the elimination period and the **two years** immediately following the expiry of the elimination period, you are incapable of performing the overall duties of the occupation you held at the onset of your disability, and
- subsequently, you are incapable of engaging in remunerative work compatible with your training, your education and your experience.

Rehabilitative employment means a program intended to help the Participant reintegrate the labour force according to his abilities.

WAIVER OF PREMIUM

The payment of premiums for the present benefit is under waiver **beginning on the first day of the month following the start of long term disability payments** and for as long as monthly benefits are paid to you because of your total disability.

RECURRENT DISABILITIES

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

When successive periods are considered as a same disability, the elimination period is not applied a second time and the same amount as for the initial disability (subject to indexation, if applicable) is payable for the remainder of the maximum period originally set.

If your new disability is due to causes unrelated to your prior disability and you have returned to active work for at least one full day, you may be eligible for a new period of disability subject to the elimination period.

REHABILITATION PROGRAM

While receiving Long Term disability benefits, you may take part in a remunerative rehabilitative employment program for a period not exceeding 24 months. Such employment does not affect your right to disability benefits, when the program is supervised by your physician and approved by the Insurer.

While participating to a rehabilitative employment program, your benefits are reduced by 50% of the monthly remuneration received under this program, provided that the total of your benefits and of the remuneration earned from the rehabilitative program does not exceed your income before the start of disability.

If, as a result of your disability, you are unable to complete the rehabilitative program, benefits will revert back to the amount of benefits received before the start of the program.

INDEXATION
(Extended coverage only)

On the first day of January of each year, the monthly benefits then being paid for a continuing total disability which has persisted for more than 12 months since the expiry of the elimination period will increase according to the Consumer Price Index (CPI) published by Statistics Canada, subject to the maximum percentage of indexation specified in the Benefit Summary.

EXCLUSIONS

1. Reduction

The monthly benefits are reduced by other income, as follows:

- disability benefits from the Canada or Quebec Pension Plan (excluding payments made in respect of dependent children);
- disability benefits from any workers' compensation board/commission;
- disability benefits available under any other government program;
- disability benefits paid or available under another group insurance plan;
- disability benefits payable under any automobile insurance legislation;
- wages or remuneration payable from any employer (including severance pay);
- retirement benefits provided by any employer or government program.

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

2. Coordination

If the total amount of the monthly benefits payable in accordance with this insurance benefit and with all other disability payments mentioned in section **1. Reduction** above, plus any Canada Pension Plan or Quebec Pension Plan family benefits, exceeds 85% of the net monthly income, the monthly benefits payable in accordance with this insurance benefit will be reduced so not to exceed the above percentage.

3. Alcoholism and drug addiction

If the disability results directly from alcoholism or drug addiction, benefits are paid only if you are participating, under medical supervision, to a recognized in-house rehabilitation program specifically for the treatment of substance abuse.

4. Exclusions

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

- period during which you receive maternity benefits under any provincial or federal law.
- during a maternity or parental leave taken in accordance with any provincial or federal law or any agreement between you and your employer.
- during a leave of absence authorized by the employer or during a temporary lay-off
- portion of a period of disability during which you are confined in a penal institution or other house of correction as a result of conviction for a criminal or other public offence.

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

- voluntary injury, whatever your state of mind at the time of the incident;
- injury sustained during active participation in a civil commotion, riot or an insurrection, except while performing the duties of your occupation, or injury sustained during a war;
- injury sustained while committing or attempting to commit a criminal act.

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

- you refuse to undergo a medical examination requested by the Insurer;
- you refuse to participate to a medical or rehabilitative employment program judged reasonable and appropriate by both the Insurer and your attending physician;
- you fail to produce proof satisfying the Insurer of the persistence of disability;
- you engage in remunerative work, unless it is part of a rehabilitation program;
- you move outside Canada, unless you notified the Insurer in writing and he has agreed in advance;
- your disability no longer meets the contract definition.

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

TERMINATION OF BENEFIT

The LONG TERM DISABILITY INSURANCE coverage ends on termination of your employment, at retirement or when you reach age 65, whichever occurs first.

DRUG INSURANCE

This insurance benefit covers expenses for eligible drugs, incurred by you or your dependents as a result of an illness, a pregnancy or an accident, subject to the deductible and percentage of reimbursement specified in the Benefit Summary for each level of coverage.

DEDUCTIBLE

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

DEDUCTIBLE FOR THE DRUG INSURANCE BENEFIT (if any) IS COMBINED WITH THE DEDUCTIBLE APPLICABLE TO THE **ACCIDENT AND SICKNESS INSURANCE BENEFIT** DESCRIBED IN THE FOLLOWING SECTION. Only one deductible must be satisfied for both benefits.

For details concerning the deductible amount applicable to each of the three levels of coverage, please refer to the Benefit Summary.

ELIGIBLE DRUGS

Charges for drugs that are included on the Insurer's **Regular List**. This **Regular List** consists of the usual and reasonable charges for drugs or products purchased in Canada that cannot be obtained without a prescription. They must be prescribed by a physician or a dentist and dispensed by a pharmacist, for use in respect of a pregnancy, illness or injury. The quantity must not exceed a 90-day supply.

The drug or product must be sold in accordance with the Food and Drugs Act of Canada. It must bear a Drug Identification Number (D.I.N.) and be used in accordance with the official indications for which the drug or product has been authorized.

Limitation :

- drugs used to treat erectile dysfunction are limited to a maximum benefit of $500 per Insured, per plan year;
- drugs for the treatment of infertility are limited to a maximum lifetime benefit of $2,500 per Insured;

Are also included:

- any injectable drug or any serum prescribed by a physician for the purpose of treating an illness (varicose vein injections for medical purposes are payable to a maximum of $20 per visit);
- vaccines and immunizations for the preventive treatment of communicable diseases;
- syringes, needles, lancet devices, pen needles, urine testing supplies, alcohol swabs, test strips for the control of diabetes, as well as an aerochamber and spinhaler;

- certain drugs essential for the Insured's survival or for the treatment of a clearly diagnosed chronic illness, mainly in case of heart disease, pulmonary disease, diabetes, arthritis, Parkinson's disease, epilepsy, cystic fibrosis and glaucoma. The claim must then include, as corroboration, the physician's prescription and written statement giving his diagnosis and the period for which the drugs were prescribed;
- smoking cessation aids, up to the eligible amount provided for in accordance with the Act Respecting Prescription Drug Insurance (RAMQ), per Insured, per plan year;
- Botox for medical reasons.

This benefit must always include the drugs and products that appear on the List provided by the Régie de l'assurance-maladie du Québec (RAMQ) and dispensed by a pharmacist on the written prescription of a physician or a dentist. Some of these drugs are covered only in the cases, on the conditions and for the therapeutic indications specified in the regulation, namely exception drugs.

EXCLUSIONS

Expenses related to the following products or drugs are excluded:

- Products for the care of contact lenses.
- Proteins or dietary supplements, amino acids.
- Processed food for infants.
- Hygiene products, including soaps and emollients.
- Softeners and protective substances for the skin.
- Minerals.
- Homeopathic products.
- Hair growth stimulants.
- Sexual stimulants.
- Anabolic steroids.
- Growth hormones.
- Drugs and injections for the treatment of obesity (except Xenical and Meridia).
- Drugs administered for experimental purposes.
- Drugs and all forms of drugs without therapeutic indication and intended exclusively to improve the quality of life.
- Mouthwashes, dressings, syrups and cough drops.∗
- Shampoos, oils, creams. ∗
- Vitamins and multivitamins. ∗
- Prenatal supplements or vitamins. ∗

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

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

- All expenses incurred due to an illness or accident covered under any occupational health and safety board or any automobile insurance plan, if applicable.
- Services, treatments or products received free of charge by the Participant.

TERMINATION OF BENEFIT

The DRUG INSURANCE coverage ends at your retirement or the termination of employment, whichever occurs first. Coverage for your dependents ends either on the date you cease to be covered (but not upon your death) or on the date they no longer meet the definition of dependent, whichever occurs first.

SURVIVORS' BENEFITS

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

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

PROVISIONS APPLICABLE TO QUEBEC RESIDENTS

When they reach the **age of 65**, the Participant and his Spouse have a decision to make regarding their drug coverage.

Decision to join the RAMQ plan at age 65
The Participant or his spouse who reaches the age of 65 may choose to be insured under the basic prescription drug insurance plan provided by the Act respecting prescription drug insurance (RAMQ's plan) rather than to maintain his drug coverage under the group insurance plan.
Such choice is then irrevocable.

If, at age 65, the Participant chooses to be insured under the RAMQ's plan, he and his dependents, regardless of their age, will no longer be eligible for coverage under the group insurance plan (except for supplementary coverage, as mentioned in 1. and 2. below).

If, at age 65, the spouse chooses to be covered under the RAMQ's plan, then he will no longer be eligible for coverage under the group insurance plan (except for supplementary coverage, as mentioned in 1. and 2. below).

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

1. deductible and coinsurance paid by the Participant under the RAMQ's plan; and
2. **subject to the deductible and the percentage of reimbursement mentioned in the Benefit Summary for drug coverage**: reimbursement of any prescription drug which does not appear on the list provided by the RAMQ, but which is covered under the Insurer's list of drugs.

Decision to cancel registration with the RAMQ at Age 65

When a Quebec resident reaches the age of 65, he is automatically registered by the RAMQ as a beneficiary of its prescription drug coverage. The Participant or his spouse who reaches the age of 65 **must therefore cancel their automatic registration** with the RAMQ plan in order to continue the coverage under the group insurance plan.

At age 65, an **active employee** may decide to maintain his single or family coverage **without the payment of an extra premium.**

At age 65, a **retiree** may decide to maintain his coverage providing he pays **the extra premium** (the amount of the premium varying for single or family coverage), and as mentioned in the renewal conditions of the contract.

ACCIDENT/SICKNESS INSURANCE

This insurance covers eligible expenses incurred by you or your dependents as the result of an illness, pregnancy or accident, subject to the deductible applicable to each of the three levels of coverage and the percentage of reimbursement specified in the Benefit Summary.

Expenses must be incurred in the Insured's province. For information regarding eligible expenses incurred outside the province or outside Canada, please refer to the Travel insurance.

DEDUCTIBLE

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

THE DEDUCTIBLE FOR THE ACCIDENT AND SICKNESS INSURANCE BENEFIT IS COMBINED WITH THE DEDUCTIBLE APPLICABLE TO THE **DRUG INSURANCE BENEFIT** DESCRIBED IN THE PRIOR SECTION.
Only one deductible must be satisfied for both benefits.

For information regarding the deductible amount and details as to which eligible expenses it applies, please refer to the Benefit Summary.

TERMS OF REIMBURSEMENT

The eligible expenses must be:

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

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

ELIGIBLE EXPENSES

BASIC COVERAGE

1. Hospital expenses

- Hospitalization charges for an Insured admitted for acute care in a hospital after the effective date of his insurance, for his stay in a semi-private or private room, as long as he is entitled to insured services, and subject to a maximum reimbursement of $120 per day;

- Charges for a stay in a convalescent home, rehabilitation centre or a chronic care hospital, if the Insured is admitted less than 7 days after obtaining his discharge from a hospital where he received acute care for at least 5 days, up to the amount that the hospital is allowed to charge to patients for a **semi-private accommodation** and subject to a maximum of 180 days **per disability**.

  Recurrent disabilities

  A new maximum of 180 days is applicable:

  - When the Insured incurs expenses for an illness or accident that is different from and unrelated to the cause of the prior disability, or

  - When a period of 14 consecutive days has elapsed since the last disability and the Insured has not been admitted as a patient in a hospital, a convalescent home or a physical rehabilitation centre during that period.

2. Ambulance service

- Charges for ambulance transportation to or from the nearest medical centre able to provide the emergency care required.

- When medically required, licensed ambulance service (including air ambulance) or any other means of public transport, including airport hospital transfer to transport the patient to the nearest hospital or medical facility able to provide the appropriate care.

3. Nursing care

Services of a registered nurse (or registered nursing assistant when a registered nurse is not available), who is unrelated by blood or marriage to either the Participant or any of his dependents and who does not normally reside with him nor his dependents, provided such services are rendered at the Insured's home and they are not mainly for custodial care, subject to an overall maximum reimbursement of $10,000 per Insured, per plan year.

4. Diagnostic and screening tests, health assessments

- Diagnostic and screening tests
  When they are judged necessary to screen for a disease or following an accident:

  - laboratory analyses, radiographs, scans, electrocardiograms, ultrasounds in a private office, Prenatest (including ultrasound and blood sample) and magnetic resonance imaging.

- Health assessments
  Health assessments, excluding administrative fees charged by the clinic, are limited to one health assessment per Plan year.

5. Other medical expenses

- Charges for casts, trusses, surgical dressings, splints, orthopaedic supports and ortheses, as well as charges for the rental or purchase of crutches, canes or walkers;
- with the Insurer's prior approval, the purchase or rental of a wheelchair, up to the usual cost of a standard manual wheelchair or a standard manual hospital-type bed for a bedridden patient;
- oxygen and rental of appliances for the administration thereof as well as respiratory assistance devices;
- purchase of artificial limbs (including stump socks), and artificial eyes;
- purchase of mammary prostheses when required following a mastectomy, subject to a maximum reimbursement of $300 per 2 plan years. Surgical brassieres are also covered, up to a maximum of 2 brassieres per plan year.
- purchase of capillary prostheses required for medical reasons, subject to a maximum reimbursement of $500 per plan year.
- charges for medical elastic stockings, subject to a maximum reimbursement of $25 per Insured, per plan year;
- purchase of intrauterine contraceptive devices (I.U.D.),
- purchase of a reflectometre or glucometre, subject to an overall maximum reimbursement of $250 per period of 60 consecutive months;
- purchase of an insulin pump including disposable peripherals;
- purchase of supplies relating to colostomy, ileostomy and ureterostomy.

6. Intraocular lenses

The cost of intraocular lenses implanted during cataract surgery, subject to $200 per eye per period of 24 months.

7. Dental care

Dental services required to repair and replace sound natural teeth damaged due to an accidental blow received while the person is insured under this benefit. Treatment must begin within 90 days following the accident and be rendered within two years of that date.

The eligible amounts are set in accordance with the suggested Fee Guide for Dental Services approved by the Dental Surgeons' Association of the Insured's province of residence.

8. Intrauterine contraceptive device (IUD)

Charges for the purchase of an intrauterine contraceptive device (IUD).

STANDARD COVERAGE

1. Hospital expenses

- Hospitalization charges for an Insured admitted for acute care in a hospital after the effective date of his insurance, for his stay in a semi-private or private room, as long as he is entitled to insured services, and subject to a maximum reimbursement of $120 per day;

- Charges for a stay in a convalescent home, rehabilitation centre or a chronic care hospital, if the Insured is admitted less than 7 days after obtaining his discharge from a hospital where he received acute care for at least 5 days, up to the amount that the hospital is allowed to charge to patients for **a semi-private accommodation** and subject to a maximum of 180 days **per disability**.

  Recurrent disabilities

  A new maximum of 180 days is applicable:

  - When the Insured incurs expenses for an illness or accident that is different from and unrelated to the cause of the prior disability, or

  - When a period of 14 consecutive days has elapsed since the last disability and the Insured has not been admitted as a patient in a hospital, a convalescent home or a physical rehabilitation centre during that period.

2. Ambulance service

- Charges for ambulance transportation to or from the nearest medical centre able to provide the emergency care required.

- When medically required, licensed ambulance service (including air ambulance) or any other means of public transport, including airport hospital transfer to transport the patient to the nearest hospital or medical facility able to provide the appropriate care

3. Nursing care

Services of a registered nurse (or registered nursing assistant when a registered nurse is not available), who is unrelated by blood or marriage to either the Participant or any of his dependents and who does not normally reside with him nor his dependents, provided such services are rendered at the Insured's home and they are not mainly for custodial care, subject to an overall maximum reimbursement of $10,000 per Insured, per plan year.

4. Vision Care

- The cost of eyeglasses or contact lenses, when prescribed by an ophthalmologist or optometrist, as well as laser eye surgery, subject to an overall maximum reimbursement of $200 per Insured, per period of 24 consecutive months.

  Are excluded:
  Charges for non-corrective sunglasses and safety glasses.

- Eye examination
  Eye examination by an ophthalmologist or an optometrist, subject to a reimbursement of $40 per period of 24 consecutive months.

5. Diagnostic and screening tests, health assessments

- Diagnostic and screening tests
  When they are judged necessary to screen for a disease or following an accident:

  - laboratory analyses, radiographs, scans, electrocardiograms, ultrasounds in a private office, Prenatest (including ultrasound and blood sample) and magnetic resonance imaging.

- Health assessments
  Health assessments, excluding administrative fees charged by the clinic, are limited to one health assessment per Plan year.

6. Other medical expenses

- Charges for casts, trusses, surgical dressings, splints, orthopaedic supports and ortheses, as well as charges for the rental or purchase of crutches, canes or walkers;
- with the Insurer's prior approval, the purchase or rental of a wheelchair, up to the usual cost of a standard manual wheelchair or a standard manual hospital-type bed for a bedridden patient;
- oxygen and rental of appliances for the administration thereof as well as respiratory assistance devices;
- purchase of artificial limbs (including stump socks), and artificial eyes;
- purchase of mammary prostheses when required following a mastectomy, subject to a maximum reimbursement of $300 per 2 plan years. Surgical brassieres are also covered, up to a maximum of 2 brassieres per plan year.
- purchase of capillary prostheses required for medical reasons, subject to a maximum reimbursement of $500 per plan year.
- charges for medical elastic stockings, subject to a maximum reimbursement of $25 per Insured, per plan year;
- purchase of intrauterine contraceptive devices (I.U.D.),
- purchase of a reflectometre or glucometre, subject to an overall maximum reimbursement of $250 per period of 60 consecutive months;
- purchase of an insulin pump including disposable peripherals;
- purchase of supplies relating to colostomy, ileostomy and ureterostomy.

7. Intraocular lenses

The cost of intraocular lenses implanted during cataract surgery, subject to $200 per eye per period of 24 months.

8. Dental care

Dental services required to repair and replace sound natural teeth damaged due to an accidental blow received while the person is insured under this benefit. Treatment must begin within 90 days following the accident and be rendered within two years of that date.

The eligible amounts are set in accordance with the suggested Fee Guide for Dental Services approved by the Dental Surgeons' Association of the Insured's province of residence.

9. Intrauterine contraceptive device (IUD)

Charges for the purchase of an intrauterine contraceptive device (IUD).

10. Paramedical services (without medical recommendation)

The services of an acupuncturist, audiologist, chiropodist, chiropractor, dietician, homeopath, massotherapist, naturopath, occupational therapist, osteopath, physiotherapist (or rehabilitation technician or athletic therapist), podiatrist, psychologist, psychotherapist and speech therapist, subject to a maximum reimbursement of $800 per Insured, per plan year, for all professionals combined.

Also included are charges for x-rays taken by a professional mentioned above, up to an eligible maximum of $50 per Insured, per plan year, for all professionals combined.

11. Hearing aids

Purchase and repair of hearing aids, subject to a maximum reimbursement of $500 per 3 plan years.

12. Orthopaedic shoes

Purchase of orthopaedic shoes, namely deep shoes and custom-made shoes, as well as podiatric ortheses, subject to a maximum of one pair of shoes and one pair of ortheses per Insured, per plan year. Purchases must be made from a recognized orthopaedic supplier. A medical recommendation must be presented to the Insurer with the initial purchase and with all subsequent purchases.

EXTENDED COVERAGE

1. Hospital expenses

- Hospitalization charges for an Insured admitted for acute care in a hospital after the effective date of his insurance, for his stay in a semi-private or private room, as long as he is entitled to insured services, and subject to a maximum reimbursement of $120 per day;

- Charges for a stay in a convalescent home, rehabilitation centre or a chronic care hospital, if the Insured is admitted less than 7 days after obtaining his discharge from a hospital where he received acute care for at least 5 days, up to the amount that the hospital is allowed to charge to patients for a **semi-private accommodation** and subject to a maximum of 180 days **per disability**.

  Recurrent disabilities

  A new maximum benefit period of 180 days is applicable if the Insured incurs the expenses described below:

  - When the Insured incurs expenses for an illness or accident that is different from and unrelated to the cause of the prior disability, or
  - When a period of 14 consecutive days has elapsed since the last disability and the Insured has not been admitted as a patient in a hospital, a convalescent home or a physical rehabilitation centre during that period.

2. Ambulance service

- Charges for ambulance transportation to or from the nearest medical centre able to provide the emergency care required.
- When medically required, licensed ambulance service (including air ambulance) or any other means of public transport, including airport hospital transfer to transport the patient to the nearest hospital or medical facility able to provide the appropriate care

3. Nursing care

Services of a registered nurse (or registered nursing assistant when a registered nurse is not available), who is unrelated by blood or marriage to either the Participant or any of his dependents and who does not normally reside with him nor his dependents, provided such services are rendered at the Insured's home and they are not mainly for custodial care, subject to an overall maximum reimbursement of $10,000 per Insured, per plan year.

4. Vision Care

- The cost of eyeglasses or contact lenses, when prescribed by an ophthalmologist or optometrist, as well as laser eye surgery, subject to an overall maximum reimbursement of $400 per Insured, per period of 24 consecutive months.

  Are excluded:
  Charges for non-corrective sunglasses and safety glasses.

- Eye examination
  Eye examination by an ophthalmologist or an optometrist, subject to a reimbursement of $40 per period of 24 consecutive months.

5. Diagnostic and screening tests, health assessments

- Diagnostic and screening tests
  When they are judged necessary to screen for a disease or following an accident:

  - laboratory analyses, radiographs, scans, electrocardiograms, ultrasounds in a private office, Prenatest (including ultrasound and blood sample) and magnetic resonance imaging.

- Health assessments
  Health assessments, excluding administrative fees charged by the clinic, are limited to one health assessment per Plan year.

6. Other medical expenses

- Charges for casts, trusses, surgical dressings, splints, orthopaedic supports and ortheses, as well as charges for the rental or purchase of crutches, canes or walkers;
- with the Insurer's prior approval, the purchase or rental of a wheelchair, up to the usual cost of a standard manual wheelchair or a standard manual hospital-type bed for a bedridden patient;
- oxygen and rental of appliances for the administration thereof as well as respiratory assistance devices;
- purchase of artificial limbs (including stump socks), and artificial eyes;
- purchase of mammary prostheses when required following a mastectomy, subject to a maximum reimbursement of $300 per 2 plan years. Surgical brassieres are also covered, up to a maximum of 2 brassieres per plan year.
- purchase of capillary prostheses required for medical reasons, subject to a maximum reimbursement of $500 per plan year.
- charges for medical elastic stockings, subject to a maximum reimbursement of $25 per Insured, per plan year;
- purchase of intrauterine contraceptive devices (I.U.D.),
- purchase of a reflectometre or glucometre, subject to an overall maximum reimbursement of $250 per period of 60 consecutive months;
- purchase of an insulin pump including disposable peripherals;
- purchase of supplies relating to colostomy, ileostomy and ureterostomy.

7. Intraocular lenses

The cost of intraocular lenses implanted during cataract surgery, subject to $200 per eye per period of 24 months.

8. Dental care

Dental services required to repair and replace sound natural teeth damaged due to an accidental blow received while the person is insured under this benefit. Treatment must begin within 90 days following the accident and be rendered within two years of that date.

The eligible amounts are set in accordance with the suggested Fee Guide for Dental Services approved by the Dental Surgeons' Association of the Insured's province of residence.

9. Intrauterine contraceptive device (IUD)

Charges for the purchase of an intrauterine contraceptive device (IUD).

10. Paramedical services (without medical recommendation)

The services of an acupuncturist, audiologist, chiropodist, chiropractor, dietician, homeopath, massotherapist, naturopath, occupational therapist, osteopath, physiotherapist (or rehabilitation technician or athletic therapist), podiatrist, psychologist, psychotherapist and speech therapist, subject to a maximum reimbursement of $1,500 per Insured, per plan year, for all professionals combined.

Also included are charges for x-rays taken by a professional mentioned above, up to an eligible maximum of $50 per Insured, per plan year, for all professionals combined.

11. Hearing aids

Purchase and repair of hearing aids, subject to a maximum reimbursement of $500 per 3 plan years.

12. Orthopaedic shoes

Purchase of orthopaedic shoes, namely deep shoes and custom-made shoes, as well as podiatric ortheses, subject to a maximum of two pairs of shoes and two pairs of ortheses per Insured, per plan year. Purchases must be made from a recognized orthopaedic supplier. A medical recommendation must be presented to the Insurer with the initial purchase and with all subsequent purchases.

EXCLUSIONS

The following expenses are not reimbursed under the plan:

- Medical care to which you or your dependents are entitled under any federal or provincial government legislation or that is covered under such legislation.
- Services, treatments or products received free of charge.
- Services, treatments or products for experimental purposes.
- Preventive care (except vaccines and the eligible annual health assessment).
- Cosmetic treatment or prostheses.
- Services of a nurse, at home, when acting as a midwife or psychotherapist, or when services other than nursing care are provided.
- Dental services, with the exception of treatment rendered after an accident.
- With the exception of intrauterine contraceptive devices (I.U.D.), all processes relating to family planning, including artificial insemination and laboratory, drugs or any other charges incurred in any infertility treatment.
- Charges incurred to obtain medical certificates.
- All charges, services, articles or supplies that do not appear on the above ELIGIBLE EXPENSES list.
- Services rendered by a person who usually resides with the Insured, or who is related to the Insured by blood or marriage.
- All charges that would not have been made if no insurance coverage had existed.
- Charges for any care, treatment, services or products other than those declared necessary by competent authorities.
- Charges incurred outside the province of residence (these are covered by the Travel Insurance).
- All expenses incurred due to an illness or accident covered under any Workers' Compensation statute or similar legislation.
- <u>Eligible charges incurred because of</u>
  - bodily injuries the Insured self-inflicts intentionally, whether sane or not;
  - injury sustained during active participation in a civil commotion, riot or insurrection, except while performing the duties of your occupation, or injury sustained during war;
  - the commission or attempt to commit a criminal act.

TERMINATION OF BENEFIT

The ACCIDENT/SICKNESS INSURANCE coverage ends at your retirement or the termination of employment, whichever occurs first. Coverage for your dependents ends either on the date you cease to be covered (but not upon your death) or on the date they no longer meet the definition of dependent, whichever occurs first.

SURVIVORS' BENEFITS

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

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

TRAVEL INSURANCE

TO BE COVERED UNDER THIS BENEFIT, YOU AND YOUR DEPENDENTS MUST AT ALL TIMES BE COVERED UNDER THE GOVERNEMENT HEALTH INSURANCE PROGRAM IN YOUR PROVINCE OF RESIDENCE.

The Travel Insurance includes three sections:

i. Hospital and Medical Travel Insurance
ii. Trip Cancellation and Interruption Insurance
iii. Baggage Insurance

Payment of eligible expenses is limited to amounts that are in excess of coverage provided by any other plan. Where a court determines that the policy and any other plan(s) provide primary coverage, this benefit will be coordinated with the other plan.

To be reimbursed, incurred eligible expenses must first be authorized by Canassistance.

All amounts of money mentioned below, as well as all sums payables under this benefit, are in the legal currency of Canada.

Specific definition

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

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

Stable means the Participant, in the 90 days before the departure date (or 90 days before the booking date for Trip Cancellation and Interruption Insurance), has not:

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

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

HOSPITAL AND MEDICAL HEALTH INSURANCE

This insurance benefit covers emergency expenses occurring when you and your dependents are travelling outside of your province of residence.

The plan reimburses all usual and reasonable expenses incurred following an emergency situation resulting from an accident or an illness, up to a lifetime maximum of $5,000,000 per Insured.

Eligible treatments are those declared necessary to stabilize the medical condition and benefits are additional to those provided for by government plans.

Hospital, medical and paramedical expenses

- The cost of hospital services that exceeds the amount refundable under the government health program in your province of residence.
- Expenses inherent (telephone, television, parking, etc.), to hospitalization up to a maximum of $100 per hospitalization.
- The difference between the fees charged by a physician and the benefits provided under the government health program in your province of residence.
- The purchase or rental cost of crutches, canes or splints and the rental cost of standard manual wheelchairs, orthopaedic devices and other medical appliances, when prescribed by the attending physician.
- Fees of a registered nurse (other than a relative) for private care while hospitalized and when prescribed by the attending physician.
- Charges for laboratory tests and X-rays when prescribed by the attending physician.
- The cost of drugs prescribed by a physician when they are required for an emergency treatment.
- Dental treatment required to repair or replace sound natural teeth damaged as the result of an accidental blow to the mouth, up to a maximum refund of $2,000 per accident for each Insured. Treatment must begin during the period of coverage and be completed within six months of the accident.
- Fees of a dental surgeon for any other emergency treatment required to relieve pain are reimbursed up to a maximum of $200 per Insured.

Transportation expenses

The following services must be approved and planned by Canassistance:

- The cost of ground or air ambulance for transportation to the nearest qualified medical facility, including inter-hospital transfer when the attending physician and Canassistance determine that existing facilities are inadequate to treat or stabilize the patient's condition.
- The cost of repatriating the Insured to his province of residence to receive immediate medical attention, following authorization of the attending physician and Canassistance.

- The cost of simultaneously repatriating a travelling companion or any member of the Insured's immediate family also covered under this benefit, if he is unable to return to the departure point by means of the transportation initially planned for such return.
- The economy class-round trip fare for transportation of a family member going to
  - the hospital where the Insured has been confined for more than 7 days, or
  - to identify the deceased, where required, prior to disposal of the body.
- The cost of returning an Insured's vehicle, either private or rental, by a commercial agency, subject to a maximum refund of $1,000. A medical certificate is required from the attending physician, stating that the Insured is incapable of using his vehicle.
- Up to $7,500 for the cost of preparing and transporting the mortal remains (excluding the cost of a coffin), or for the cost of cremation or burial at the place of death.

Subsistence allowance

Up to $3,000 (maximum of $150 per day for up to 20 days) for accommodation and meals in a commercial establishment, when your return must be delayed due to sickness or bodily injury to yourself, or to an accompanying member of your immediate family, or to a travelling companion.

Travel Assistance

The Insurer provides you, through Canassistance, with a toll free emergency hotline, 24 hours a day, seven days a week, to assist you if you must consult a physician or require hospitalization following an accident or sudden illness. Canassistance will intervene where required and provide the following supportive services :

- For the State of Florida, direct the Insured to an appropriate clinic or hospital in the Preferred Patient Care network.
- For the State of South Carolina, direct the Insured to an appropriate clinic or hospital in the Preferred Personal Care network.
- For all other destinations, direct the Insured to an appropriate clinic or hospital and advance funds to the hospital, if necessary.
- Confirm the medical insurance coverage to spare the Insured a substantial monetary deposit.
- Ensure follow-up of the medical file and communicate with the family physician.
- Co-ordinate repatriation, when necessary.
- Co-ordinate the safe return home of dependent children, if a parent is hospitalized.
- Make the necessary arrangements for transporting a family member to the patient's bedside if you are hospitalized for at least seven days and if the attending physician advises such attendance.
- Co-ordinate the return of your vehicle if you are unable to bring it back due to illness or accident.

You will also be provided with the following services:

- Toll-free assistance lines available 24 hours a day and seven days a week
- Transmittal of urgent messages
- Co-ordination of claims
- Services of an interpreter for emergency calls
- Referral to legal counsel in the event of a serious accident
- Settlement of formalities in the event of death
- Assistance in the event of loss or theft of identity papers
- Information regarding embassies and consulates.

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

TRIP CANCELLATION AND INTERRUPTION INSURANCE

The amount of benefits of the Trip Cancellation and Interruption Insurance is limited to expenses that can not be reimbursed at the time of the event causing the cancellation, subject to a maximum of $3,000 per Insured and per event.

Notification

Upon the occurrence, prior to the departure date, of an event listed amongst the insured risks, the Insured must contact the travel agent or carrier, as the case may be, within 48 hours of the event in order to cancel the trip. The Insurer must also be notified within the same time limit.

Risks insured

Coverage applies when you must either cancel your trip altogether, or interrupt or prolong it after it has begun, for any of the following reasons.

- Illness, hospitalization, bodily injury, as well as your death or the death of a member of your family, the death of a travelling companion or of a member of his family.
- Illness, hospitalization, bodily injury, death of a business associate or key employee.
- Diagnosis of pregnancy after the date of purchase or of the non-refundable initial deposit for the trip or ticket, if the departure or return date of the trip falls within eight weeks preceding or following the expected date of delivery.
- Summons for jury duty, quarantine, or hijacking.
- Disaster that renders your main residence inhabitable.
- A transfer requested by your employer and requiring that you relocate your permanent residence.
- Summons to police officers, voluntary firefighters, reservists and members of the armed forces (excluding military service during a war, declared or not or participation to peace efforts).

- Delay due to mechanical failure of your vehicle, bad weather, a traffic accident or an emergency roadblock set up by the police which results in the Insured missing a connection or preventing him to continue the trip as planned, provided the vehicle was due to arrive at the transfer point at least two hours before the scheduled departure time.
- Death or hospitalization, prior to departure of your host at destination.
- Subpoena to appear as a witness in a trial to be heard during the trip, excluding law enforcement officers.
- Involuntary loss of your permanent job held with the same employer for at least one year.
- An event in the country of destination that incites the Government of Canada to issue a general recommendation to its citizens urging them to avoid travelling within that country during a period that includes the scheduled trip. Travel arrangements must have been made before the recommendation was disclosed.
- Cancellation of a business meeting due to illness, hospitalisation or bodily injury of the person being met.
- Rejection of your visa application to stay in the country to be visited, provided that you were eligible for such visa and that rejection is not due to late submittal of the application or subsequent to a previous refusal.

ELIGIBLE EXPENSES

In the event of trip cancellation, the plan guarantees reimbursement of the following expenses:

- Pre-paid, non-refundable travel expenses.
- Additional expenses incurred for new occupancy charges when you decide to travel as originally planned when your travelling companion must cancel his trip for a cause that is covered, subject to an amount equal to the cancellation penalty applicable at the time the travelling companion must cancel.
- The additional cost of an economy-air-fare to the point of departure and the unused, non-refundable portion of pre-paid travel expenses, upon the occurrence of a covered risk.

The benefit also guarantees reimbursement of the following expenses:

- Non-refundable, unused pre-paid travel costs, if weather conditions prevent you from transferring from one carrier to another causing an interruption of your trip of at least 30% of the total duration initially planned and if you decide not to pursue your trip.
- The additional cost of an economy-fare (by airline, bus or train) to the destination or vacation point when you miss a connection for one of the following reasons:
  - Delay of the connecting carrier.
  - A traffic accident involving your private or rental vehicle or taxi you occupy.
- Economy-fare to join an excursion or group if you miss part of the trip due to the occurrence, after departure, of one of the risks covered.

- Economy air-fare (one way only) to the point of departure, whenever you must delay your return due to illness or bodily injury sustained by yourself, or a member of your immediate family accompanying you, or a travelling companion.

BAGGAGE INSURANCE

The Baggage Insurance covers the loss or damage to the baggage owned by the Insured during a trip in or outside the province of residence, within the period of coverage, subject to a combined maximum of $500.

In the event the checked baggage is delayed by the carrier for 12 hours or more while en route and before returning to the point of departure, the Insurer will reimburse a maximum of $250, for the purchase of necessary toiletries and clothing. Proof of delay of checked baggage from the carrier along with receipts of purchases must accompany the claim upon presentation to the Insurer when returning from the trip.

This insurance covers expenses to replace passport, driver's license, birth certificate or travel visa in case these documents are lost or stolen, up to a maximum of $50.

Conditions particular to this insurance

- Where loss is due to theft, burglary, vandalism or disappearance, the Insured must notify the police upon discovery of the loss. Failure to report the said loss to the authorities invalidates any claim under this insurance for such loss.
- In the event of loss, the Insured must notify the Insurer as promptly as possible and take all reasonable precautions to protect, safeguard or recover his property and must also promptly notify the police and obtain from them written confirmation regarding such loss. The Insured must obtain written confirmation from the hotel manager, tour guide or transportation authorities. He must furnish proof of loss or damage and value with a sworn statement within 90 days of the date of loss. Failure to comply with these conditions invalidates claims under this benefit.
- If the covered property is checked with a public carrier and delivery is delayed until after expiry of the coverage, coverage will continue until such property is delivered by the public carrier.
- The Insurer is not liable beyond the actual cash value of the property at the time any loss or damage occurs and may elect to repair or replace any damaged or lost property with other of like quality or value.
- Upon the occurrence of any loss for which a claim is made, the amount of the applicable limit of liability is reduced by the amount equivalent to such loss.
- This insurance may not profit, directly or indirectly, any carrier or guarantor.

EXCLUSIONS AND LIMITATIONS

a) ***Applicable to sections i. and ii.***

No benefits are paid to Insureds in the following cases:

- Failure to communicate with Canassistance in the event of medical consultation or hospitalization or an event giving rise to a claim.
- Expenses incurred after you have been repatriated for medical reasons.
- Expenses incurred due to pregnancy or complications arising from it within eight weeks prior to the expected date of delivery.
- Accident sustained while participating in a sport for remuneration, any kind of motor-vehicle or speed contest, gliding or hang-gliding, mountain climbing (routes graded 4 ou 5 according to the *Yosemite Decimal System - YDS*), parachuting or skydiving or bungee jumping.
- Abuse of medication or use of drugs, and driving a motor vehicle, an aircraft or a boat while under the influence of drugs or with an alcohol level exceeding 80 milligrams in 100 millilitres of blood.
- Expenses for any care other than those declared medically necessary.
- Nurses' fees for custodial care or services rendered mainly for the patient's convenience.
- Expenses incurred for cosmetic purposes.
- Expenses incurred outside your province of residence, when such expenses could have been incurred in your province of residence without endangering your life or health.
- Expenses incurred when travelling outside your province of residence primarily or incidentally to seek medical advice or treatment, even if such a trip is on the recommendation of a physician.
- Medical or hospital costs incurred outside your province of residence that are not covered under the government health program in your province of residence.
- The following products are not covered under this plan, even when obtained with a prescription:

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

- Eligible expenses arising from:
  - Suicide, attempted suicide or self-inflicted injury, whether the Insured is sane or not.
  - Injury sustained during the Insured's participation in a public confrontation, a riot or an insurrection;
  - Injury sustained during a war or an act of war, declared or not;
  - Injury or illness resulting directly or indirectly from any force or threat entailing the use of nuclear, chemical or biological agents or weapons by a person, a group of persons or an organization for a political, religious or ideological purpose;
  - Committing or attempting to commit a criminal act.
- Expenses refunded or liable for refund through the government health program in your province of residence.
- For Trip Cancellation and Interruption Insurance, expenses for a trip undertaken to visit or care for a sick or injured person, when this person's medical condition or death is the cause of cancellation, early return or late return.
- For Trip Cancellation and Interruption Insurance, the inability to obtain the desired accommodation, financial difficulties, fear of flying or aversion to the trip.

b) ***Applicable to section iii.***

The benefits are reduced or not payable in the event of or with regard to:

- Loss of or damage to automobiles or automobile equipment, motorcycles, bicycles (unless registered with the carrier), boats, motors or other conveyances or their accessories, household furnishings or accessories, false teeth, artificial limbs, glasses, contact lenses, cash notes, securities, tickets and documents, professional equipment or property, goods brought with the intent of trading them, antiques and collectors items, perishable articles, cosmetics, personal effects, animals or any item that is not part of the usual baggage.
- Breakage of fragile or brittle articles unless caused by fire or theft.
- Loss or damage due to confiscation or damage by order of any government or public authority, or to illegal transportation or trade, war, demonstration or insurrection or hostilities between nations (whether or not war is declared).
- Loss or damage caused by wear and tear, gradual deterioration, moths or vermin or while the article is actually being worked upon or processed.
- Theft from an unattended automobile, trailer or other vehicle, unless such vehicle was securely locked or was equipped with a closed compartment which was securely locked and the theft occurred as a result of forcible entry (of which there must be visible marks).
- The maximum amount payable for loss or damage for each item comprising the Insured's baggage is $125.

For the purpose of calculating the maximum, the following items are grouped in categories, and each category is considered, pursuant to the contract, as a single article:

- **jewelry :** jewelry, watches, silver, gold or platinum items ;
- **furs :** fur or fur-trimmed articles
- **photography equipment :** cameras and photography equipment, video cameras and video or audio equipment.

In addition, the maximum amount payable for loss or damage of the total of the 3 categories mentioned above is $250.

- In the event of the loss of an article which is part of a set, the measure of loss will be in reasonable and fair proportion to the total value of the set, giving consideration to the importance of such article and with the understanding that such loss cannot be construed to mean total loss of the set.
- Loss or damage caused by any imprudent action or omission by the Insured. When an article or personal property in question cannot be located and the circumstances of its disappearance cannot be explained or do not lend themselves to a reasonable conclusion that a theft occurred.
- Loss or damage to articles specifically insured under any other insurance contract at the time this benefit is in effect.

TERMINATION OF BENEFIT

The Travel Insurance coverage ends at your retirement, the termination of employment or when you reach age 75, whichever occurs first. Coverage for your dependents ends either on the date you cease to be covered (but not upon your death) or on the date they no longer meet the definition of dependent, whichever occurs first.

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

SURVIVORS' BENEFITS

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

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

TRAVEL ASSISTANCE LINES

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

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

For better service, be sure to give your name, the number of the phone from which you are calling and your Blue Cross group and certificate numbers.

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

The guidelines and the numbers you must dial to contact CANASSISTANCE appear on the back of your identification card. Do not leave without it.

DENTAL CARE INSURANCE

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

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

Expenses are subject to the deductible, percentages of reimbursement and overall maximums specified in the Benefit Summary for each of the two levels of coverage.

CALCULATION OF ELIGIBLE EXPENSES

The eligible amount for insured services is the amount indicated in the *Suggested Fee Guide for Dental Services* approved by the *Dental Surgeons' Association* or the *Denturists' Fee Guide* of your province of residence (current year edition).

PREDETERMINATION OF BENEFITS

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

ELIGIBLE EXPENSES

STANDARD COVERAGE

Preventive treatment

- examinations and diagnostics
  - Complete oral examination (once every 24 months)
  - Recall oral examination (once every 9 months)
  - Emergency oral examination
  - Specific oral examination
- X-rays
  - Intra-oral films - periapical
  - Intra-oral films – occlusal and bitewings
  - Extra-oral films
  - Sialography
  - Panoramic film (once every 24 months)
  - Radiopaque dyes
- Laboratory tests and examinations
  - Bacterial culture
  - Biopsy
  - Cytological examination
- Preventive treatment
  - Polishing (once every 9 months)
  - Scaling:
    - Insureds under 13 years of age: once per period of 9 consecutive months;
    - Other insureds: Unlimited
  - Application of fluoride (once every 9 months)
  - Oral hygiene instruction (lifetime maximum of two instructions)
  - Pit and fissure sealants (for Insureds under 18 years old)
- Space maintainers (for Insureds under 18 years old).

Basic treatment

- Restorations
  - Amalgam, acrylic, silicate or composite
  - Retentive pins
  - Pre-formed steel or plastic crowns
- Endodontic services
  - Pulp capping
  - Pulpotomy and emergency pulpotomy
  - Endodontic traumatism
  - Root-canal therapy
  - Endodontic surgery
  - Bleaching (endodontically treated teeth)
  - Apexification
- Periodontics
  - Periodontal surgery
  - Provisional splinting
  - Management of acute infections
  - Desensitization (maximum of 3 teeth per period of 12 consecutive months)
  - Other adjunctive periodontal services
  - Periodontal curettage and root planning
- Removable denture adjustments
  - Minor adjustments
  - Rebasing and relining
  - Prophylaxis and polishing
- Oral surgery
  - Removal of erupted tooth (uncomplicated)
  - Complicated surgical removal: Pre-determination of benefits or x-rays is required
  - Surgical excision of cysts and tumours
- General adjunctive services
  - Anaesthesia (related to surgery)
- Temporary dressing for the emergency relief of pain
- Finishing restorations

Major restorative treatment

- Restorations
  - Gold foil (if no other material can be used)
  - Inlays
  - Porcelain inlays (if no other material can be used)
- Other restorative services
  - Cast post
  - Prefabricated metal post
  - Recementation of inlay or crown
  - Removal of crown or inlay
- Crowns (single restorations only), other than pre-formed stainless steel and polycarbonate crowns and replacement of an existing crown if such crown is at least four years old.
- Prosthodontic appliances (e.g. fixed bridgework and permanent removable partial or complete dentures) other than dentures with precision or stress-breaker attachments or precision attachments and telescoping crown units for fixed bridgework, as follows:
  - If such appliance was necessary because of the extraction of at least one natural tooth while insured under this benefit,
  - if the existing appliance is at least five years old, or
  - if the existing appliance is temporary and is replaced by a permanent appliance within twelve months of the installation date of the temporary one.
- Denture repairs (two per 12-month period).

Preventive treatment

- examinations and diagnostics
  - Complete oral examination (one every 24-months)
  - Recall oral examination (one every 6 months)
  - Emergency oral examination
  - Specific oral examination
- X-rays
  - Intra-oral films - periapical
  - Intra-oral films – occlusal and bitewings
  - Extra-oral films
  - Sialography
  - Panoramic film (one every 24 months)
  - Radiopaque dyes
- Laboratory tests and examinations
  - Bacterial culture
  - Biopsy
  - Cytological examination
- Preventive treatment
  - Polishing (once every 6 months)
  - Scaling:
    - Insureds under 13 years of age: once per period of 6 consecutive months;
    - Other insureds: unlimited
  - Application of fluoride (once every 6 months)
  - Oral hygiene instruction (lifetime maximum of two instructions)
  - Pit and fissure sealants (for Insureds under 18 years old)
- Space maintainers (for Insureds under 18 years old).

Basic treatment

- Restorations
  - Amalgam, acrylic, silicate or composite
  - Retentive pins
  - Pre-formed steel or plastic crowns
- Endodontic services
  - Pulp capping
  - Pulpotomy and emergency pulpotomy
  - Endodontic traumatism
  - Root-canal therapy
  - Endodontic surgery
  - Bleaching (endodontically treated teeth)
  - Apexification
- Periodontics
  - Periodontal surgery
  - Provisional splinting
  - Management of acute infections
  - Desensitization (maximum of 3 teeth per period of 12 consecutive months)
  - Other adjunctive periodontal services
  - Periodontal curettage and root planning
- Removable denture adjustments
  - Minor adjustments
  - Rebasing and relining
  - Prophylaxis and polishing
- Oral surgery
  - Removal of erupted tooth (uncomplicated)
  - Complicated surgical removal: Pre-determination of benefits or x-rays is required
  - Surgical excision of cysts and tumours
- General adjunctive services
  - Anaesthesia (related to surgery)
- Temporary dressing for the emergency relief of pain
- Finishing restorations

Major restorative treatment

- Restorations
  - Gold foil (if no other material can be used)
  - Inlays
  - Porcelain inlays (if no other material can be used)
- Other restorative services
  - Cast post
  - Prefabricated metal post
  - Recementation of inlay or crown
  - Removal of crown or inlay
- Crowns (single restorations only), other than pre-formed stainless steel and polycarbonate crowns and replacement of an existing crown if such crown is at least four years old.
- Prosthodontic appliances (e.g. fixed bridgework and permanent removable partial or complete dentures) other than dentures with precision or stress-breaker attachments or precision attachments and telescoping crown units for fixed bridgework, as follows:
  - If such appliance was necessary because of the extraction of at least one natural tooth while insured under this benefit,
  - if the existing appliance is at least five years old, or
  - if the existing appliance is temporary and is replaced by a permanent appliance within twelve months of the installation date of the temporary one.
- Denture repairs (two per 12-month period).

Orthodontic treatment

The plan reimburses reasonable charges for orthodontic treatment when incurred to correct dental irregularities of an adult or a dependent child between the ages of six and 19 at the time treatment begins.

Eligible charges include:

- Oral examination
- Unmounted diagnostic casts
- Removable active appliances for tooth guidance
- Fixed or cemented appliances
- Appliances to control harmful oral habits
- Retention appliances
- Comprehensive treatment

EXCLUSIONS

The following expenses are not covered:

- Treatment or appliance, related directly or indirectly to full mouth reconstruction, or to correct vertical dimension and temporomandibular joint dysfunction.
- Services rendered by a dental hygienist but not administered under the supervision of a dentist.
- Dental services eligible under the Accident/Sickness Insurance.
- Services and supplies relating to any appliance worn in the practice of a sport.
- Expenses that are payable under a public or private plan or that would normally be so if a claim had been submitted.
- All expenses incurred due to an illness or accident covered under any Workers' Compensation statute or similar legislation.
- Services that are not medically required, that are given for cosmetic purposes or that exceed the ordinary services given in accordance with current therapeutic practice (this exclusion does not apply to composite restoration).
- Care or services rendered free of charge, or that would be if there were no insurance coverage, or that are not chargeable to the Insured.
- Expenses incurred for implants.
- Splinting for periodontal reasons, where crowns or inlays are used for this purpose, with or without onlays.
- Expenses incurred as the result of
  - any suicide attempt or any self-inflicted injury, whether the Insured is sane or not,
  - any injury or illness resulting from active participation to civil unrest, riot, insurrection, unless while performing work-related functions, or injury sustained in a war.
- All charges, services, articles or items that are not included in the list of eligible expenses described in this benefit.

Restriction

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

TERMINATION OF BENEFIT

The Dental Care Insurance coverage ends at your retirement or the termination of employment, whichever occurs first. Coverage for your dependents ends either on the date you cease to be covered or on the date they no longer meet the definition of dependent, whichever occurs first.

HEALTH SPENDING ACCOUNT

The Health Spending Account is an account set up in the name of the Participant by the Insurer. The Participant must deposit, at the beginning of the year, the Flex Dollars allocated by ABBVIE that are leftover once the level of coverage has been selected. That money can be used to pay medical or dental expenses with dollars before taxes.

To comply with the tax rules, the Health Spending Account must meet the following criteria:

- only the Employer's money (flex-dollars) can be deposited;
- the Participant must use the money during the same plan year it is deposited in the account or during the following Plan year (otherwise the unused amount is forfeited);
- if the Participant ceases to work for ABBVIE, any amount that is unused within 30 days with respect to expenses incurred before the termination date is forfeited.

* The Participant's surviving spouse, if applicable, will benefit from flex-dollars unused by the Participant on the date of his death, until such amount is exhausted or until the date limit as specified in item b) above, whichever occurs first.

DEFINITION OF DEPENDENTS

The definition of dependents is the same as appears in the section DEFINITIONS of this booklet.

EXPENSES ELIGIBILITY CRITERIA

The expenses that can be considered under the Health Spending Account must

- qualify as tax deductible under the Canadian Income Tax Act
- not be paid under any other private or government plan.

ELIGIBLE EXPENSES

The Health Spending Account can reimburse the following expenses:

- deductible;
- portion of expenses not reimbursed under the Health and Dental Care Insurance benefits;
- health or dental expenses in excess of maximum coverage amounts;
- expenses not covered under the Health and Dental Care Insurance benefits.

The expenses eligible for reimbursement under the Health Spending Account are the following:

- over-the-counter drugs, provided they are prescribed by a physician;
- insulin infusion pumps, or devices to mesure the blood sugar level of an Insured with diabetes;
- supplies required by reason of incontinence caused by illness, injury or affliction;
- prescribed eyeglasses or contact lenses ;
- laser eye surgery;
- injections for the treatment of varicose veins;
- in vitro fertilization procedures and follow-up visits;
- artificial limbs; artificial kidney machine, charges for the repair and maintenance of the appliance and supplies;
- services of practitioners such as a dietician and dental hygienist;
- services of a dental prosthesis maker or denturologist;
- ambulance transportation;
- rocking bed for poliomyelitis patients;
- power-operated wheel chair, scooter and geriatric chair on wheels;
- mechanical device or equipment to assist a person to enter or leave a bathtub or shower, or to get on or off a toilet ;
- renovations and alterations to a home when the Insured has a severe and prolonged mobility impairment;
- power-operated lift or transportation equipment designed exclusively for use by, or for, an Insured who is disabled to allow him access to a building or to a vehicle;
- a laryngeal speaking aid and artificial larynx;
- rehabilitative therapy, including training in lip reading and sign language to adjust for the patient's hearing or speech loss;
- device or equipment designed exclusively for use by an Insured suffering from a severe chronic respiratory ailment or a severe chronic immune system disregulation, but not including an air conditioner, humidifier, dehumidifier, heat pump or heat or air exchanger;
- seeing-eye dog for the blind and the deaf;
- teletypewriter or similar device, including a telephone ringing indicator, that enables an Insured who is deaf or mute to make and receive telephone calls;
- optical scanner or similar device designed to enable an individual who is blind to read print;
- device designed to be attached to an infant diagnosed as being prone to sudden infant death syndrome in order to sound an alarm if the infant ceases to breathe;
- any other expense qualifying as a medical expense tax credit.

HOW TO SUBMIT A CLAIM

How to Obtain a Claim Form?

Health benefit (Drug insurance, Accident/Sickness insurance, Travel in Canada insurance, Dental care insurance) and Health Spending Account claim forms can be obtained from any one of the following sources:

- the plan member website (see instructions below);
- one of our Quick Pay locations;
- your group benefits administrator; or
- our Customer Information Contact Centre at the toll-free number listed below.

All claim forms for life or disability benefits can be obtained through your group benefits administrator.

How to Submit a Claim?

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

- ***Provider eClaims***

  For Approved Providers who have registered to submit claims to Blue Cross through our electronic claims submission service, our e-claim service allows approved health care professionals to instantly submit claims at the time of service. This eliminates the need for you to submit your claim to Blue Cross and means you only pay the amount not covered under your group benefits plan (if any).

- ***Member eClaims***

  You can quickly and easily submit your health benefit (Drug insurance, Accident/Sickness insurance, Travel in Canada insurance, Dental care insurance) and Health Spending Account claims through our secure plan member website. Simply take or scan a digital image of your paid-in-full receipts and submit it through the applicable link on our plan member website.

- ***Mobile App***

  Filing a claim has never been quicker or easier! Submit your claims through the Medavie Mobile app and have your reimbursement deposited directly to your bank account.
  Visit **www.medavie.bluecross.ca/app** for more information or to download the app.

- ***Quick Pay®***

  Quick Pay® is a unique service of Blue Cross. Through Quick Pay, you may submit all your Health benefit (Drug insurance, Accident/Sickness insurance, Travel in Canada insurance, Dental care insurance) and Health Spending Account claims and receive immediate adjudication and reimbursement.

  Quick Pay provides you with an opportunity to discuss how the claim was adjudicated, Co-ordination of Benefits, subrogation or other details of your benefit program. You meet face-to-face with a customer service representative equipped to answer your questions.

  To find the Blue Cross office or Quick Pay location nearest you, visit our website at **www.medavie.bluecross.ca/ouroffices**.

- You can also mail your completed claim form to the nearest Blue Cross office.

For insurance purposes, you and your dependents are deemed covered under the Hospital and Health Insurance acts of Quebec or of any other province, and under no circumstances will the amount paid by the Insurer to an insured without such coverage ever exceed the amount that would have been paid had he been insured under such acts, unless specified otherwise.

You can submit your claims for **life or disability benefits** to Blue Cross by:

- mail, fax or scan to the address indicated on the applicable claim form;
- dropping the form off at one of our Quick Pay locations; or
- providing them to your group benefits administrator.

Plan Member Website

The plan member website is a secure, user-friendly website that is available 24 hours a day, 7 days a week. The website provides additional information regarding your coverage and other useful options including:

- ***Coverage inquiry:*** Detailed information about your group benefits plan;
- ***Forms:*** Printable versions of Blue Cross forms;
- ***Requests for new identification cards;***
- ***Addition/updating of banking information*** for direct deposit of claim payments;
- ***Member statements:*** view claims history for you and your Dependents;

- ***Record of payments:*** view transactions issued to yourself or the service provider;
- ***Submit claims*** electronically.

To register for the plan member website, visit **www.medavie.bluecross.ca** and log in.

What is the time limit Time to Submit a Claim?

Life Insurance
Blue Cross must receive proof of claim as soon as is reasonably possible and in no event later than 12 months following the date of death.

Drug/Health Insurance
The duly completed claim form must be sent to the Insurer no later than 12 months after the date expenses are incurred.

Travel Insurance in Canada
The duly completed claim form must be filed with the Insurer no later than six months after the date expenses are incurred.

Health Spending Account
Claims under the Health Spending Account must be submitted no later than 180 days following the end of the Plan year during which expenses were incurred.

Who has access to my confidential information file?

The personal information transmitted to us will be kept in your Medavie Inc. and Blue Cross Life Insurance Company of Canada insurance file. This information will be used solely in the settlement of your claims. Only duly authorized employees and representatives of the insurer will have access to this information in the course of the company's current business practices.

Upon a 30-day written notice, you will be entitled to access the information contained in your file and, if necessary, request that it be corrected, according to the provisions of the provincial or federal legislation regarding Privacy applicable in your province of residence. Please forward your inquiries to:

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

COORDINATION OF BENEFITS

The total amount of benefits from all plans can never exceed the amount of expenses.

If you or your dependents are entitled under any other insurance contract to compensation for expenses otherwise payable hereunder, the amount of compensation payable under such other contract will be deducted from the benefits payable hereunder.

The benefits payable under any coverage include benefits to which the Insured would have been entitled had he duly submitted a claim.

Applicable rules

- the expenses incurred by the spouse covered as an employee under another insurance contract, are first reimbursed by his own group plan, and the balance if any by the present plan;
- the expenses incurred by children covered as dependents of both parents are first reimbursed by the plan of the parent with the earlier birth date in the calendar year.

If you and your spouse are separated or divorced, the plan which will pay benefits for your children will be determined in the following order:

1. the pan of the parent with custody of the child;
2. the plan of the spouse of the parent with custody of the child;
3. the plan of the parent without custody of the child;
4. the plan of the spouse of the parent without custody of the child.

LIMITATION OF BENEFITS

For insurance purposes, all Insureds are deemed covered under the Hospital and Health Insurance acts of Quebec or of any other province, and under no circumstances will the amount paid by the Insurer to an Insured without such coverage ever exceed the amount that would have been paid had he been insured under such acts, unless specified otherwise.

APPENDIX

SHORT TERM DISABILITY
(not underwritten by Medavie Blue Cross and provided by the employer)

*Permanent part-time and Temporary Long Term salaried employees **are not eligible** for this coverage.*

This plan provides a continuation of 100% of your regular salary up to 26 consecutive weeks of absence due to illness or injury. A doctor's certificate may be required at any time. Recurrent absence due to illness or injury not separated by at least two consecutive weeks of work will be considered as one absence for the purposes of this plan.

Coverage terminates on the date you reach age 65, on termination of your employment or on the date you retire, whichever occurs first, and as outlined in the General Provisions section.

BUSINESS TRAVEL ACCIDENT PLAN
(This plan is provided by ABBVIE and not underwritten by any Insurer in Canada)

DEATH

In the event of your death as a result of injuries sustained in an accident, while traveling on company business, within 365 days of that date, this plan pays your beneficiary:

5 x your salary to a maximum of $1,000,000 US

The premiums are paid by the Company.

DISMEMBERMENT

This insurance also provides coverage in case serious accidental injuries sustained during business travel (i.e., loss of use of a hand or foot, paralysis). The benefit paid is a percentage of the principal sum payable if accidental loss of life occurs: this percentage varies according to injury severity.