30376 CALEDONIA EARLY CARE

Assurance collective des chambres de commerce

Chambers Plan Employee Benefits

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Benefit Summary

This Benefit Summary forms part of this booklet and should be read with the information in the rest of this booklet. Please see the related benefit sections for more detailed information and any conditions, limitations or exclusions that could apply to your plan.

The booklet is a summary of your group contract. If there are discrepancies between the group contract and the information in this booklet, the group contract will take priority as permitted by law.

Teladoc Medical Experts and myStrength

Teladoc Medical Experts	Teladoc Medical Experts services can help you make medical decisions with confidence. Whether you're dealing with a chronic condition, questioning surgery or facing a life-threatening illness, Teladoc Medical Experts services can guide you in the right direction with the following services: • Expert Medical Opinion • Personal Health Navigator • Find a Doctor / Care Finder
Teladoc myStrength	myStrength is a flexible and comprehensive digital mental health program with proven tools to help you manage stress, depression, sleep quality, and more. Teladoc myStrength can guide you with the following: • **Personalized plan** - myStrength will create a plan designed just for you, based on your needs and goals. • **Recommended digital content and resources** - An in-app coach can help you navigate self-guided activities and tools. • **In-the-moment tools** - Calm yourself down, shift your thinking, get inspired and feel more hopeful.
Termination	These benefits terminate on the Plan Anniversary Date following the Certificate holder's 75th birthday.

Contact Teladoc Medical Experts directly at 1 877 419 2378

Please have your Firm and Certificate numbers ready to identify yourself as a Chambers of Commerce Group Insurance Plan member. When you contact Teladoc Medical Experts services, you will be assigned a Member Advocate (a clinician*) who will assess your medical issue, answer your questions, determine what service would be best to meet your needs and keep you informed about the progress of your case.

- A Member Advocate is assigned for the Expert Medical Opinion and Personal Health Navigator services.

Employee Life Insurance (Option: LVA)

Benefit	Level benefit of $25,000 for Managers and Employees, providing 24-hour coverage of death at any time or place, from any cause.

Living Benefit	Disabled individuals suffering from a terminal illness may be eligible for payment of a Living Benefit equal to the lesser of $25,000 or 50% of their Life Benefit.
Reduction	Coverage will reduce at age 65 to 25% of the face value.
Termination	Insurance will terminate on the Plan Anniversary Date following your 75th birthday.

Accidental Death & Dismemberment (Option: LVA)

Benefit	Level benefit of $25,000 for Managers and Employees.
Accidental Dismemberment	A benefit is paid if you suffer a loss (or use) of limb and/or sight as listed below: • 200% of Principal Sum for: Both Arms, Both Legs, Both Hands, Both Feet, Quadriplegia, Paraplegia, Hemiplegia, Use of Both Arms, Use of Both Legs, Use of Both Hands, Use of Both Feet • 100% of Principal Sum for loss of: Life, Entire Sight of Both Eyes, One Hand and One Foot, Either Hand or Foot and Sight of One Eye, Speech and Hearing in Both Ears, Brain Death, Use of One Hand and One Foot, Use of Either Hand or Foot and Entire Sight of One Eye • 75% of Principal Sum for loss of: One Arm, One Leg, One Hand, One Foot, Sight of One Eye, Speech, Hearing (in Both Ears), Use of One Arm, Use of One Leg, Use of One Hand, Use of One Foot • 33% of Principal Sum for loss of: Hearing (in One Ear), Thumb and Index Finger of Either Hand, Four Fingers of Any One Hand, Use of Thumb and Index Finger of Either Hand, Use of Four Fingers of Any One Hand • 25% of Principal Sum for loss of: All toes of one foot
Additional Provisions	You may also be entitled to additional benefits including: • Day Care Benefit • Education costs for Dependent Children (up to $10,000/year) • Home Alteration and Vehicle Modification • In Hospital Benefit (up to $2,500/month) • Psychological Therapy (up to $5,000) • Rehabilitation costs for re-training (up to $15,000) • Repatriation costs (up to $15,000) • Seat Belt Benefit (an additional 10% of the principal sum) • Spousal Education Benefit (up to $15,000)
Reduction	Coverage will reduce at age 65 to 25% of the face value.
Termination	This benefit terminates on the Plan Anniversary Date following your 75th birthday.

Dependent Life Insurance (Option: 2)

Benefit	$10,000 of Life Insurance coverage for the spouse of the insured. $5,000 coverage for each child of the insured. The face amount is payable in the event of death at any time or place from any cause.

Beneficiary	The employee is the beneficiary of any insurance benefits payable under this coverage.
Termination	Insurance will terminate on the Plan Anniversary Date following the employee's 75th birthday. Dependent coverage also ends if the spouse or child ceases to be a dependent of the employee.

Extended Health (Option: E41)

Voyage Assistance (Emergency Travel Coverage)

To access these services under your Health coverage, contact the Voyage Assistance Coordination Centre at Sigma Assistel's office in Montreal, Quebec.

- Inside Canada or the US: **1.800.465.6390**
- Outside Canada or the US (call collect): **514.875.9170**

Reimbursement	80% coverage of prescription drugs* listed on the ASSURE National Formulary 50% coverage of prescription drugs* NOT listed on the ASSURE National Formulary 100% coverage of Out-of-Country, Hospital and Vision Care benefits 80% coverage of all other eligible benefits *Drugs will be covered at an additional 10% when filled through PocketPills**.** Applicable to plans with less than 100% drug coinsurance. Due to provincial legislation, the 10% additional coinsurance is not available in Quebec. Restrictions on certain types of drugs may apply.
Coverage	There is no overall maximum though specific benefits may have annual or lifetime limits.
Prescription Drugs	Up to **$1,000 per person per calendar year**. Fertility drugs; smoking cessation aids; erectile dysfunction drugs/items; travel vaccines; and drugs, injections or products for treatment of obesity are not covered. The plan substitutes generic equivalents whenever possible. (In Quebec, prescription drug coverage will meet provincial plan requirements) Prescription drug purchases are processed at the pharmacy using the ASSURE card.

Paramedical services	Up to **$300 per specialty per person per calendar year** for the following paramedical specialists: • acupuncturists • audiologists • chiropractors • massage therapists/Registered Kinesiotherapists (RKT)/Kinesiologists • naturopaths • osteopaths • physiotherapists • podiatrists/chiropodists Up to **$500 per specialty per person per calendar year** for the following paramedical specialists: • clinical dieticians • psychologists/social workers/Registered Clinical Counsellor (RCC)/Canadian Certified Counsellor (CCC)/Psychotherapist or any other certified mental health practitioner covered under the plan and belonging to an accredited association or organization that answers to a disciplinary committee (subject to the approval of the Insurance Company). • speech therapists All Paramedical services have a combined annual maximum of $2,500 per certificate.
Vision Care	Maximum benefit is **$200 per person**. The maximum applies to any 24 month period for adults, and any 12 month period for children.
Eye exams	Up to **$75 per adult** every 24 months; **$75 per child** every 12 months.
Hospital	Semi-private / convalescent hospital.
Nursing care	Up to **$25,000 per person** every 24 months.
Hearing aids	Up to **$500 per person** every 48 months.
Ambulance	Transport as a result of emergency or in-patient treatment - ground: **unlimited** / air: **$4,000 per calendar year**.
Dental Accidents	Dental repairs as a result of an accident while insured - up to **$2,000 per person per calendar year**.
Other services and equipment	Medical Equipment, up to a combined maximum of **$2,000* per year** (some items may have annual, lifetime or other limits), including: • wheelchairs, hospital beds, • respirators, oxygen (including CPAP and sleep apnea appliances), • breast prosthesis, artificial limbs, eyes, • braces for limb truss, walking aids, wigs as a result of chemotherapy • diabetic, colostomy and ileostomy supplies. **rental, purchase or repair of a wheelchair; rental or purchase of a hospital bed or respirator and oxygen to a lifetime maximum of $1,000 each (at the discretion of the Insurance Company)*

	Orthotics up to **$200 per person** per calendar year. Orthopaedic shoes (custom designed) up to **$225 per person** per calendar year.
Medical Travel Benefit	Travel costs for medically necessary treatments, up to **$750 per person** every 24 months.
Medical Emergency Assistance / Travel Health Benefits	24 hour emergency assistance finding medical help abroad, including emergency medical payments and evacuation, where required. Hospital and physician charges for emergency treatment outside Canada. The Plan covers the first number of days of a trip based on the age of the certificate holder, as follows: • up to age 65 - 180 days; • age 65 to 69 - 90 days; • age 70 to 74 - 60 days; and • age 75 to 80 - 30 days.
Survivor Benefit	24-month Survivor Benefit for a deceased employee's insured spouse and dependents.
Teladoc Telemedicine	Your Extended Health Care benefit under Chambers Plan includes free access for you and your insured dependents to Teladoc® Telemedicine – a global service providing convenient access to high-quality care to millions of people in more than 130 countries. Teladoc telemedicine service allows you to consult with a physician about non-urgent medical matters by video conference or by phone, from wherever you are in Canada or the United States, 24 hours a day, 365 days a year. During your visit, you can receive a diagnosis, treatment recommendations, and even be prescribed medication when necessary.
Teladoc Mental Health Navigator	Teladoc's Mental Health Navigator includes free access for you and your insured dependents to Mental Health Navigator. The program offers guidance and navigation to members with a mental health condition seeking an expert opinion on an existing diagnosis and treatment. You are supported every step of the way by your personal navigator and expert mental health professionals including Canadian psychiatrists and psychologists. You will be provided an assessment of your diagnosis and recommended an appropriate treatment plan.
Termination	All health benefits will cease on the day following the day last worked, but no later than the Anniversary Date following your 80th birthday.

Dental (Option: D32)

Reimbursement	80% coverage of Basic services
Deductible	$25 single / $50 family calendar year deductible.
Fee Guide	Benefits are based on your Province's current Dental Fee Guide.
Maximums	$700 maximum per person per calendar year (plans for 1 & 2 person firms have a $2,500 per calendar year family maximum).

Coverage	***Basic*** services covered: • Recall Exams (Check-up) - 2 times (anytime) within the calendar year • Complete Exams (Dental history) - once every 36 months • Tests, lab exams, treatment planning • Fluoride treatments - 2 times (anytime) within the calendar year • Polishing - 2 units (anytime) within the calendar year • Scaling - 4 units (anytime) within the calendar year • X-rays including 1 full mouth series and panoramic film every 24 months • Consultations / Pit and fissure sealants • Space maintainers for children • Fillings (nonbonded, composite, acrylic & silicate) • Extractions of impacted teeth and simple extractions • Oral surgery • General anaesthesia (if performed in conjunction with oral surgery) • Relining and rebasing of dentures • Repairs to dentures / fixed bridgework • Oral Hygiene Instruction is not covered under the Plan ***Endodontic and Periodontal services*** are not covered.
Survivor Benefit	24-month Survivor Benefit for a deceased employee's insured spouse and dependents.
Termination	All dental benefits will cease on the day following the last day worked, but no later than the Anniversary Date following your 80th birthday.

Arive Employee Assistance Program (Option: A1)

Arive (Employee Assistance Program)

Access Arive Employee Assistance services by calling **1.877.412.7483**

Benefit	The Employee Assistance Program (EAP) provides up to a total of 12 hours of in person, video or telephone counselling per Certificate holder per year, per family unit to address issues like: • Personal and relationship counselling • Work-related challenges • Addiction or dependency concerns • Family challenges Telephone consultation is also available for assistance with: • Legal issues and financial concerns (to a maximum of three hours each, per family unit, per calendar year) • Nutritional guidance • Eldercare issues • Childcare navigation support
Termination	This benefit terminates on the Plan Anniversary Date following the Certificate holder's 75th birthday.

Business Assistance Service (BAS)

Providing owners the resources to help manage their business more efficiently at NO ADDITIONAL COST.

MANAGEMENT SERVICES | Provides up to nine hours of Legal, Accounting and Specialized Human Resource services combined, per calendar year (*time used after nine hours is contracted directly with the professional and is the sole responsibility of the individual or organization).*

Legal Advice | When faced with a legal dilemma, this service provides practical and current interpretations of company, partnership, taxation and insolvency law, plus all relevant aspects of common and civil law. Receive answers to questions concerning shareholders, directors, employees, creditors and other stakeholders, including consumers, the community and the environment.

Accounting Advice | When the numbers don't add up, advice from a professional enables owners and managers to strengthen management and control functions through expert counsel. Obtain answers and recommendations to solve business accounting challenges, make informed compliance decisions and better manage company finances.

Specialized Human Resource Services | When facing a technical human resource issue, from termination processes and overtime pay to legislative/labour law concerns, this service provides you answers confidentially, via telephone.

HUMAN RESOURCE COACHING | Confidential telephone coaching helps address a wide range of challenging people issues, including performance management, absenteeism, conflict and difficult behaviour. The coaching service provides up to 30 minutes of service per call, to a maximum of two hours per issue, for unlimited issues per calendar year.

CONFIDENTIAL EMPLOYEE REFERRAL | When an employee is consistently absent from work, or underperforming, there is a strong probability a personal issue is the cause. You now have the resources available to help employees deal with the four most common situations affecting performance:

Work-related / Dependency / Marital and family / Personal problems

Help your staff get back on track, and back to work, through face-to-face counselling with a trained professional. This referral service includes up to three hours of counselling per insured employee, per calendar year (*if the firm also has Arive EAP, the total number of hours under both BAS and EAP will not exceed the annual maximum of the EAP benefit. Physical health conditions and issues are not covered by this benefit).*

Bereavement Counselling | The survivor bereavement benefit provides counselling for up to three months for the dependents of an insured employee who dies.

Counselling Extension | Employees undergoing counselling at the time of termination of their group policy will be offered a further two hours of consultation. This ensures adequate time to transfer to another professional.

ACCESS IS SIMPLE

The Chambers Plan has retained Arete® Human Resources Inc. as the independent service provider of Business Assistance Service.

To access the Management Services and Human Resource Coaching, call Arete's toll-free number 1.877.922.8646 and have your Firm number and your organization's name, as shown on your policy, on hand. A trained specialist will ask some basic questions to identify how best to help you. Contact with a professional lawyer, Certified Accountant or Certified General Accountant, or Human Resource specialist will be arranged for your telephone counselling services.

To access the Confidential Referral to assist employees, please have your employee call Arete's toll-free number 1.877.922.8646, and ensure they have their Firm and Certificate number handy. A representative will assist them in connecting with a counsellor for their specific need.

Hugr: Authentic Connections

Hugr is a mental wellness app designed to help people feel connected. The self-guided digital program can help users measure their level of social connection, discover how to build and maintain authentic connections, and regularly share how they're feeling with those closest to them.

As a Chambers Plan member, the premium version of Hugr is free to you, and can be downloaded from the App Store or Google Play.

- **DISCOVER your level of social connection** by completing self-awareness check-ins—identifying strengths and opportunities for growth and action.
- **DEVELOP evidence-based skills** to identify and close gaps in your social connections through iCBT-based learning.
- **TRACK and view trends** to see correlations in your social connections, experience at work, loneliness, isolation and anxiety.
- **SHARE your journey with those closest to you** so the caring and trusted people in your lives can seamlessly know how you're feeling.

Teladoc Medical Experts

General description of coverage

Every Chambers Plan program also includes Teladoc Medical Experts services. Teladoc Medical Experts is a confidential service offered to you and your eligible dependents as part of your employee benefits. They help provide clarity, confidence, and understanding if you have any concerns or doubts about a diagnosis, need help deciding on a treatment option, or question the need for surgery.

Their leading medical experts provide a wide range of services to help you and your treating physician make the best possible decision for your health. Teladoc Medical Experts gives you the peace of mind you deserve under any medical circumstance.

As part of your Teladoc Medical Experts benefit, your parents and parents-in-law have access to the same expert medical benefits as you.

As long as you are insured under the Chambers of Commerce Group Insurance Plan, you and your dependents will have unlimited access to the following:

Expert Medical Opinion	Review of an existing diagnosis and treatment from a world-renowned expert to confirm them or recommend a change. More than a second opinion regarding a medical diagnosis or treatment plan, Teladoc Medical Experts will conduct an in-depth analysis of your medical records, including imaging scans, X-rays, test results and any available pathology (which can be retested). You will receive a written summary of their findings, which includes diagnosis and treatment recommendations that you can share with your doctor.
Personal Health Navigator	Teladoc Medical Experts can help you navigate the Canadian healthcare system and get you the information you need for a variety of health topics. Teladoc Medical Experts provides you with a variety of tools and resources when you're facing medical uncertainty, and can offer advice and wellness support if you need it. You'll gain peace of mind knowing you're making an informed decision about your healthcare.
Find a Doctor	If you're searching for a local specialist let Teladoc Medical Experts do the work for you. They provide names of specialists and take into account your unique medical history and geographic location, matching you with the right physician for your condition.
Care Finder	If you need a specialist outside of Canada they can make it possible through their Care Finder service. They will cater the search to your unique medical history and geographic location, as well as availability of the specialist and/or facility.

Accessing Teladoc Medical Experts Services

Contact Teladoc Medical Experts directly at **1 877 419 2378**. Please have your Firm and Certificate numbers ready to identify yourself as a Chambers of Commerce Group Insurance Plan member. When you contact Teladoc Medical Experts services, you will be assigned a Member Advocate (a clinician*) who will assess your medical issue, answer your questions, determine what service would be best to meet your needs and keep you informed about the progress of your case.

** A Member Advocate is assigned for the Expert Medical Opinion and Personal Health Navigator services.*

Teladoc Medical Experts services are available without charge to all Chambers Plan insureds and their dependents as defined in your benefit plan as well as your parents and parents-in-law. You are responsible for any expenses associated with medical treatment (not covered by your provincial or health care plan), travel and lodging. Teladoc Medical Experts does not make referrals or appointments for members.

Teladoc myStrength

General description of coverage

MyStrength is a self-guided platform that uses a digital-first approach to delivering evidence-based interventions, including cognitive behavioral therapy, acceptance and commitment therapy, positive psychology, mindfulness and motivational interviewing to help resolve clinical conditions, build resiliency, manage stress, improve mood, sleep better or simply find daily inspiration.

myStrength provides guidance for a full spectrum of mental health needs, which might range from depression to stress and relationship support. myStrength's evidence-based resources address key focus areas, including depression, stress, anxiety, drug, alcohol and opioid recovery, chronic pain, mindfulness and meditation, elder care, focused support for 2SLGBTQIA+ people, insomnia, balancing emotions, weight management, smoking cessation, and lifestyle topics (parenting, relationships and more).

It is also a convenient and effective mental health support. You have access to the guidance of an in-app coach to explore a personalized program of digital in-the-moment tools, activities, and resources based on your individual mental wellness needs and goals.

As long as you are insured under the Chambers of Commerce Group Insurance Plan, you and your dependents will have unlimited access to the following:

Personalized plan	myStrength will create a plan designed just for you, based on your needs and goals.
Recommended digital content and resources	An in-app coach can help you navigate self-guided activities and tools.
In-the-moment tools	Calm yourself down, shift your thinking, get inspired and feel more hopeful.

Accessing myStrength

You can access myStrength with your Teladoc account. You can create an account or sign in by visiting Teladoc.ca or by downloading the Teladoc app.

From there, you go through a brief set of scientifically validated assessments to be directed to the optimal program. Although these assessments are used for diagnosis in clinical settings, the use of them via myStrength does not constitute a diagnosis.

myStrength is available without charge to all Chambers Plan insureds and their dependents as defined in your benefit plan.

Employee Life Insurance

General description of coverage

The amount of your coverage is shown on the *Certificates of Insurance*. This is called the face amount. Life insurance coverage decreases to 25% of the face amount on the Policy Anniversary (April 1) on or after your 65th birthday.

Benefit

Group Life provides 24-hour coverage of death at any time or place, from any cause. If your insurance ends and you die within 31 days, benefits are payable equal to the amount of life insurance you were entitled to under the *Conversion Option*.

Beneficiary	A beneficiary is the person assigned to receive the Group Life benefit in the event of your death. If there is no living beneficiary when you die, the life insurance proceeds are payable to your estate. Life insurance benefits are not taxable. However, the beneficiary or the estate is responsible for tax on any interest which accrues on the benefit, from the date of your death to the date the funds are paid by the Insurance Company. With regards to life insurance only and subject to legal provisions, you may designate or revoke, at any time, one or several beneficiaries of the insurance on written notice. The rights of a beneficiary who dies before you reverts to the latter.
Change of Beneficiary	You can change the beneficiary at any time, subject to any limits set by law. To do so, complete an *Employee Change Request* and mail the completed request to the Plan Administrator.
Waiver of Premium	If you become totally disabled before age 65 and while insured for this benefit, you keep this life insurance coverage (subject to any age limit reduction) as long as you remain disabled. If your plan includes Long Term Disability coverage, you will be considered totally disabled as defined under your Long Term Disability benefit. While you are receiving monthly income payments, no further life insurance premiums are required. If your plan does not include Long Term Disability coverage, to be considered totally disabled, you must be unable, as a result of sickness or injury, to engage in any gainful occupation for which you may become reasonably qualified by training, education, or experience. Proof of continuous total disability will be required periodically. After 6 months of continuous total disability, and on approval from the Insurance Company, no further life insurance premiums are required. Partial disability does not qualify you for any waiver of premium.

Living Benefit	A terminally ill employee may request an advance of life insurance benefits equal to the lesser of $25,000 or 50% of the face amount. You must provide satisfactory evidence to the Insurance Company that death will most likely occur within 12 months, be totally disabled for at least six months and be approved for Life Waiver of Premium. The employer and any designated beneficiary must consent to the payment. At your death the advanced funds plus interest are deducted from the face amount.
Conversion Option	Life insurance ends 31 days after the date of termination of coverage. An employee under the age of 66 may apply to the Insurance Company to convert the group life coverage to an individual policy. No medical evidence is required as long as written application is submitted and the first premium is paid within 31 days of the date of termination. If you are converting this insurance due to the firm's termination, you and the firm must have been insured continuously with this plan for five years prior to termination.
Extension of Benefit	If you die within 31 days of the termination of the insurance under this benefit, the amount of life insurance you were eligible to convert will be payable.

Claims

A completed claim form must be submitted to the Plan Administrator within 90 days of death. Before settling any claim, written proof of the occurrence, cause and circumstances of the death will be required. Written proof means a completed claim form accompanied by either an original funeral director's statement or original death certificate. Notarized copies of the funeral director's statement or death certificate will be accepted if originals cannot be submitted.

All benefits described here are governed by the Master Contract underwritten by Desjardins Financial Security Life/Assurance Company.

Accidental Death & Dismemberment (AD&D)

General description of coverage

The policy provides a lump sum benefit to help ease the financial impact and assure your family's needs are met if you should suffer loss of life as a result of an accident. Your accident coverage also provides you with 'living benefits' should an accident leave you paralyzed or should you lose through severance, or loss of use of a limb, sight, speech or hearing.

You are automatically covered for a Principal Sum equal to the amount of insurance shown on your *Certificate of Insurance*. Your plan provides generous Accidental Death & Dismemberment benefits for injuries as a result of covered accidents. Your coverage is in force around-the-clock, at work, at home or at play, anywhere in the world.

Benefits and Coverages

Permanent Total Disability Benefit	Benefit Amount Equal to the Principal Sum
Comatose Benefit	Maximum Benefit Amount Not to exceed the Principal Sum
Repatriation Benefit	Benefit payable on an expense incurred basis Maximum Benefit Amount $15,000
Identification Benefit	Benefit payable on an expense incurred basis Maximum Benefit Amount $15,000
Rehabilitation Benefit	Benefit payable on an expense incurred basis Maximum Benefit Amount $15,000
Rehabilitative Physical Therapy Benefit	Benefit payable on an expense incurred basis Maximum Benefit Amount $10,000
Funeral Benefit	Benefit payable on an expense incurred basis Maximum Benefit Amount $5,000
Bereavement Benefit	Benefit Amount $1,500
Spousal Retraining Benefit	Benefit payable on an expense incurred basis Maximum Benefit Amount $15,000
Special Education Benefit	The actual cost charged by any accredited college, university or other institution of higher learning up to: Benefit Amount - 5% of Principal Sum Maximum Benefit Amount - $10,000 per year Maximum Number of Annual Payments for Each Surviving Dependent Child - 5
Day Care Benefit	The actual cost charged by any accredited day care centre up to: Benefit Amount - 5% of Principal Sum Maximum Benefit Amount - $5,000 per year Maximum Number of Annual Payments for Each Surviving Dependent Child - 5

Family Transportation Benefit	Benefit payable on an expense incurred basis Maximum Benefit Amount $15,000
Home Alteration and Vehicle Modification Benefit	Benefit payable on an expense incurred basis Maximum Benefit Amount - $10,000 or 10% of the Insured Person's Principal Sum to a maximum of $50,000, whichever is greater.
Workplace Accommodation and Alteration Benefit	Benefit payable on an expense incurred basis Maximum Benefit Amount - $7,000
Hospital Confinement Monthly Income Benefit	Benefit Amount 1% of Principal Sum Maximum Benefit Amount $2,500
Burn Benefit	Benefit payable according to the Burn Schedule shown in the Burn Benefit Maximum Benefit Amount $25,000
Psychological Therapy Benefit	Benefit payable on an expense incurred basis Maximum Benefit Amount $5,000
Critical Disease Benefit	Benefit Amount 10% of the Principal Sum Maximum Benefit Amount $5,000
Seat Belt Benefit	10% of benefit payable
Felonious Assault Benefit	Benefit Amount 10% of benefit payable
Waiver of Premium Benefit	As outlined in this Policy
Continuation of Coverage Benefit	As outlined in this Policy
Conversion Privilege	As outlined in this Policy

Additional Limitation(s) and/or Exclusions

In addition to the exclusions shown under the Exclusion section(s) of this Policy, the following limitation(s) and/or exclusion(s) also apply to coverage provided under this Policy: Not applicable

Definitions

For the purposes of this Policy, certain words with specific meanings are capitalized throughout the document. The definition of any word, if not defined in the text where it is used, may be found in the Schedule of Benefits or in this Definitions Section.

ACCIDENT means a single sudden, unexpected event that results in bodily Injury to the Insured Person at the time the event occurs, arises from an external source to the Insured Person and occurs at an identifiable time and place.

ACTIVELY AT WORK means the Insured Person is present at his or her usual place of employment with the Policyholder, or is at another location as assigned or directed by the Policyholder, and is mentally and physically capable of performing the regular duties of the job for which he or she is employed. On any day that is not an Insured Person's regularly scheduled work day (vacation, personal days, and weekends

or holidays) the Insured Person will be considered Actively at Work on such day provided he or she is not absent due to any type of leave and was Actively at Work on his or her last regularly scheduled work day. An Insured Person who usually performs the regular duties of his or her job at their home is considered Actively at Work if they meet all the above requirements and could work at the Policyholder's usual place of employment if required to do so.

ACTIVE SERVICE means an Insured Person is either 1) Actively at Work performing all regular duties on a full time basis either at his or her Employer's place of business or someplace the Employer requires him or her to be; or 2) if not employed, able to engage in substantially all of the usual activities of a person in good health of like age and sex and not confined in a Hospital or rehabilitation or rest facility.

ADMINISTRATOR there are two administrators, a primary and a secondary administrator. Johnston Group Inc. is the primary administrator and Sutton Special Risk Inc. is the secondary administrator.

CONVEYANCE means any motorized craft, vehicle or mode of transportation licensed or registered by a governmental authority with competent jurisdiction.

COVERED ACCIDENT means an Accident that occurs while coverage is in force for an Insured Person and results in a Covered Loss or Injury for which benefits are payable.

COVERED ACTIVITY means any activity indicated in the Schedule of Benefits and insured under the Policy.

COVERED EXPENSES means expenses actually incurred by or on behalf of an Insured Person for treatment, services and supplies covered by this Policy. Coverage under the Policyholder's Policy must remain continuously in force from the date of the Covered Accident until the date treatment, services or supplies are received for them to be a Covered Expense. A Covered Expense is deemed to be incurred on the date such treatment, service or supply, that gave rise to the expense or the charge, was rendered or obtained.

COVERED LOSS or **COVERED LOSSES** means an Injury occurring or Sickness which first manifests itself during the policy period for which an Insured Person is covered under this Policy.

DEPENDENT means an Insured Person's:
1. lawful Spouse, or if there is no such person, a person who qualifies as the Insured Person's common law or domestic partner under the provisions of the laws of the jurisdiction in which the Insured Person resides;
2. unmarried Child(ren) under age 23;
3. unmarried Child(ren) at least 23 years of age but less than age 26 who are:
   (a) not regularly employed on a full-time basis; and
   (b) primarily dependent upon the Insured for support and maintenance; and
   (c) enrolled as a full-time student at an accredited college, university or other institution of higher learning or a vocational or licensed technical school.

The age limitations will not apply to an Insured Person's unmarried Child who is incapable of self-support due to a mental disability or physical handicap. Proof of such incapacity must be furnished to Us immediately upon enrollment or within 31 days of the Child reaching the age limitation. Thereafter proof will be required whenever reasonably necessary, but not more often than once a year after the 2-year

period following the age limitation.

The term “Child” as used herein means the Insured Person’s natural child, legally adopted child, or child placed in the Insured Person’s home for purposes of adoption, foster child, stepchild, or other child for whom the Insured Person has legal guardianship (proof will be required). A child must reside with the Insured Person in a parent-child relationship and be eligible to be claimed as an exemption on the Insured Person’s federal income tax return. NOTE: In the event the Insured Person shares physical custody of the child with another parent, the requirement that the child reside with the Insured Person will be waived.

EMPLOYEE means for eligibility purposes, an Employee, of the Employer, who is in one of the Classes of Eligible Persons.

EMPLOYER means the Policyholder and any affiliates, subsidiaries or divisions shown in this Policy and which are covered under this Policy on the date of issue or subsequently agreed to by Us.

HOSPITAL means an institution that:
1) operates as a Hospital pursuant to law for the care, treatment and providing in-patient services for sick or injured persons; is a duly licensed institution, operated lawfully in its area;
2) provides 24-hour nursing service by registered nurses on duty or call;
3) has a staff of one or more licensed Physicians available at all times;
4) provides organized facilities for diagnosis, treatment and surgery, either
   a)on its premises; or
   b)in facilities available to it, on a pre-arranged basis;
5) is not primarily a nursing care facility, rest home, convalescent home or similar establishment, or any separate ward, wing or section of a Hospital used as such; and
6) is not a facility for the treatment of drug addiction, alcoholism, treatment of the aged.

We will not deny a claim for services rendered in a hospital having one or more of the following accreditations solely because the Hospital lacks major surgical facilities and is primarily of a rehabilitative nature, if such rehabilitation is specifically for the treatment of a physical disability:
1) the Joint commission of Accreditation of Hospitals; or
2) the American Osteopathic Association; or
3) the Commission on the Accreditation of Rehabilitative Facilities.

HOSPITAL CONFINED OR CONFINEMENT means any period for which a charge for room and board is made by a Hospital; or any period during which an Insured Person incurs Covered Medical Expenses as a result of emergency care within 72 hours following an accidental bodily injury; or any period during which an Insured Person incurs Covered Medical Expenses as a result of surgery performed at a Hospital on an out-patient basis.

HOSPITAL STAY means a stay of 24 or more consecutive hours as a registered resident bed-patient in a Hospital.

IMMEDIATE FAMILY MEMBER means the Insured Person, the Insured Person’s spouse, and the parents, child(ren) (includes legally adopted or step child(ren), brothers or sisters of the Insured Person and of the Insured Person’s spouse.

INJURY means bodily Injury caused by the direct result of an Accident occurring while the Policy is in force as to the Insured Person whose Injury is the basis of the claim which results directly and independently of all other causes in a Covered Loss.

INSTITUTION OF HIGHER LEARNING includes but is not limited to, an accredited institute, college, university, CEGEP or trade school.

INSURED PERSON means an eligible person who is within the covered class(es) listed in the Policy and for whom the required premium is paid when due.

OCCURENCE means all losses or damages that are attributable directly or indirectly to one cause or one series of similar causes. All such losses will be added together and the total amount of such losses will be treated as one occurrence without regard to the period of time or the area over which such losses occur.

PHYSICIAN means a person who is a qualified doctor of medicine. As such, he or she must be acting within the scope of his or her license under the laws in the jurisdiction in which he or she practices and providing only those medical services which are within the scope of his or her license or certificate. It does not include an Insured Person or an Insured Person's spouse, son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law (all of the previous include natural, adopted and step relationships), grandson, granddaughter, grandfather or grandmother or other relative.

PLAN YEAR means the twelve (12) consecutive month period defined for the Policyholder for which the coverage is in force, from the effective date or an anniversary of the Policy.

TRIP means travel by air, land, or sea.

USUAL (REASONABLE) AND CUSTOMARY CHARGES means the amount standardly charged by most providers for treatment, service or supplies in the geographic area where the treatment, service or supply is provided.

WE, OUR, US means the Insurer providing this insurance or its authorized representative Sutton Special Risk Inc.

Accidental Death & Dismemberment Benefit Provisions

Eligibility for Insurance

If the Insured Person is in one of the Classes of Eligible Persons shown on the Policy Schedule of Benefits, he or she is eligible to be covered on the Policy Effective Date; or on the date he or she completes the Eligibility Waiting Period, if applicable and if later.

Insured Person's Effective Date

An Insured Person's coverage under this Policy begins on the later of:

1) the Policy Effective Date;
2) the first day of the Plan Year;
3) the date such Insured Person becomes eligible, subject to any required waiting period; as described in the Schedule of Benefits.

An Insured Person must be Actively at Work as of his or her effective date of coverage. If on the date coverage under this Policy would otherwise take effect, the Insured Person is not Actively at Work, his or her effective date of coverage will be deferred until the day the Insured Person returns to work.

Deferred Effective Date

If the Insured Person is not Actively at Work on the date coverage would otherwise be effective, coverage will be effective on the date he or she returns to an Actively at Work status.

Insured Person's Termination Date

An Insured Person's coverage under this Policy ends on the earliest of:

1) The date this Policy terminates or insurance for a Class of Eligible Person's is terminated;
2) The date the Insured Person enters full-time active duty in the armed forces of any country or international authority;
3) The date the Insured Person ceases to be eligible as described in this Policy provided all required premiums are paid;
4) The last day of the last period for which premiums have been paid;
5) The date the Insured Person is no longer Actively at Work, provided all required premiums are paid, unless otherwise provided in this Policy;
6) The next premium due date after the date the Employee is no longer in a Class of Eligible Persons or satisfies the eligibility requirements under this Policy; or
7) The next premium due date after the Employee attains the maximum Age for insurance under this Policy, as shown in the Schedule of Benefits.

Scope of Coverage

The Insurer hereby agrees with the Policyholder, to the extent and in the manner hereinafter provided, that if at any time during the Period of this Insurance an Insured Person shall sustain any bodily injury caused by an Accident, which shall solely and independently of any other cause within twelve calendar months from the date of the Accident causing such Injury occasion his/her death or disablement as hereinafter defined, the Insurer will pay to the Insured Person, or to the Insured Person's Beneficiaries, Executors or Administrators, according to the Schedule of Benefits attached provided such injuries are sustained by an Insured Person under the circumstances and in the manner described in the Hazard outlined in this Policy, which is applicable to such person.

Air Travel

Insurance provided under this Policy includes bodily Injury sustained by an Insured Person while riding as a passenger in, alighting from, or boarding (but not while operating, learning to operate or serving as a member of a crew of) ANY AIRCRAFT having a valid airworthiness certificate from the governmental authority having jurisdiction over private aircraft in the country of its registry and flown by a licensed pilot, excluding while crop dusting, crop spraying, seeding, sky-writing, racing, testing, exploration or any other purpose except transportation.

Exposure

If, while insured under this Policy, the Insured Person is unavoidably exposed to the elements because of a Covered Accident and if, as a result of such exposure and within 365 days of the Accident, the Insured Person sustains a loss for which benefits are otherwise payable hereunder, such loss will be covered under this Policy.

Disappearance

If while insured under this Policy, the Insured Person disappears and his/her body is not found within one year after his/her disappearance and sufficient evidence is produced satisfactorily to the Insurer that leads it inevitably to the conclusion that he/she sustained accidental bodily injury and that such injury caused his/her death, the Insurer shall forthwith pay the Principal Sum under this Insurance provided that the person or persons to whom such sum is paid shall sign an undertaking to refund such sum to the Insurer if the Insured Person is subsequently found to be living.

Aggregate Limit of Liability

The maximum amount the Insurer will pay for all Covered Losses resulting from the same Covered Accident will not exceed the Aggregate Limit of Liability as described in the Schedule of Benefits.

If the total amount payable for all Covered Losses in any one Accident exceeds the Aggregate Limit of Liability, each Insured Person's Covered Loss will be paid at the same ratio that the Aggregate Limit of Liability has to the total amount of all Covered Losses. The Insurer shall not be liable for amounts in excess of the Aggregate Limit of Liability.

Hazard 1

24 Hour Accident Protection - Business and Pleasure

The Hazards described in this Hazard 1 apply only to those Insured Persons who are within a class to which this Hazard applies as stated in the Schedule of Benefits.

Description of Hazard

Such insurance as is afforded to an Insured Person to which this Hazard 1 applies, shall apply only to Injury, as defined in this Policy, sustained by such person anywhere in the world.

Schedule of Covered Losses

The following provisions explain the Accidental Death & Dismemberment Benefits available under the Policy. All benefits payable are shown in the Schedule of Benefits. .

If Injury sustained by an Insured Person results in any of the following losses within 365 days of the date of Accident, the Insurer will pay the Percentage of the Principal Sum set opposite such loss. If more than one of the following losses is sustained by an Insured Person as the result of one Accident, the total amount payable in respect of such losses shall not exceed the Principal Sum or in the case of paralysis benefits or Loss of or Loss of Use of both Arms, Both Hands, Both Legs or Both Feet, shall not exceed 200% of the Principal Sum, up to a maximum benefit amount of $1,000,000.

The Principal Sum is the amount of Principal Sum applicable to the Insured Person as determined in accordance with the Schedule of Benefits.

100% **(Percentage of Principal Sum)**	Loss of: Life Entire Sight of Both Eyes One Hand and One Foot Either Hand or Foot and Sight of One Eye Speech and Hearing in Both Ears Use of One Hand and One Foot Use of Either Hand or Foot and Entire Sight of One Eye Brain Death
200% **(Percentage of Principal Sum)**	Loss of: Both Arms Both Legs Both Hands Both Feet Quadriplegia Paraplegia Hemiplegia Use of Both Arms Use of Both Legs Use of Both Hands Use of Both Feet
75% **(Percentage of Principal Sum)**	Loss of: One Arm One Leg One Hand One Foot Sight of One Eye Speech Hearing (in Both Ears) Use of One Arm Use of One Leg Use of One Hand Use of One Foot

33% **(Percentage of Principal Sum)**	Loss of: Hearing (in One Ear) Thumb and Index Finger of Either Hand Four Fingers of Any One Hand All Toes on Any One Foot Use of Thumb and Index Finger of Either Hand Use of Four Fingers of Any One Hand

"Loss of a Hand or Foot" means complete severance through or above the wrist or ankle joint. "Loss of Sight" means total and permanent loss of sight that is irrecoverable, including by surgical and artificial means. "Loss of Speech" means total and permanent loss of audible communication that is irrecoverable by natural, surgical or artificial means. "Loss of Hearing" means permanent total deafness in both ears such that it cannot be corrected by any aid or device. "Loss of Thumb and Fingers of Any One Hand" means complete severance of each through or above the metacarpophalangeal joint of both digits of the same hand. "Loss of Toes of Any One Foot" means the complete severance through the metatarsophalangeal joint. Severance means the complete separation and dismemberment of the part from the body.

"*Paralysis*" means total loss of use.

"*Hemiplegia*" means total Paralysis of the upper and lower limbs on one side of the body.

"*Paraplegia*" means total Paralysis of both lower limbs.

"*Quadriplegia*" means total Paralysis of both upper and lower limbs.

"*Loss of Use*" means loss of functional, normal, or characteristic use or paralysis of the entire arm or leg, hand and or foot, including but not limited to Quadriplegia, Paraplegia or Hemiplegia; which continues without interruption for a period of 12 consecutive months and at the end of such period is determined by a Physician to be continuous, permanent and irrecoverable. The final determination as to whether a "Loss of Use" is permanent and irrecoverable will be made through use of the most current edition of the "Guides to the Evaluation of Permanent Impairment" published by the American Medical Association. (In the event the referenced guide ceases to be published, We will select another appropriate measurement of impairment values.) The determination must be made by a Physician. We have a right, at Our own expense, to have the determination verified by a Physician of Our choice.

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

Permanent Total Disability Benefit

If as the result of an Injury the Insured Person is wholly and continuously disabled and prevented from performing the major duties pertaining to his or her occupation or profession, for a period of 52 consecutive weeks, and such period commences within 365 days after the date of the Accident causing such Injury; and at the expiration of such 52 week period, the Insured Person is permanently disabled, as defined herein, the Insurer shall pay the Benefit stated in the Schedule of Benefits as applicable to such person and this Benefit.

The term "permanently disabled" as used herein shall mean that the Insured Person is completely and irreversibly unable to perform at least two (2) of the following Activities of Daily Living without assistance from another person, as deemed by a Physician and as supported by objective medical evidence.

"*Activities of Daily Living*" mean the following:

- *Bathing* – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of equipment.

- *Dressing* – the ability to put on and remove necessary clothing including braces, artificial limbs or other surgical appliances.
- *Toileting* – the ability to get on and off the toilet and maintain personal hygiene.
- *Bladder and Bowel Continence* – the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained.
- *Transferring* – the ability to move in and out of a bed, chair or wheelchair, with or without the use of equipment.
- *Feeding* – the ability to consume food or drink that already has been prepared and made available, with or without the use of adaptive utensils.

If as a result of such injury, insurance is afforded such person both under this Benefit and under a Benefit provided in the Accidental Death & Dismemberment Benefit, the total limit of the Insurer's liability to such person with respect to both such Benefits shall be the Insurer's liability under the one such Benefit which affords the larger payment for such Injury.

Comatose Benefit

When as the result of an Injury, and commencing within 365 days of the date of the Accident, an Insured Person becomes Comatose as defined below, the Insurer will pay, provided such condition has continued for a period of 31 consecutive days and is total, continuous and permanent at the end of this period, the Principal Sum less any other amount paid or payable under this Policy as the result of the same Accident.

“Comatose” means being in a state of total unconsciousness with no reaction to external stimuli or internal needs, persisting continuously with the use of life support systems, resulting in a neurological deficit which, as determined by a licensed Physician, and in the opinion of the Insurer, is of a permanent nature.

Repatriation Benefit

If injury sustained by an Insured Person shall result in a claim being paid for Accidental Death and such injuries occurred more than 50 kilometers from the Insured Person's place of residence, in addition, the Insurer will pay the actual expenses incurred for preparation of the Insured Person for burial or cremation and transportation of the Insured Person from the place of the accident to the Insured Person's place of residence, up to the maximum shown in the Schedule of Benefits.

In the event an Insured Person is covered by two or more Policies issued by the Insurer, the Insurer's aggregate liability for loss sustained by such Insured Person shall not be cumulative and shall in no event exceed the largest amount available under any one of the Policies.

Identification Benefit

In the event an Insured Person dies more than 150 kilometers away from home or outside Canada, as the result of an Accident, the Insurer will pay up to the maximum shown in the Schedule of Benefits, for lodging and board up to a maximum of three consecutives days, for a member of the immediate family or authorized representative while enroute and/or during the stay in the city or town where the Insured Person’s body is located for the purpose of identifying his body, including transportation by the most direct route by a vehicle or licensed common carrier to and from such location.

In the event an Insured Person is covered by two or more Policies issued by the Insurer, the Insurer's

aggregate liability for loss sustained by such Insured Person shall not be cumulative and shall in no event exceed the largest amount available under any one of the Policies.

Rehabilitation Benefit

If injury sustained by an Insured Person shall result in a claim being paid other than for Accidental Death, in addition, the Insurer will pay:

The reasonable and necessary expenses actually incurred up to the maximum shown in the Schedule of Benefits for special training of the Insured Person provided:
1. such training is required because of such Injury and in order for the Insured Person to be qualified to engage in an occupation in which he or she would not have been engaged except for such Injury,
2. expenses are incurred within three years from the date of the Accident; and,
3. no payment will be made for room or board or other ordinary living, travelling, or clothing expenses.

In the event an Insured Person is covered by two or more Policies issued by the Insurer, the Insurer's aggregate liability for loss sustained by such Insured Person shall not be cumulative and shall in no event exceed the largest amount available under any one of the Policies.

Rehabilitation Physical Therapy Benefit

In the event the Insurer makes a payment to an Insured Person making a claim under the Accidental Death & Dismemberment Benefit other than for Loss of Life, the Insurer will pay, in addition:

The reasonable and necessary expenses actually incurred up to the maximum shown in the Schedule of Benefits for Rehabilitative Physical Therapy of the Insured Person provided:
1. such Rehabilitative Physical Therapy is prescribed and recommended by the attending Physician;
2. expenses are incurred within three (3) years from the date of the accident; and
3. no payment will be made for room or board or other ordinary living, travelling, or clothing expenses.

“Rehabilitative Physical Therapy” means treatment or treatments through exercises and/or equipment specially designed to facilitate the process of recovery from accidental injury to as normal a condition as possible. Surgical intervention is specifically excluded.

In the event an Insured Person is covered by two or more Policies issued by the Insurer, the Insurer's aggregate liability for loss sustained by such Insured Person shall not be cumulative and shall in no event exceed the largest amount available under any one of the Policies.

Funeral Benefit

If an Injury results in the Loss of Life of an Insured Person, the Insurer will pay up to the maximum shown in the Schedule of Benefits, for the services and/or materials provided by a mortician, undertaker, crematorium or funeral home, related to the burial or cremation of a deceased Insured Person and charges for the purchase of a burial plot, gravesite or mausoleum for the interment of the remains thereof, including any markers or monuments. Payment will be made if, as a result of an accident, the expenses are actually incurred at the time of the Insured Person’s death, less any charges for preparation of the remains for travel which are reimbursed under the Repatriation Benefit.

In the event an Insured Person is covered by two or more Policies issued by the Insurer, the Insurer's

aggregate liability for loss sustained by such Insured Person shall not be cumulative and shall in no event exceed the largest amount available under any one of the Policies.

Bereavement Benefit

If an Injury results in the Loss of Life of an Insured Person, the Insurer will pay the reasonable and necessary expenses actually incurred by the Spouse and Dependent Children of the Insured Person for grief counselling, by a Professional Counsellor, up to the maximum shown in the Schedule of Benefits.

Spousal Retraining Benefit

In the event accidental Loss of Life is sustained by an Insured Employee, and indemnity for such loss shall become payable within the terms of this insurance, the Insurer will pay the reasonable and necessary expenses actually incurred within 30 months from the date of such Accident by the Spouse of the Insured Employee who engages in a formal occupational training program in order to become specifically qualified for active employment in an occupation for which he/she would not otherwise have sufficient qualifications. The aggregate amount for all such expenses shall not exceed the maximum shown in the Schedule of Benefits. Payment shall not be made for room, board, or other ordinary living, travelling or clothing expenses.

In order to qualify for such benefits, the Spouse of the Insured Employee shall:
1. not be employed in a full time occupation on the date of such Accident;
2. enroll as a full-time student in a school of higher education or vocational training for the purpose of preparing for full-time employment.

In the event an Insured Person is covered by two or more Policies issued by the Insurer, the Insurer's Aggregate Liability for loss sustained by such Insured Person shall not be cumulative and shall in no event exceed the largest amount available under any one of the Policies.

Special Education Benefit

If an Insured Person loses his (her) life in an Accident while this Policy is in force, the Insurer will pay, in addition to all other benefits, 5% of the Principal Sum, up to the maximum shown in the Schedule of Benefits, on behalf of any Dependent Child who, on the date of Accident, was enrolled as a full time student in any Institution of higher learning beyond the Secondary School level, or, was at the Secondary School level and subsequently enrolls as a full time student in an Institution of higher learning within 365 days following the said Accident.

The Benefit is payable annually for a maximum of five consecutive payments but only if the Dependent Child continues his/her education.

In the event an Insured Person is covered by two or more Policies issued by the Insurer, the Insurer's Aggregate Liability for loss sustained by such Insured Person shall not be cumulative and shall in no event exceed the largest amount available under any one of the Policies.

Day Care Benefit

If indemnity becomes payable under this Policy for accidental loss of life of an Insured Person, the Insurer will pay an amount equal to the lesser of the following amounts:
1. The actual cost charged by such Day Care centre per year, or
2. 5% of the Insured Person's Principal Sum, or

3. The maximum amount shown in the Schedule of Benefits per year,

on behalf of any Child who was an Insured Person's Dependent at the time of such loss and is under age 13 and is currently enrolled or subsequently enrolled in an accredited Day Care centre within 365 days following such loss.

The Benefit is payable annually for a maximum of five consecutive payments but only if the Dependent Child continues his or her enrolment in an accredited Day Care centre.

In the event an Insured Person is covered by two or more Policies issued by the Insurer, the Insurer's Aggregate Liability for loss sustained by such Insured Person shall not be cumulative and shall in no event exceed the largest amount available under any one of the Policies.

Family Transportation Benefit

When an Insured Person covered under this Policy is on a trip and is confined as an inpatient in a Hospital because of injuries sustained due to an Accident and subsequently requires the personal attendance of a Member of the Immediate Family (as defined below) or an authorized family representative, the Insurer will pay for the expense incurred by the Member of the Immediate Family or the authorized family representative, for accommodation and transportation by the most direct route by a licensed common carrier, to the confined Insured Person but not to exceed the maximum amount shown in the Schedule of Benefits.

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

Payment will not be made for board or ordinary living, travelling or clothing expenses.

In the event an Insured Person is covered by two or more Policies issued by the Insurer, the Insurer's Aggregate Liability for loss sustained by such Insured Person shall not be cumulative and shall in no event exceed the largest amount available under any one of the Policies.

Home Alteration and Vehicle Modification Benefit

If an Insured Person receives a payment under the dismemberment benefit and was subsequently required due to the cause of the same Accident, to use a wheelchair, this benefit will pay, upon presentation of proof payment:
(a) The one-time cost of alterations to the injured Insured Person's residence to make it wheel-chair accessible and habitable; and
(b) The one-time cost of modifications necessary to a motor vehicle, owned by the injured Insured Person, to make the vehicle accessible or driveable for the Insured Person.

Benefit payments herein will not be paid unless:
1. Home alterations are made by a person or persons experienced in such alterations and recommended by a recognized organization, providing support and assistance to wheel-chair users; and
2. Vehicle modifications are carried out by a person or persons with experience in such matters and modifications are approved by the Provincial vehicle licensing authorities.

The maximum payable under both items A and B combined will not exceed the maximum shown in the

Schedule of Benefits.

In the event an Insured Person is covered by two or more Policies issued by the Insurer, the Insurer's Aggregate Liability for loss sustained by such Insured Person shall not be cumulative and shall in no event exceed the largest amount available under any one of the Policies.

Workplace Accommodation and Alteration Benefit

When an injury to the Insured Person results in the Insurer making a payment under the section titled "Accidental Death & Dismemberment Benefit" and such Insured Person requires special adaptive equipment and/or workplace alteration in order to reasonably accommodate his return to active full-time employment with the Policyholder, the Insurer will pay the reasonable and necessary expenses actually incurred by the Policyholder provided:
1. The Policyholder agrees in writing to provide the special adaptive equipment and/or make alterations to the workplace for the purpose of making it accessible and adaptable to the needs of such Insured Person;
2. The Policyholder acknowledges in writing that the performance of the essential duties of such Insured Person's occupation may be altered;
3. The proposed special adaptive equipment and/or workplace alteration must have prior written approval by the Insurer;
4. The Insurer reserves the right to examine the Insured Person to evaluate the appropriateness of the proposed alteration.

This benefit will be paid to the Policyholder upon the Insured Person's return to active full-time employment with the Policyholder and the Insurer has been provided with written proof of the expenses incurred. This benefit is not payable if the Policyholder does not incur any cost in providing the special adaptive equipment and/or workplace alterations.

The maximum amount payable under this benefit shall not exceed the maximum shown in the Schedule of Benefits.

In the event an Insured Person is covered by two or more Policies issued by the Insurer, the Insurer's aggregate liability for loss sustained by such Insured Person shall not be cumulative and shall in no event exceed the largest amount available under any one of the Policies.

Hospital Confinement Monthly Income Benefit

If, as a result of an Accident, an Insured Person is Hospital Confined as an in-patient for a minimum period of at least 1 day and is under the care of a legally qualified and registered Physician or surgeon other than himself/herself, this Policy will pay for each full month of confinement, 1% of the Insured Person's benefit amount, up to the maximum shown in the Schedule of Benefits, or one-thirtieth of such monthly benefit for each day of a partial month, retroactive to the 1st day of such confinement but not to exceed 365 days in the aggregate for each "period of Hospital Confinement."

"In-patient" means an Insured Person admitted to a Hospital as a resident or bed-patient.

In the event an Insured Person is covered by two or more Policies issued by the Insurer, the Insurer's aggregate liability for loss sustained by such Insured Person shall not be cumulative and shall in no event exceed the largest amount available under any one of the Policies.

Burn Benefit

If the Insured Person, as the result of an Injury, is disfigured due to a third degree burn, the Insurer will determine the payment according to the Burn Schedule below, not to exceed the maximum shown in the Schedule of Benefits.

The amount of benefit that the Insurer will pay for any one loss is determined by multiplying the percentage of body surface actually burned times the Principal Sum, up to the maximum shown in the Schedule of Benefits. The attending Physician will determine the actual percentage applicable to each burn.

The **"Burn Schedule"** represents the maximum percentage of the Principal Sum that the Insurer will pay for any one loss. As specifically indicated above, the attending Physician will determine the actual percentage applicable to each burn and this will be the amount of benefit payable by the Insurer, subject to the maximum percentage of the Principal Sum indicated in the "Burn Schedule" and the maximum shown in the Schedule of Benefits. If the Insured Person sustains burns in more than one (1) area as a result of any one (1) Accident, the total benefit for all such burns will not exceed the maximum shown in the Schedule of Benefits. The most the Insurer will pay for any combination of burned body parts as the result of any one (1) Accident is the maximum shown in the Schedule of Benefits.

Burn Schedule

Maximum Percentage of Benefit Amount Payable:	Body Part:
99%	Face, Neck, Head
22.5%	One Hand & Forearm
13.5%	One Upper Arm
36%	Front or Back Torso
9%	One Thigh
27%	One Lower Leg (below the knee)

In the event benefits are payable under this section and the section titled "Accidental Death & Dismemberment Benefit", the total benefits payable will not exceed the Principal Sum.

In the event an Insured Person is covered by two or more Policies issued by the Insurer, the Insurer's aggregate liability for loss sustained by such Insured Person shall not be cumulative and shall in no event exceed the largest amount available under any one of the Policies.

Psychological Therapy Benefit

When an Injury to the Insured Person results in the Insurer making a payment under the section titled "Accidental Death & Dismemberment", the Insurer will increase the benefit amount payable up to the maximum shown in the Schedule of Benefits, for the Reasonable and Customary charges for treatment or counseling for Psychological Therapy as determined by a Physician and authorized by the Policyholder.

Benefit payments herein will be paid until the earlier occurrence of one of the following:
1. the maximum benefit amount has been paid; or
2. two (2) years have elapsed from the date of the Accident; or
3. death of the Insured Person.

Psychological Therapy must be provided by a therapist or counsellor (other than the Insured Person or a Member of the Immediate Family) who is licensed to provide such treatment, whether on an out-patient basis or while a patient at a medical facility licensed to provide such treatment.

"Reasonable and Customary" means the lesser of:
(a) the usual charge made by Physicians or other health care providers for a given service or supply; or
(b) the charge the Insurers determine to be the prevailing charge made by the Physicians or other health care providers for a given service or supply in a geographical area where it is furnished; or
(c) the amount negotiated by the Insurer and the health care provider.

Critical Disease Benefit

If an Insured Person, prior to age 65, is diagnosed by a qualified Physician with any of the following diseases listed below while this Policy is in force with respect to such Insured Person, the Insurer will pay up to 10% of the Insured Person's applicable Principal Sum up to the maximum shown in the Schedule of Benefits, provided that the Insured Person survives for a period of at least thirty (30) days after the diagnosis has been made.

The covered critical diseases are:

"Major Burns" which means the Diagnosis by a plastic surgeon of a third (3rd) degree burn covering at least 20% of the surface area of the body of the Insured Employee.

"Major Organ Failure Requiring Transplant" which means the irreversible failure of the heart, liver, both lungs or both kidneys requiring receipt of a transplant of that organ, resulting in the Insured Employee being accepted into a recognized transplant program in Canada. The Insured Employee must survive at least thirty (30) days following the date of enrollment into the transplant program.

"Major Organ Transplant" which means the undergoing of a surgery, as a recipient by transplant of any one (1) or more of the following organs or tissues; heart, liver, lung, or kidney.

"Motor Neuron Disease" which means an unequivocal diagnosis of amyotrophic lateral sclerosis (Lou Gehrig's Disease), primary lateral sclerosis, progressive bulbar palsy, or pseudo-bulbar palsy. Other variations of motor neuron disease are specifically excluded.

"Multiple Sclerosis" which means an unequivocal diagnosis by a neurologist of at least two (2) episodes of well-defined neurological abnormalities lasting for a continuous period of at least six (6) months and confirmed by modern imaging techniques.

"Necrotizing fasciitis" which means an unequivocal diagnosis of insidiously advancing soft tissue infection of the deeper layers of skin and subcutaneous tissues (fascia).

“Parkinson’s Disease” which means the Diagnosis by a neurologist of primary idiopathic Parkinson’s Disease which is characterized by the clinical manifestation of two (2) or more of the following; a) tremor; b) rigidity; c) Bradykinesia. All other types of Parkinsonism are excluded.

This benefit is only payable if investigations leading to the diagnosis of the covered disease(s) are initiated more than ninety (90) days following the effective date of insurance coverage with respect to the Insured Person.

Payment of the Critical Disease Benefit is limited to only the first covered disease to occur.

In the event an Insured Person is covered by two or more Policies issued by the Insurer, the Insurer’s aggregate liability for loss sustained by such Insured Person shall not be cumulative and shall in no event exceed the largest amount available under any one of the Policies.

Seat Belt Benefit

When an injury to the Insured Person results in the Insurer making a payment under the section titled “Accidental Death & Dismemberment Benefit”, the Insurer will increase the benefit amount payable by an additional 10%, provided that:

1. the loss occurs while the Insured Person is a passenger or driver of a private passenger type Vehicle;
2. the Seat Belt is properly fastened; and
3. verification of the actual use of the Seat Belt is part of the official report of the Accident or certified by the investigating officer.

“Seat Belt” means those belts that form a restraint system and includes infant and child restraint systems when properly used with a seat belt and the restraining belts which are a part of a stretcher used in the transportation of sick or injured persons by ambulance.

"Vehicle" means a passenger car, self-propelled motor home, station wagon, van, jeep-type automobile or truck, ambulance or any type of motorized vehicle used by municipal, provincial or federal police forces.

Felonious Assault Benefit

When an Occupational Illness or Injury to the Insured Person results in the Insurer making a payment under the section titled “Accidental Death & Dismemberment Benefit”, the Insurer will increase the benefit amount payable by an additional 10%, provided that the loss occurs:

1. as a result of a Criminal Act of Violence; and
2. while the Insured Person is engaged in the business of the Policyholder, whether on or off the premises of the Policyholder.

This benefit will not be payable, however, if a Criminal Act of Violence is being carried out by or participated in by an Insured Person.

“Criminal Act of Violence” includes but is not limited to robbery, theft, assault and battery, sniping or murder.

Waiver of Premium Benefit

If, while this Policy is in force and as a result of total disability from an accident or sickness, an Insured Person's life insurance is extended under a waiver of premium provision provided under the Policyholder's Basic Group Life Insurance Policy, coverage under this benefit shall also be extended.

Due written proof of the Insured Person's total disability must be received by the Insurer within twelve months after the commencement of total disability for benefits under this section to become effective.

Premium payments will be waived until the earlier occurrence of the following:
(a) recovery of the Insured Person from total disability;
(b) the Insured Person's attainment of the maximum eligibility age under this Policy or termination of eligibility; or
(c) termination of this Policy.

Coverage provided for under this section will be subject to the terms and conditions of this Policy in effect as of the date of commencement of disability, including any conditions providing for reduction in amounts of insurance.

Notwithstanding anything contained to the contrary in this Policy, in no event will benefits payable for any loss which occurs while coverage is being continued under this section exceed the Principal Sum of the Insured Person at the date of commencement of disability, less any amounts of indemnity which were payable prior to such loss as the result of the same Accident.

Continuation of Coverage Benefit

Coverage under this Policy will be continued on any Insured Person while on an approved leave of absence or lay-off, up to a maximum of 12 months. Coverage will be continued up to a maximum of 18 months while an Insured Person is on maternity or paternity leave. Payment of premiums must be continuous through active employment and the scheduled leave.

In all other respects the provisions and conditions of the Policy remain the same.

Conversion Privilege

If this Policy is terminated due to any reason other than non-payment of premium or attainment of age 75, the Insured Person shall be entitled to have issued to him or her by the Insurer, an individual Policy (herein referred to as the Converted Insurance) subject to the conditions stated below.

Eligibility for Conversion

The Insured Person must make application and pay the initial premium for the Converted Insurance to Sutton Special Risk Inc. on behalf of the Insurers within 90 days after the date of termination. The Insured Person shall be eligible to convert only Accidental Death or the Accidental Death and Dismemberment Benefit under the Insured Person's Coverage of this Policy and the Principal Sum under the Converted Insurance will be equal to or less than the Insured Person's Principal Sum, to a maximum of $500,000. No medical evidence of insurability will be required by the Insurer.

Converted Insurance Provisions

The Converted Insurance will be issued on the form then available from the Insurer for purposes of conversion which provides Accidental Death and Dismemberment coverage on a 24 hour a day basis. The premium applicable to the Converted Insurance will be the Insurer's rate in effect at the time of conversion for a class of risk and age of the Insured Person as of the effective date of the Converted Insurance.

Subject to the conditions set forth herein, the Converted Insurance will become effective on the latter to occur of (1) the date of termination under this Policy or (2) the date of application for the Converted Insurance.

Benefit Exclusions

This Insurance does not cover any claim arising out of bodily Injury caused or contributed to by:

1. declared or undeclared War or any act thereof or invasion;
2. training, serving, or taking part in any capacity in the armed forces (land, sea or air) or their operations, of any country or international authority;
3. being in or on or boarding an aircraft for the purpose of flying therein, or alighting therefrom following a flight, except as provided in the Section entitled "Air Travel";
4. suicide or attempted suicide or intentional self-injury;
5. injury sustained while riding in, boarding or alighting from an aircraft owned or leased, by or on behalf of the Policyholder or any subsidiary or affiliate of such Policyholder, unless specific written agreement has been obtained from the Insurer; or
6. Acts of Terrorism which involve the use or release or the threat thereof of any nuclear weapon or device or chemical or biological agent, regardless of any contributory cause(s).

Acts of Terrorism means any act, including but not limited to the use of force or violence and/or the threat thereof, of any person or group(s) of persons, whether acting alone or on behalf of or in connection with any organization(s) or government(s), committed for political, religious, ideological or similar purposes including the intention to influence any government and/or to put the public, or any section of the public, in fear.

War means invasion, acts of foreign enemies, hostilities or warlike operations whether war be declared or not, civil war or commotions, rebellion, revolution, insurrection, riots, military or usurped power or martial law.

Additional Limitation(s) and/or Exclusions:

Any additional limitations and/or exclusions that apply to coverage under this Policy are shown in the Schedule of Benefits under the heading Additional Limitation(s) and/or Exclusion(s).

Claims Provisions

NOTICE OF CLAIM: Written notice of claim, death or Injury must be given to our Underwriter within 31 days after a Covered Loss begins. Failure to give notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to give such notice and that notice was given as soon as was reasonably practicable. Notice can be given to our Underwriter at the address

identified in this Policy or such other place as We may designate for this purpose. Notice should include the Insured Person's name, address, Policyholder's name and Policy Number.

CLAIM FORMS: When through our Underwriter, We receive a notice of claim, Our Underwriter will send forms for filing proof of loss. If claim forms are not sent within 15 days, the claimant will satisfy the requirements of written proof of loss by sending the written proof as shown below. Proof of loss must describe the occurrence, extent and nature of the loss.

PROOF OF LOSS: Written proof of loss must be given to Us through our Underwriter within 90 days after the date of loss. If the proof of loss is not submitted within 90 days, it should be sent as soon as reasonably possible; otherwise the claim may be reduced or invalidated. In no event, except in the absence of legal capacity, should proof of loss be sent later than one year from the time proof is otherwise required.

Such proof of loss includes but is not limited to the circumstances of the happening of the Accident or the commencement of the disability, and the loss occasioned thereby, the right of the claimant to receive payment, his or her age, and the age of the Beneficiary if relevant and may be required by Us to furnish a satisfactory certificate as to the cause or nature of the Accident or disability for which claim may be made under the Policy and as to the duration of such disability.

BENEFICIARY: The beneficiary(ies) of an Insured Person shall be the person(s) designated in writing by the Insured Person on file with the Policyholder. Any Insured Person who has not made an irrevocable designation of beneficiary may designate a new beneficiary at any time by filing with the Policyholder a written request for such change, but such change shall become effective only upon receipt of such request. The change of beneficiary shall relate back and take effect as of the date of execution of the written request, but without prejudice to Us on account of any payment made by it.

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

PAYMENT OF CLAIMS: We, through Our Underwriter, will pay a claim after receipt of acceptable proof of loss. Any payment made in good faith will discharge Our liability to the extent of the claim.

Benefits for Loss of Life are payable to the Insured Person's beneficiary. The designation shall be as follows:
1) Beneficiaries designated in writing by the Insured Person for this Policy on file with the Policyholder, if any, otherwise;
2) Beneficiaries as designated in writing for any Group Life Insurance plan or its renewals in force for the Policyholder, if any, otherwise;
3) The Insured Person's estate.

All other claims will be paid to the Insured Person. In the event the Insured Person is a minor, incompetent or otherwise unable to give a valid release for the claim, We through our Underwriter may make arrangement to pay claims to the Insured Person's legal guardian, committee or other qualified representative.

DISCLAIMER
This booklet is a summary of the principal features of the plan which is governed by the terms of the Group Master Policy 417/028549A with the Human Resources Department. In the event of any discrepancy between this booklet and the master policy, the master policy prevails.

UNDERWRITTEN BY:
Certain Underwriters at
Lloyds, London through
Sutton Special Risk Inc.
33 Yonge Street, Suite 400 P.O. Box 311
Toronto, Ontario M5E 1G4

All benefits described here are governed by the Master Contract underwritten by Lloyds, London through Sutton Special Risk Inc.

Dependent Life Insurance

General description of coverage

The amount of life insurance for a spouse and each eligible dependent child is specified on your *Certificate of Insurance.*

Benefit

The face amount is payable in the event of death at any time or place from any cause.

If a dependent is hospitalized on the date insurance would normally become effective, that dependent's insurance does not take effect until the day of discharge from the hospital.

If you add dependents, a new spouse's coverage takes effect on the date of marriage, and children's coverage takes effect on the date of birth or adoption.

Beneficiary	The employee is the beneficiary of any insurance benefits payable under this coverage.
Waiver of Premium	Waiver conditions are the same as Group Life.
Conversion	If your coverage ends, a spouse under age 66 may apply for an individual policy of life insurance without medical evidence as long as written application is submitted and the first premium is paid within 31 days of the date of termination of your coverage. The alternative policies include any plan, other than term insurance, offered by the Insurance Company.
Extension of Benefit	If a spouse dies within 31 days of the termination of the insurance under this benefit, the amount of life insurance the spouse was eligible to convert will be payable.

Claims

A completed claim form must be submitted to the Plan Administrator within 90 days of death. Before settling any claim, written proof of the occurrence, cause and circumstances of the death will be required. Written proof means a completed claim form accompanied by either an original funeral director's statement or original death certificate. Notarized copies of the funeral director's statement or death certificate will be accepted if originals cannot be submitted.

All benefits described here are governed by the Master Contract underwritten by Desjardins Financial Security Life/Assurance Company.

Extended Health Care

General description of coverage

This plan covers reasonable and customary charges for supplies and services used to treat injury or illness. There is no overall lifetime maximum benefit, but certain types of expenses are subject to limits and conditions. Any benefit maximum applies to a calendar year (January through December).

To receive benefits, employees and dependents must be registered with their provincial health plan. If an employee or dependent is hospitalized before the effective date of this coverage, no benefits are payable for any charges during the hospitalization and coverage will begin on the date of discharge.

Your plan has a coinsurance amount which is shown on the *Certificate of Insurance* and *Benefit Summary*.

Benefits

Prescription Drugs	Coverage includes drugs approved in Canada, available only by prescription and administered for medical necessity. Oral contraceptives are considered eligible drugs. All drugs must be prescribed by a physician, surgeon, dentist or dental surgeon or, where legal, by a licensed, certified or registered health practitioner. The drug must be dispensed by a licensed organization or registered pharmacist.
	Coverage also includes serums, vaccines (not for travel purposes) and injectables. These items are not available through the Assure card, and must be submitted for reimbursement.
Drug Card	Prescription drug expenses will be handled on a card system referred to as the Assure Card.
Maximum	**The maximum limit available per person is $1,000 per calendar year**. Prescriptions are limited to a one month supply, except for "maintenance prescriptions" such as oral contraceptives which are limited to a three month supply.
Coverage does not include	This coverage does not include proprietary or patent medicines, drugs available over-the-counter or off-the-shelf, experimental drugs, vaccines for travel purposes, drugs used in the treatment of infertility and hair loss, dietary or health foods, vitamins, nutritional products, nicotine patches or smoking cessation drugs and programs, and charges for the administration of drugs, serums or vaccines. **Injections normally administered to patients admitted to hospital for treatment are ineligible**.
National Formulary	Your Plan reimburses prescription drug purchases on a two tier system. If the DIN (Drug Identification Number) is on the National Formulary, coverage will be at the reimbursement percentage shown on the Benefit Summary. Eligible prescription drugs not on the Formulary will be covered at 50%.

	If the drug your physician prescribes is not on the Formulary, a 'therapeutic alternative' providing similar treatment likely will be. With your doctor's advice, you have two options: • you can ask your doctor to prescribe a drug that is on the Formulary, covered at the higher reimbursement percentage, or • you can fill the unlisted prescription and be reimbursed 50% of the eligible cost. For more information on the National Formulary, visit www.chamberplan.ca > Plan Members > Forms and Recourses > Your Health Coverage
Generics	The Plan uses Generic substitution whenever possible. Where there is a Generic drug that is considered interchangeable with a Brand drug, only the cost of the lowest price Generic will be reimbursed. Though the Plan substitutes Generic equivalents wherever possible, a Brand drug will be dispensed if the Generic is unacceptable. Your physician need only specify "No Substitution" on the prescription. If your plan includes a tiered formulary, the Plan will reimburse the eligible Brand cost, based on the reimbursement percentage of the tier in which the DIN is found.
Quebec residents	If you are a resident of Quebec, this plan will reimburse you for all drugs normally provided under the Quebec Universal Drug Plan. If a brand name drug is purchased where a generic substitute is available, the plan will cover the cost of the brand name drug up to the maximum coinsurance currently allowed under the Quebec Universal Drug Plan.
Paramedical Services	The plan will cover the costs for the paramedical specialists listed on the *Benefit Summary* up to reimbursement levels indicated provided the practitioner is operating within the scope of their licence. Charges for group sessions are not eligible expenses. Services of a chiropractor include one diagnostic x-ray per year and charges for the x-ray are combined in the maximum. Services of a naturopath exclude food supplements or vitamins. Services of a registered dietician exclude fees for weight loss programs and require a written referral from a physician.
Vision Care	The maximum benefit is **$200 per insured**. The maximum applies in any 24 month period for adults and in any 12 month period for children. Eligible expenses include: • eye glass frames and/or lenses, including contact lenses; • replacement of above prescribed as a result of an eye exam by a licensed ophthalmologist or optometrist; • the cost of laser eye surgery. The per person benefit applies only to items to be used exclusively by the insured. The coverage is not transferable and does not include: • any charges for fitting eyeglasses; • industrial safety glasses, sunglasses or any tinting of glasses;

	• charges covered in whole or in part by Workers' Compensation, any other government entity, or any third party; • the cost of eye examinations which are covered separately under the Extended Health Care benefit.
Eye Exams	Eye exams are covered to **$75 per person** when performed by a qualified ophthalmologist or licensed optometrist. Adults are covered for one such exam in any 24 month period while dependent children are covered once in any 12 month period.

Other Services and equipment

Ambulance	This benefit allows charges for licensed **ground ambulance** service when used to transport an insured person as a result of emergency or in-patient treatment: • from the place the insured suffers injury or illness to the nearest hospital where adequate treatment is available; • from one hospital to another; • from a hospital to the insured's residence when condition of patient warrants it. Proof of the medical necessity of an ambulance may be required from the attending physician.
Emergency Air Transportation	Emergency transportation by a licensed **air ambulance** is covered to the nearest hospital qualified to provide the necessary treatment when certified as essential by the attending physician to a maximum of **$4,000 per person** each calendar year.
Cardiac Rehabilitation	When prescribed by their attending physician, cardiac patients may participate in a recognized rehabilitation program after a heart attack, bypass surgery, valve replacement or management of angina pectoris. The benefit has a lifetime maximum of **$300 per individual**.
Dental Accidents	To a maximum of **$2,000 per person per calendar year**, this plan covers the services of a dentist required for the repair and replacement of sound natural teeth injured by an accidental blow to the insured's mouth while insured under this benefit. This coverage does not include damage resulting from an object wittingly or unwittingly placed in the mouth. Treatment must begin or a treatment plan must be sent to the Plan Administrator within 90 days of the injury. No benefits are payable for treatment more than 2 years after the date of the accident. An *Accidental Dental* claim form must be submitted. Benefits paid by the Plan are based on the last approved Fee Guide established by the Provincial Dental Association.
Hearing Aids	The plan allows for the purchase and installation of, but not rental of, batteries for or repair of hearing aids on the written recommendation of a physician. The benefit is limited to **$500 per person** in any 4 year period.
Hospital	This plan pays the additional cost charged by the hospital for a **semi-private room** over a standard public ward. It will also cover the additional cost of a private room, if the attending physician provides a written recommendation of its medical necessity. Coverage does not include care or treatment for substance abuse.

Convalescent/Rehabilitation Hospital	The benefit provides **$30 per day for up to 180 days** per confinement for the cost of room and board in a convalescent hospital approved by a province's appropriate hospital authority. The insured must be admitted to the convalescent facility within 14 days of discharge as an in-patient at a hospital. Coverage excludes nursing homes, homes for the aged and chronically ill, homes for the mentally ill, rest homes, or any place for the care or treatment of substance abusers.
Hostel Accommodation	The plan pays the reasonable and customary charges in the province of residence for the patient's hostel accommodation associated with the hospital performing diagnostic testing or treatment and recommended by a physician up to 180 days. The hostel must be in the province of residence and located more than 60 km from the insured's home.
Medical Equipment	This group plan includes charges for the following to a **maximum of $2,000 per person per calendar year** (unless otherwise indicated): • purchase, but not repair, of a **spinal brace**(at the discretion of the Insurance Company) or **artificial limb or eye** where the loss occurs while the individual is insured; replacement is covered only when required because of changes to the insured's body; Artificial limbs require a Doctor's letter and are limited to reasonable and customary charges. • purchase or rental, but not repair or replacement, of a brace (at the discretion of the Insurance Company) for a **limb truss or crutch**. Braces prescribed solely for athletic purposes are not covered; Claims for braces require a written medical necessity from your medical provider (MD). • rental, purchase or repair of a **wheelchair**; rental or purchase of a **hospital bed** (at the discretion of the Insurance Company); Hospital beds require a physician letter and are defined to have adjustable head, foot and height levels and guardrails. • **respirator and oxygen** purchase or rental to a lifetime maximum of $1,000 per person (including CPAP and sleep apnea appliances); • purchase of **colostomy, ileostomy** or **uretherostomy** supplies; • purchase of one **glucometer** on the written recommendation of a physician; • purchase of reagent strips and other eligible **diabetic supplies**; • purchase of a **breast prosthesis** as a result of a total or radical mastectomy performed while the patient is insured, to a maximum of $200 per person every calendar year; • purchase of two **surgical brassieres** each calendar year when required as a result of a total or radical mastectomy; • purchase of an **aerochamber inhaler**; • purchase of two pair of **surgical elastic stockings** per year, on the written recommendation of a physician;

	The Plan only covers medically necessary surgical stockings with a compression factor of 20 mmHg or higher.
	• **plasma, blood** or blood substitutes and their administration; • purchase of **wigs required as a result of chemotherapy** or accidental injury to a lifetime maximum of $1,000 per person; • rental or purchase of other prescribed, approved, **medical equipment** up to a lifetime maximum of $250 per person.
Medical Travel	The benefit will provide up to **$750 per person** each 24 months to transport an insured from their normal place of residence to a medical facility (in Canada) for medically necessary treatment under the following conditions: • The treatment cannot be available in the normal place of residence and must be ordered by a physician; • The treatment must take place within 60 days from the date of the physician's referral; and • The round trip distance must be 300 kilometers or more. Covered expenses include: • Expenses for the person requiring the treatment and one traveling companion; • Cost of transport including economy class of a scheduled flight, rail, bus or ferry, or automobile fuel expenses; and • Cost to accommodate the patient in a commercial facility for up to $75 per day for a maximum of 5 days either before or after medical treatment. Telephone and meal expenses are not covered.
Orthopaedic Supplies	Coverage includes: • **$225** towards the purchase of, but not repair of, one pair of **custom designed orthopaedic shoes** from a recognized orthopaedic supplier each calendar year. This does not include off-the-shelf, regular stock shoes or shoes for athletic purposes.
	The Plan requires written medical necessity (condition/diagnosis) from your medical provider and a detailed description from the manufacturer of the shoes to confirm how the shoes are/have been made.
	• purchase of a **custom-made foot orthotic** or arch support, to a maximum of $200 per person per calendar year.
	A custom made foot orthotic is specifically made for the individual and fabricated from a three-dimensional model/cast of the foot which captures the foot alignment and shape. A biomechanical assessment by a physician, chiropractor, podiatrist, chiropodist, pedorthist, or orthotist is required.

Private Duty Nursing	On the written recommendation of the insured's doctor, charges will be covered for nursing visits in the insured's home. They must be provided by a professional nurse who is not related by blood, or connected by marriage, not a close friend or does not normally reside in the insured's home. Nursing services must be consistent with the insured's diagnosis and treatment of the condition and not primarily for custodial care. A *Nursing Care Questionnaire* is required and approval is at the discretion of the Insurance Company. Maximum payment is **$25,000 per insured** in any consecutive 24 month period.

Out-Of-Province/Out-Of-Country

Coverage	An insured and eligible dependents including students, who incur charges for emergency medical treatment outside their province of residence, are covered. An individual must be covered under their government health and hospital insurance plans to be eligible for coverage and the individual's provincial health plan must be prepared to pay a portion of any claim. Coverage for an insured and any dependents is based on the age of the certificate holder. The Plan covers the first: • 180 days of a trip for certificate holders up to age 65, • 90 days of a trip for certificate holders age 65 to 69, • 60 days of a trip for certificate holders age 70 to 74, and • 30 days of a trip for certificate holders age 75 to 80.
	All totally disabled employees who qualify for Waiver of Premium under the life insurance benefit will not be covered for any Out-of-Province/Out-of-Country expenses.
	The emergency expenses must be reasonable and customary for the area in which they are charged. This plan will pay for eligible expenses that exceed the provincial health insurance plan schedule in the insured's home province. Covered services include: • semi-private hospital room; • hospital medical services and supplies; • physicians' services; • prescription drugs; • licensed ground or air ambulance to the **nearest** hospital equipped to provide the required treatment.
	If you have a medical emergency, you must contact Voyage Assistance immediately to receive benefits. They will confirm your coverage and help connect you to eligible services. You'll find the toll-free emergency numbers on the back of your Chambers Plan wallet card. Inside Canada or U.S. 1 800 465.6390 Outside Canada or U.S. 1 514 875.9170

Voyage Assistance	Contacting the Voyage Assistance Centre will not only confirm your eligibility for coverage, but it will also make the following services available to you or any Dependent insured under the Extended Health Care benefit of this policy: *After Hospital Convalescence* | *Bedside Visit* *Emergency Medical Payments* | *Legal Assistance* *Lost Luggage and Documents* | *Meals and Accommodation* *Medical Assistance and Consultation* | *Medical Evacuation* *Return of Deceased* | *Return of Dependent Children* *Return of Vehicle* | *Telephone Interpretation Services* *Trip Interruption* | *Urgent Messages* Please read the Voyage Assistance brochure for full details of these services. It can be found at *www.chamberplan.ca > Plan Members > Your Coverage.*
Excluded Services	Chambers Plan coverage does not pay for elective, non-emergency treatment or surgery, when this service could have been provided in the province of residence of either the employee and any of their dependents without endangering their life or health, even if such service is provided as a result of a sudden illness or an accident requiring emergency treatment, or if the purpose of the trip is to obtain medical services for which the either the employee or any of their dependents was advised as necessary, but not readily available in the province of residence.
Travel Claims	Claims for hospital and medical expenses incurred while travelling must be submitted to the Plan Administrator. Complete a *Travel Health* claim form and send it along with itemized receipts for all services received. The insurance company will coordinate payments on your behalf with your provincial government plan. The provincial health plan must be prepared to pay a portion of any claim. All foreign bills must be translated prior to submission. Eligible claims are payable on a reimbursement basis in Canadian currency at the conversion rate in force on the date the claim is paid.

Exclusions and Limitations

Extended Health benefits are not payable under any of the following circumstances:

- experimental services, treatments or supplies;
- drugs, injections or products for treatment of obesity;
- travel vaccines;
- services, treatment or supplies provided to the employee by the employer;
- services, treatment or supplies not included in the list of eligible expenses;
- expenses as a result of intentionally self-inflicted injuries while sane or insane;
- cosmetic treatment expenses, except as a result of an accidental injury;
- treatment for injuries sustained while committing or attempting to commit a criminal offence;
- expenses for which payment is provided under any Workers' Compensation Act or similar legislation, government plan or any other plan;
- injuries caused directly or indirectly by insurrection and war, participation in a riot or civil disorder;
- personal comfort items and erectile dysfunction drugs/items;
- patent medicines;
- general health exams;
- physicians' fees;

- services, treatment or supplies which the individual received without charge;
- charges for services which are not medically necessary;
- travel time, broken appointments, transportation costs, telephone or other indirect consultations;
- amounts in excess of reasonable and customary charges for the least expensive treatment that is medically appropriate;
- expenses related to temporomandibular joint dysfunction;
- out of province referrals.

Survivors' Benefit

There is a 24 month extension of coverage for dependents (without payment of premiums, and in accordance with the other provisions of the plan), until the earliest of the following after the death of the insured.

- the end of a 24 month period following the death of the Employee,
- the date on which the spouse remarries,
- the date on which the spouse becomes an employee or dependent under this or any other group plan,
- the date on which the Member Firm is no longer insured under this benefit,
- the date on which this benefit terminates.

Claims

All claims should be sent to the Plan Administrator and signed by the employee. Completed claim forms must be submitted within one year from date of service. Original receipts are required. Upon termination, claims must be submitted within 120 days after the termination date.

All benefits described here are governed by the Master Contract underwritten by Desjardins Financial Security Life/Assurance Company.

Teladoc Telemedicine

General Description of Coverage

Your Extended Health Care benefit under Chambers Plan includes free access for you and your insured dependents to Teladoc® Telemedicine – a global service providing convenient access to high-quality care to millions of people in more than 130 countries. Teladoc telemedicine service allows you to consult with a physician about non-urgent medical matters by video conference or by phone[1], from wherever you are in Canada or the United States[2], 24 hours a day, 365 days a year. During your visit, you can receive a diagnosis, treatment recommendations, and even be prescribed medication when necessary.

Convenience	• You have confidential access to a doctor via app or telephone[1] who is available anytime. • You get treated for non-emergency conditions like the flu, bronchitis, and much more. • When necessary, prescriptions are sent directly to your pharmacy of choice.
Greater Access	• Visits occur within an hour of contact, so you get the care you need when you need it, without the wait. • The service is even available when you travel to the United States[2].
Clinical Quality	• Each doctor is board-certified by the College of Family Physicians of Canada to ensure the highest standards of quality. • Every visit provides the opportunity for a copy of your visit to be sent to your family physician.

Accessing Teladoc Telemedicine

Simply download the Teladoc app from Apple or Google Play (icons), complete the registration, and request a consultation either, by video conference or by phone[1], at **1-877-419-2378**.

Prior to your first consultation, you must complete an electronic health record for the doctor to review.

For more information visit **teladoc.ca**.

Teladoc's Telemedicine services are available without charge to all insureds and their dependents holding a Chambers Plan Extended Health benefit. You are responsible for any expenses associated with medical treatment (not covered by your provincial or health care plan), travel and lodging.

[1] In Quebec, telemedicine services must be offered by video conference.

[2] Teladoc Health services in the U.S. can only be accessed by telephone.

Teladoc Mental Health Navigator

General Description of Coverage

Mental Health Navigator is a concierge-styled program is ideal for those who have been diagnosed with a mental health issue and are struggling or feel overwhelmed. Our experts can help you navigate the mental health system and get ongoing support.

Expert psychologists and psychiatrists carefully review each diagnosis and treatment plan and deliver a personalized action plan. An assigned navigator then guides the member through each step with collaborative, ongoing support.

We support members across a broad range of mental health conditions, including diagnosis such as (not limited to): ADHD, Autism Spectrum Disorders, Bipolar Disorder, Global/Specific Development Delays, Depression, Eating Disorders, and Anxiety Disorders.

The Navigator will work with you to ensure they implement their action plan and help you identify the right resources to implement the plan. The Navigator and Experts do not provide care.

Access to experts	• Provide you solutions if you are not benefitting from your current care or if you need an expert assessment of your current treatment plan.
Improved outcomes	• Members experience less absenteeism and increased productivity on their path to wellness.
Navigation support	• Provides relief to you by helping to navigate the complexities of the mental health system.
Connection	• You are guided in connecting with appropriate family doctors, local counseling, employee assistance programs (EAP) and community support.

Process

You initiate by web or phone and answer a series of simple questions to help us understand your concerns. You then speak with a mental health navigator who will guide you through the process. The clinical team will conduct an intake and gather your medical records (with signed consent). A clinical summary, following all the relevant records, will be provided to our expert. A mental health expert clinician reviews the case and provides recommendations in a comprehensive report and action plan for you to follow. The mental health navigator links you to the best resources based on their customized action plan.

Accessing Mental Health Navigator

Simply phone **1-877-419-2378** to start the confidential process. Once the process is started you can sign in or create a Teladoc account at Teladoc.ca or within the Teladoc app.

Confidentiality is very important to Teladoc and we follow the same strict security protocols as we do for our core services. All medical records are kept in a secure environment and Teladoc does not share the information with anyone unless the patient makes a specific request or as required by law.

Dental

General description of coverage

Dental benefits paid by the plan are based on the last approved Fee Guide established by the Provincial Dental Association. While they are not required to do so, the majority of dentists charge according to the rates set out in the Fee Guide. If the dentist charges more than the Fee Guide, you are responsible for the excess charges.

The maximum benefit is $700 per person per calendar year (January through December) for all services combined based on reasonable and customary charges (plans for 1 & 2 person firms have a $2,500 per calendar year family maximum). *Late Entrants* have a maximum benefit of $250 per person for their first 12 months of coverage.

A deductible is the dollar amount for which you are responsible. Your plan deductible and/or coinsurance percentage is on the *Certificate of Insurance*. This amount is applied to eligible expenses incurred each calendar year prior to reimbursement by the plan.

If you or a dependent needs more than $500 of treatment at one time, you should send the dentist's Treatment Plan, to the Plan Administrator for review by the Insurance Company. The Insurance Company will confirm how much the plan will pay and what your share of the expenses will be, if any. Treatment Plan decisions will not be given verbally over the phone. These Treatment Plans are only valid for 90 days.

Benefits

This plan is primarily designed to cover dental expenses that occur most often. Dental services are categorized as Basic, Major and Orthodontic services. **Please note your plan covers Basic services only excluding Endodontic and Periodontal procedures**.

Basic services, covered at the coinsurance level shown on the *Certificate of Insurance*, include:	
Oral examinations	• two recall oral exams (check-ups) in any calendar year • complete Exams (Dental History) once every 36 months • emergency or specific oral exams
X-rays	• one complete series of periapical films and panoramic film in any 24 month period • bitewing films and x-rays, excluding duplicate x-rays and x-rays for temporomandibular joint procedures
Consultations and Special Visits	• consultations with another dentist • house or hospital call and after-hours office visit

Preventive	• one unit of polishing and two units of scaling twice each calendar year • topical application of fluoride twice each calendar year • pit and fissure sealants • space maintainers for missing primary teeth (except when used for orthodontic purposes)
Restorative services	• amalgam, acrylic, silicate or composite restorations • duplicate fillings on the same tooth will not be covered within one year • repair, rebasing and relining of partial or complete dentures, not including the replacement of teeth on a denture • repair of fixed bridgework
Oral surgery	• including uncomplicated removal of erupted or impacted teeth or residual roots

Other Services	• Laboratory examinations
	• Anaesthesia (if performed in conjunction with oral surgery)
	  o general anaesthesia
	  o neuroleptanalgesic
	  o conscious sedation

Exclusions

Dental benefits are not payable under any of the following circumstances:

- charges for services not previously listed;
- charges for services that are not reasonable and customary;
- treatment for full mouth reconstruction, vertical dimension correction, occlusion restoration, temporomandibular joint (TMJ) correction or permanent splinting of teeth;
- any dental treatment which is not yet approved by the Canadian Dental Association or which is experimental in nature;
- replacement of lost, stolen or mislaid dentures and appliances;
- oral hygiene instruction, plaque control programs, nutritional counselling, chlorzoin treatment and sterilization of equipment;
- implant expenses or services related to implant procedures;
- non-emergency dental treatment provided outside of Canada;
- treatment for cosmetic purposes, i.e. veneers, bleaching, etc.;
- services, treatment or supplies provided to the employee by the employer;
- expenses as a result of intentional self-inflicted injuries while sane or insane;
- treatment for injuries sustained while committing or attempting to commit a criminal offence;
- expenses for which payment is provided under any Workers' Compensation Act or similar legislation, government plan or any other plan;
- injuries caused directly or indirectly by insurrection and war, participation in a riot or civil disorder;
- services, treatment or supplies which the individual received without charge;
- travel time, broken appointments, transportation costs, charges for completion of claim forms, telephone or other indirect consultations;
- facility fees.

Limitations

Reimbursement will not be made over the suggested charge in the appropriate Fee Guide for the least expensive treatment that will provide a professional result.

Reimbursement of lab fees will be limited to the reasonable and customary charge for such services. Total reimbursement will not exceed 60% of the suggested fee in the appropriate Fee Guide.

Survivors' Benefit

There is a 24 month extension of coverage for dependents (without payment of premiums, and in accordance with the other provisions of the plan), until the earliest of the following after the death of the insured:

- the end of a 24 month period following the death of the employee;
- the date on which the spouse remarries;
- the date on which the spouse becomes an employee or dependent under this or any other group plan;
- the date on which the Member Firm is no longer insured under this benefit;
- the date on which this benefit terminates.

Claims

Completed claim forms must be submitted within one year of the date the expense was incurred. Upon termination, claims must be submitted within 120 days after the termination date. All claims must be sent to the Plan Administrator and signed by the employee.

Eligible expenses will be based on the date the service or supply was provided. For bridges, crown or dentures, the date the appliance was inserted will be the date of service. For root canal therapy, the date of the final treatment will be the date of service.

All benefits described here are governed by the Master Contract underwritten by Desjardins Financial Security Life/Assurance Company.

Arive Employee Assistance Program (EAP)

General description of coverage

Your employer knows that from time to time, personal and work-related issues can affect you and how you perform your job. Arete has been retained by the Chambers of Commerce Group Insurance Plan to help you deal with the stresses and challenges you face – both at work and at home. The Arive EAP is designed to provide you with completely confidential support and guidance when you need it most.

Benefit

The Arive EAP is available to each insured employee and/or their eligible dependents. Your Arive EAP provides up to a total of 12 hours of counselling (either in person, by video or phone) per calendar year per family unit. Telephone consultation is also available for assistance with legal and financial issues (to a maximum of three hours each, per family unit, per calendar year), for nutritional guidance and eldercare issues, or for childcare navigation support. There are no out-of-pocket expenses and no claim forms to submit when using this service. Experience shows some issues are better handled in-person, while other situations can be discussed through a telephone conversation.

Counselling (offered in person, by video or phone)	*Family Challenges* - relationship or marital concerns, separation, divorce problems, marital conflict, communication issues, parenting problems, and blended families. *Work-Related Difficulties* - stress, burnout, difficulty adjusting to change, interpersonal problems with supervisors or co-workers, conflict, harassment, and bullying. *Personal Problems* - fatigue, sleep disturbances, depression, anxiety and isolation, loss of self-esteem, motivation, and coping with bereavement. *Dependency Concerns* - excessive use of drugs, alcohol, compulsive gambling and gaming, internet/electronic device dependency, and coping by self-medication.
Other Supports (offered by phone)	*Legal Issues* - divorce, child custody, domestic violence, adoption, family law advice, criminal and employment law explanation, and trusts / wills / estates / probate. *Financial Struggles* - personal money management coaching, debt reduction / budget planning, retirement planning. *Eldercare solutions* - assessment of needs and in-home safety requirements, custom care strategies, and support accessing local resources. *Nutritional Counselling* - support and education to manage chronic disease and digestive disorders, pregnancy/lactation, healthy eating, weight management and sports nutrition. *Childcare Navigation Support* - assistance researching daycare and day home facilities and vacation camp options.

Confidentiality

The success of any employee assistance plan is built on privacy. Arete manages a national network of professional counsellors, ready to assist you in a respectful, confidential manner. Their counsellors all

belong to accredited associations and abide by Canada's Personal Information Protection and Electronic Documents Act (PIPEDA) or similar legislation, and provincial laws and codes of ethics governing their professions. Arete will never disclose personal information without the express written consent of the individual involved.

Accessing Services

Simply call Arete's toll-free number **877-412-7483 (or complete a form online: https://aretehr.com/online-intake-form/)** and have your *Firm* and *Certificate number* handy.

Representatives are available 24 hours a day, 7 days a week, to speak with you and all calls are completely confidential. A trained specialist at Arete will ask some basic questions to identify how best to help you and to connect you with the professional best suited to meet your needs. Contact with a professional is then arranged for either in person, video or telephone counselling. You will always be treated with dignity and respect, and with confidentiality assured. You do not need to ask your employer's permission to use this service, nor will they be advised of your call.

RÉGIME D'ASSURANCE COLLECTIVE DES CHAMBRES DE COMMERCE[MC]
1051, rue King Edward, Winnipeg (Manitoba) R3H 0R4 | 1 800 294.4080
information@johnstongroup.ca | lecollectifdeschambres.ca

CHAMBERS OF COMMERCE GROUP INSURANCE PLAN®
1051 King Edward Street, Winnipeg, MB R3H 0R4 | 1 800 665.3365
info@chambers.ca | chamberplan.ca