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GROUP

INSURANCE

BENEFITS

Johnstone's BENEFITS

Summary of Benefits

Benefit Details

This booklet provides a summary of your Johnstone's group benefits plan. The information contained here is important to you and your family and you should keep it in a safe place. Familiarize yourself with the contents of this booklet and refer to it whenever you claim group insurance benefits.

The information in this booklet is designed to help you understand the benefits covered under your plan. **It is not a legal contract, and payment for all claims is based solely on the group master policy or contract issued by the insurer.**

Benefit	Insurer	Policy number	Effective date
Life	Industrial Alliance	23101-00	June 1, 2000
Optional dependent life	Industrial Alliance	23101-00	June 1, 2000
Accidental death & disablement	Lloyd's Underwriters	10011	September 1, 2003
Long term disability	RBC Insurance	RBC00001291	January 1, 2019
Extended health care	Industrial Alliance	23101-00	June 1, 2000
EAP	Homewood Health Inc	WB2000	June 1, 2000
Dental care	Industrial Alliance	23101-00	June 1, 2000
Health Spending Account	myHSA	n/a	January 1, 2020

Identification number

Your individual certificate number is your ID number as shown on your Johnstone's Benefit Summary ID card. If you require a replacement card at any time, contact Johnstone's Benefits.

Johnstone's Benefits website

You can find information to better understand your benefits and learn how we can help you at www.jbenefits.com

Claims Submissions

You can find claim forms for any of your benefits at our website: www.jbenefits.com. If you have any questions, call (604) 980-6227 (toll free: 1 800 432-9707).

Extended health care and dental claims

Mail or deliver extended health care and dental claims to:

Industrial Alliance
Attn: Health and Dental Claims
P.O. Box 4643, Station A
Toronto, Ontario, Canada
M5W 5E3

To submit an EHC claim, see "claiming procedures" in the EHC section of this booklet.

For dental claims, your dental office will usually submit on your behalf

To contact Industrial Alliance for assistance with your medical and dental claims and coverage, call customer service at (877) 422-6487.

Submitting claims online

Sign up for **My Client Space** and obtain access to Industrial Alliance's online services.

With **My Client Space**, you get quick and easy access to useful information:

- Submit claim online, E-claims
- Access your coverage information and booklet
- View the status of medical or dental claims
- Verify when you will be eligible for your next exam (if your plan includes vision or dental care)
- Print your certificate
- Obtain a list or processed claims for tax purposes
- Access Webhe@lth, a website dedicated to health and wellness.

Sign in or register at **www.ia.ca** to access online services 24/7.

- At the top-right corner, click on Connection then on My Client Space
- *Sign in* or *Register*

E-claims - To submit a claim online, you must first register for direct deposit and notification

- Log in to My Client Space, click E-claims, and follow the steps to submit your health, drug, vision or dental expense online.

OR

- Use the iA mobile app to submit a claim with your smartphone: iOS or Android

All other claims

Send Life, Dependent Life, AD&D and LTD claims to:

Johnstone's Benefits
3095 Woodbine Drive
North Vancouver, B.C. V7R 2S3

Written notice of life insurance, dependent life insurance, accidental death & disablement and long term disability claims must be filed with the insurer as soon as reasonably possible, after the occurrence or start of any loss. See the summary of benefits for each benefit for specific limitations.

This is a summary of your life insurance benefits. For details see the life insurance section of this booklet.

Plan Design	Details
Eligibility	Coverage is for the employee only.
Benefit formula	Two times your annual income (rounded to the next highest $1,000)
Maximum benefit	$500,000
Minimum amount	$5,000
Non-evidence amount	$500,000 This is the maximum amount of coverage available before evidence of insurability will be requested. **Note:** the non-evidence amount is subject to change without notice and will be determined at the time of your application or salary change.
Benefit reduction	Coverage reduces by 50% at age 65
Termination	At the earlier of termination of employment or retirement
Conversion privilege	If coverage under this plan terminates, conversion to a personal plan is available within 31 days of termination. For details, see Conversion privilege on page 21.
Beneficiary	Payment of this benefit will be made to the persons you have designated. **Note:** if no beneficiary is designated, proceeds will go to your estate.
Claiming deadline	Notify the insurer within 30 days, submit claim within 90 days

This is a summary of your optional life insurance benefits. For details see the optional life insurance section of this booklet.

Plan Design	Details
Eligibility	Coverage is for the employee or the spouse.
Benefit formula	Units of $25,000
Maximum benefit	$500,000
Minimum amount	$25,000
Non-evidence amount	Evidence of insurability is required for all amounts.
Benefit cost	Rates are based upon individual ages and smoking habits.
Termination	At the earlier of termination of employment, retirement or age 70.
Conversion privilege	If coverage under this plan terminates, conversion to a personal plan is available within 31 days of termination. For details, see Conversion privilege on page 22.
Beneficiary	Payment of this benefit will be made to the persons you have designated. **Note:** if no beneficiary is designated, proceeds will go to your estate.
Claiming deadline	Notify the insurer within 30 days, submit claim within 90 days

This is a summary of your dependent life benefits. For details see the dependent life section of this booklet.

Plan Design	Details
Eligibility	Coverage is for the spouse, and dependent children of an eligible employee. Dependent children are covered between the ages of 24 hours to age 21, 26 if a full-time student.
Non-evidence amount	Health evidence is not required.
Coverage termination	All coverage terminates at the earlier of the employee's termination of employment or retirement.
Dependent coverage termination	Spouse: the employee's termination or retirement date Child: age 21 or age 26 if a full-time student
Conversion privilege	If coverage under this plan terminates, conversion to a personal plan is available within 31 days of termination. For details, see page 23.
Beneficiary	Payment of this benefit will be made to the employee.
Claiming deadline	Notify the insurer within 30 days, submit claim within 90 days

Coverage options	
Option 1	**Spousal coverage:** $50,000 **Child's coverage:** $10,000
Option 2	**Spousal coverage:** $10,000 **Child's coverage:** $2,000
Option 3	**Decline coverage -** Should you decline coverage; this option will not be available at a future date.

This is a summary of your accidental death & disablement benefits (AD&D). For details see the AD&D section of this booklet.

Plan Design	Details
Eligibility	Coverage is for the employee only.
Benefit formula	Accidental death benefit: Two times your annual income (rounded to the next highest $1,000) Loss of use: see Schedule of loss on page 24.
Maximum benefit	$500,000
Aggregate	The maximum for all insured persons within your group involved in any one aircraft accident is $21,000,000.
Minimum amount	$5,000
Non-evidence amount	Accidental death coverage matches the life insurance, above. See life benefit non-evidence amount for details. This is the maximum amount of coverage available before evidence of insurability will be requested.
Benefit reduction	Coverage reduces by 50% at age 65
Termination	At the earlier of termination of employment, retirement or age 75.
Conversion privilege	If coverage under this plan terminates, conversion to a personal plan is available within 31 days of termination. For details, see page 27.
Beneficiary	Payment of the death benefit will be made to the persons you have designated. **Note**: if no beneficiary is designated, proceeds will go to your estate.
Claiming deadline	Notify the insurer within 30 days, submit claim within 90 days

This is a summary of your long term disability benefits (LTD). For details see the LTD section of this booklet.

Plan Design	Details
Eligibility	Coverage is for the employee only.
Benefit formula	Monthly benefit calculated as 66.67% of the first $2,500 and 50% of the balance of gross monthly earnings.
Definition of earnings	For the insurer's definition, see page 31.
Maximum monthly benefit	$10,000 The individual's income from **all** sources, while disabled, cannot exceed 85% of indexed pre-disability monthly income.
Non-evidence amount	$6,000 This is the maximum amount of coverage available before evidence of insurability will be requested.
Benefit starts after	The later of 112 Days or the date your accumulated sick leave or salary continuation payments end, if applicable.
Pre-existing limitation	Exclusions apply. See page 38 for details.
Benefit period	To age 65
Definition of disability	You are unable to perform the regular duties of your occupation due to your sickness or injury. After 24 months, you are unable to perform any gainful occupation for which you are reasonably fitted by education, training or experience. For the insurer's definition, see page 29.
Termination	At the earlier of termination of employment, retirement or age 65.
Taxation	Benefits paid are not taxable if the employee is deemed to have paid the entire premium.
Claiming deadline	Notify the insurer within 30 days, submit claim within 90 days.

This is a summary of your extended health care benefits (EHC). For details see the EHC section of this booklet.

Note: frequency limitations and financial maximums apply to specific benefits covered under this EHC plan. See details under the extended health care section in this booklet. Reimbursement amounts for EHC procedures, supplies, and services are always based on reasonable and customary fees as determined by your insurer.

Plan Design	Details
Eligibility	Coverage is for the employee, the spouse, and dependent children. Dependent children are covered to age 21, or 26 if a full-time student, to any age if disabled.
Reimbursement schedule (unless otherwise indicated)	Out of province emergency care: 100% All other eligible expenses: 100%
Plan maximums	$5,000,000 lifetime maximum combined with Out-of-Province and out of country emergencies
Annual deductible	$25 for singles $50 for couples $50 for families Deductible is not applicable to Hospital Room
Termination	At the earlier of termination of employment or retirement.
Conversion privilege	If coverage under this plan terminates, conversion to a personal plan is available within 60 days of termination. For details, see page 56.
Claiming deadline	Claims must be submitted to the insurer within 12 months of the date of the event.
Survivor benefit	Dependent coverage may continue without further payment of premiums for up to 24 months after the date of the employee's death.

Covered Items	Reimbursement Percentage	Details
PRESCRIPTION DRUGS	100%	No annual maximum dollar amount but reimbursement will be based on the reasonable and customary fees in the pricing file set by the insurer
Pay direct drug card		Yes. Present the card to the pharmacist and pay only the portion not covered under your plan.
Eligible drugs		Lowest-cost alternative, usually the generic prescription equivalent when available. For details see page 47.
PARAMEDICAL SERVICES		
Acupuncture **Clinical Psychologist / Psychotherapists** **Speech Therapist** **Chiropractor** **Massage therapist** **Naturopath** **Osteopath** **Physiotherapist** **Podiatrist / Chiropodist**	100%	$400 calendar year limit
VISION CARE	100%	
Prescription eyeglasses, contact lenses and eye exams		$300 every 24 months Eye exams are eligible every 12 months for dependent children.
AMBULANCE AND HOSPITAL	100%	
Ambulance		Emergency only, includes air transport
Hospital		Semi-private only (no deductible)

Covered Items	Reimbursement Percentage	Details
MEDICAL EQUIPMENT AND SUPPLIES	100%	Limits apply. See the EHC section of this booklet for details. Pre-authorization is required for large dollar amounts.
HEARING AIDS	100%	$400 every 5 calendar years Adults and dependent children
DENTAL ACCIDENTS	100%	Yes, within 52 weeks of the accident. For claims submission instructions and limitations, see page 53.
ORTHOPEDIC SHOES	100%	1 pair each calendar year
ORTHOTICS	100%	$300 each calendar year
TRAVEL **Out of province and out of country emergency coverage**	100%	$5,000,000 lifetime maximum combined with In-Province For details see page 52.
Out of Canada non-emergency referral	80%	$50,000 lifetime maximum
International medical assistance		24-hour multilingual assistance to help identify the appropriate medical care, assist in emergency medical payments, arrange medical transportation, assist travel companions. Refer to your travel assist card for the phone numbers. Call within 48 hours after your medical emergency.

This is a summary of your employee assistance program (EAP). For details see the employee assistance program section of this booklet.

Plan Design	Details
Eligibility	Coverage is for the employees and their dependents.
Benefit	The employee and family assistance plan provides all staff and their family members with confidential professional counselling.
Covered conditions	Counselling is provided by Homewood Health for personal problems including stress, grief, anger, and self-esteem, as well as for work-related issues such as conflict and job satisfaction.
How to access	**English:** 1-800-663-1142 **French:** 1-800-398-9505 International: 604-689-1717 (call collect) **TTY/TTD*:** 1-888-384-1152 *TeleTypewriter, Telephone Device for the Deaf. Visit the Homewood Health website www.homewoodhumansolutions.com for further information and additional resources to aid both you and your family members.

Homewood Health provides confidential counselling, consultations, community referrals, multimedia resources and online access to hundreds of articles, self-assessments, blogs, podcasts, calculators and more. Services are available 24 hours a day, seven days a week, and are provided at no additional cost to you and your dependents. See page 58 for more details.

This is a summary of your dental care benefits. For details see the dental care section of this booklet.

Plan Design	Details
Eligibility	Coverage is for the employee, the spouse, and dependent children. Dependent children are covered to age 21, or 26 if a full-time student, to any age if disabled.
Annual deductible	There is no deductible.
Termination	At the earlier of termination of employment or retirement.
Conversion privilege	If coverage under this plan terminates, conversion to a personal plan is available within 60 days of termination. For details, see page 65.
Fee guide	The applicable fee guide is the one in force for general practitioners in the province where the expense was incurred, on the day the services were performed. For Alberta residents, eligible fees are based on the 1997 fee guide plus an inflationary adjustment determined by the insurer. All fees in excess of the fee guide are the patient's responsibility. Your dentist has a copy of the fee guide.
Claiming deadline	Claims must be submitted to the insurer within 12 months of the date of the event.
Survivor benefit	Dependent coverage may continue without further payment of premiums for up to 24 months after the date of the employee's death.
Dental accidents	Covered under the EHC plan.

Type of Coverage	Reimbursement Percentage	Maximums
Part A: basic services	100%	$2,000 calendar year maximum for each insured person combined with Part B: major restorative services.
Recall exam limit		Two in a calendar year
Scaling (periodontal cleaning) limit		Two units in a calendar year
Part B: major restorative services including crowns, bridges, partial and full dentures	50%	$2,000 calendar year maximum for each insured person combined with Part A: basic services.
Part C: orthodontics **Coverage for dependent children only**	50%	$2,000 lifetime maximum for each eligible dependent child. Coverage for dependent children under 19 years of age.

This is a summary of your health spending account (HSA). For details see the HSA section of this booklet.

Plan Design	Details
Eligibility	Coverage is for all employees and their dependents.
Maximum benefit	$300 per employee
Termination	At the earlier of termination of employment or retirement
Benefit period	January 1 to December 31
Unused balances	Any unused benefit dollars (your allocation) that has not been used in the calendar year in which it was provided will be forfeited.
Claiming deadline	Active employees can submit for one month after the end of the policy year in which the claim was incurred. i.e. Expenses from January 1, 2020 to December 31, 2020 must be submitted by January 30, 2021.

Your health spending account can be used to pay for eligible medical and dental expenses not paid for by any other insurance. Any expense that CRA (Canada Revenue Agency) considers an eligible medical expense is covered at 100%. It operates similar to a bank account, as your account is credited with the allowed amounts and then eligible expenses are deducted.

The Canada Revenue Agency requires that spending accounts be used for the purpose they were intended for: to pay for eligible medical expenses. Unused account balances cannot be withdrawn in cash or used for other purposes.

Who is Johnstone's Benefits?

Johnstone's Benefits is an independent employee benefits advisor and third party administrator located in North Vancouver B.C. We have over 30 years experience working with employers of all sizes to develop customized employee benefit and retirement plan solutions. We have no contractual obligations to any insurance provider, which allows us to negotiate the most favourable premium costs, benefit provisions, and claims payment settlements on behalf of our clients and their employees. As a third party administrator, we provide administration support in managing employee benefits plans. If you have any questions or concerns with any aspect of this, or any other product, don't hesitate to contact Johnstone's Benefits.

Eligibility and Waiting Period

All permanent full-time employees who reside in Canada and are working at least 30 hours a week are eligible to join the plan for life insurance, accidental death & disablement, long term disability, extended health, employee assistance program and dental. Future employees will become eligible for benefits on the following basis:

Benefit	Eligible for coverage on:
All benefits	Immediate, no waiting

Note: For extended health care benefits, you and your dependents must be insured under the provincial health plan to be covered under these benefits.

Insurance Effective Dates

Insurance for you and your dependents will become effective immediately on the above noted **dates if you have completed the necessary enrolment forms and are actively at work.**

If you are absent from work for any reason other than statutory or regularly scheduled holidays when you would otherwise become insured, you will be insured on the date you return to work on an active, full-time basis.

Late Applicants

If you do not complete the necessary enrolment forms within 31 days of the eligibility date for you and your dependents, insurance will be effective on the date you and they are approved by the insurer, provided you are actively at work on that day. Medical evidence of good health is required and you will be responsible for any medical expenses involved.

For dental benefits, late applicants are limited to a maximum of $200 per person for all dental services received during the first 12 months of coverage.

Medical Evidence Requirement

For life insurance and long term disability amounts in excess of the no-evidence amounts (as shown in the summary of benefits), medical evidence of good health is required.

As previously noted, medical evidence of good health must be provided at your own expense if you fail to enroll within 31 days of your eligibility date. Contact your plan administrator for the necessary forms. For our purposes, a physician means a legally qualified physician or surgeon, other than the insured or a member of the family.

Coverage for Dependents

The employee's dependent spouse and dependent child who:

- resides in Canada;
- is not a member on active duty of the armed forces of any country.

Dependent Spouse

The spouse of the employee, and is **either**:

- a person legally married to the employee;

OR

- a person, whom he or she has been residing with for a period of at least one year and is not legally married to as the spouse, provided that a written request is made by the employee for granting insurance for such named individual, in a form satisfactory to the insurer. Unless this written request is made the person legally married to the employee is considered to be the dependent spouse. Discontinuance of cohabitation terminates the eligibility of a common-law spouse for dependent status.

Dependent Child

An unmarried child, stepchild or legally adopted child **either**:

- of the employee or the legal spouse, who lives with them and is fully dependent on them for support;

OR

- of the employee or the common-law spouse, who is in the care and custody of both, residing with them and being fully dependent on them for support;

AND

- is under age 21 or age 26 if attending an educational institute full-time and will be covered to any age if physically or mentally disabled and incapable of self-sustaining employment.

Dependents effective date of coverage

Subsequent dependents become effective on the date on which they become eligible dependents if they are registered within 31 days of becoming eligible. However, if dependents are hospitalized on the date they are to become eligible, coverage may not be effective until they are no longer hospitalized.

Employees insured under a spouse's plan

This information applies to groups that have extended health care (EHC) and dental care plans.

Opting out

Employees who have alternative coverage under a spouse's plan are permitted to waive coverage under the extended health and dental care plans. The employee must complete a waiver that identifies both the alternative coverage and carriers.

Loss of Spouse's Coverage

If coverage under your spouse's health or dental care plan terminates, either because the plan terminates or because your spouse becomes ineligible for that plan, you are eligible for immediate coverage under your company's extended health and dental care benefits **provided you apply within 31 days of the date your coverage terminates**.

For any late application (i.e. after 31 days) evidence of insurability will be required for you and your dependents at your expense. Coverage will not be effective until the day such insurability is approved.

Co-ordination of Benefits

When a person has extended health care or dental care coverage under more than one plan, benefits under this plan will be subject to co-ordination so that benefits payable from all plans do not exceed 100% of eligible expenses.

To determine which plan pays first, insurance companies follow the COB guidelines established by the Canadian Health and Life Insurance Association:

- Claims go first to the insurer who provides the employee with coverage. Before payment for your own claim can be made through your spouse's plan, it must first be submitted to your own plan (& vice versa).
- In the case of children the order of payment is determined by the month of birth of the employee and spouse. Regardless of which spouse is older, the plan covering the spouse whose birthday falls earliest in the year will always pay first. For example, if the employee was born in April and the spouse born in January, the spouse's plan will be the first payor of the children's claim.

Insurance Termination Dates

Your coverage will terminate:

- upon termination of the policy
- when you are not in an eligible class
- upon termination of employment
- upon non-payment of premium
- when termination is requested in writing
- at age 65 less the elimination period for the LTD benefit
- when a dependent is no longer eligible

Your dependents' coverage terminates along with yours, or when your dependent no longer qualifies, whichever is earlier.

Note: Termination provisions may vary under different benefits. Please refer to the summary of benefits for further details.

Personal Information

When you apply for coverage under the group benefit plan, both Johnstone's and each insurer will open a file with personal information relevant to your insurance coverage under the plan.

These files are necessary to enable the administration of all benefits you are entitled to under the group coverage provided. This includes:

- Underwriting and financial reporting
- Claims adjudication and management
- Internal and external audits
- Preparation of regulatory and statutory reports

These files are kept in the offices of Johnstone's Benefits and the respective insurers. Employees of these organizations have access to these files when required for insurance purposes. You have certain rights of access and correction with respect to the information in your files. A request for access or correction must be in writing and may be sent to us for forwarding to the insurer.

For more information on our privacy policy, go to our website: www.jbenefits.com/privacy.html

Legal Note

These provisions have been added to your booklet to comply with, or in response to, amendments to insurance legislation in certain provinces.

Access to documents

You have the right to request a copy of the policy, your application, and any written statements or other records you have provided to Johnstone's Benefits and the insurer as evidence of insurability (subject to certain limitations).

Legal actions

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is prohibited unless begun within the time set out in the Insurance Act or other applicable legislation.

Appeals

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

Benefit limitation for overpayment

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

Underwritten by Industrial Alliance
Policy Number 23101-00

Coverage is for the employee only

Note: All information in this section is supplied by the insurer. This is not a legal contract and payment of all claims is based solely on the group master policy or contract issued by the insurer.

The Employee Life Insurance Benefit pays a lump sum amount to your named beneficiary in the event of your death due to any cause. You may change your beneficiary at any time (subject to any limits set by law) by completing a form available from your administrator and returning it to him/her. If you survive your beneficiary, payment will be made to your estate.

Waiver of Premium Benefit

If you are unable to perform substantially all of the essential duties of any occupation or employment for which you are reasonably qualified by education, training or experience because you have become totally disabled due to a medically determinable mental or physical impairment prior to age 65, and are so disabled for a continuous period of 6 months, your Life Insurance will be continued in force without payment of further premiums during continuance of the disability.

The amount of Life Insurance on which payment of premium is waived shall be in accordance with the Summary of Benefits at the date your total disability commenced. This benefit is subject to proof of initial and continuing disability as set forth in the Group Policy issued to the Policyholder, and will terminate upon the attainment of age 65.

Conversion Privilege

If your Life Insurance should terminate, on or prior to your 65th birthday, you will, in specific circumstances have a conversion privilege with respect to such insurance. The conversion privilege, if any, will be as set out in the Group Policy issued to the Policyholder. Please see your Plan Administrator for further details.

Note: the total amount of Life Insurance that you can convert during the lifetime of the Plan will be $200,000.

Underwritten by Industrial Alliance
Policy Number 23101-00

Coverage is for the employee and spouse

Note: All information in this section is supplied by the insurer. This is not a legal contract and payment of all claims is based solely on the group master policy or contract issued by the insurer.

In the event of the death of you or your spouse from any cause, the amount of Optional Life Insurance for which you or your spouse is insured will be paid. However,

- no Optional Life Insurance is payable if you or your spouse's death is due to suicide within 2 years after you or your spouse's Optional Life Insurance became effective, and
- if the Optional Life Insurance on you or your spouse should increase and you or your spouse should commit suicide within two years of the date the increase takes effect, no payment will be made with respect to such increase.

Waiver of Premium Benefit

If you are insured for Optional Life Insurance, and if premiums for your insurance are waived because of your total disability, the premiums in respect of you and/or your spouse's Optional Life Insurance will also be waived.

Conversion Privilege

If the Optional Life Insurance on you or your spouse should cease on or prior to the earlier of (1) your 65th birthday and (2) your spouse's 65th birthday, you or your spouse, in specific circumstances, may have a conversion privilege with respect to such Optional Life Insurance. The conversion privilege will be as set out in the Group Policy.

Note: The total amount of Optional Life Insurance and Dependent Life Insurance that can be converted on the life of your spouse during the lifetime of the Group Policy will be $200,000.

Underwritten by Industrial Alliance
Policy Number 23101-00

Beneficiary

Any amount payable on the death of your dependent shall be payable to you.

Conversion Privilege

If the Dependent Life Insurance on your dependent should cease on or prior to the earlier of:

- your 65th birthday,
- your dependent's 65th birthday

you or your dependent will, in specific circumstances have a conversion privilege with respect to such Dependent Life Insurance. The conversion privilege, if any, will be as set out in the Group Policy issued to the Policyholder. Please see your Plan Administrator for further details.

Note: the total amount of Life Insurance that you can convert on the life of your spouse during the lifetime of the plan will be $200,000,

Waiver of Premium

When the premiums for your Life Insurance are waived because of your total disability, the premiums in respect of your dependent's Life Insurance will also be waived subject to the following:

- there will be no increase in the amount of insurance on the life of the dependent during the period premiums are being waived, and
- the insurance on the life of the dependent will not be continued beyond the time it would otherwise terminate as provided for under the terms of the Group Policy issued to the Policyholder.

Underwritten by Lloyd's Underwriters
Policy Number 10011

Coverage is for the employee only

Note: All information in this section is supplied by the insurer. This is not a legal contract and payment of all claims is based solely on the group master policy or contract issued by the insurer which may be viewed at the office of the group policyholder (the employer).

You are insured 24-hours a day, worldwide. This coverage provides lump sum, tax-free benefits in the event of an accident causing death, loss of (or loss of use of) limbs, loss of sight, etc. as outlined below.

Specific Loss Benefits Schedule

The "Principal Sum" for which you are covered is shown in the Summary of Benefits of this booklet. When injury results in any of the following losses within 365 days of the accident, the Insurer will pay for:

The **principal sum** for Loss or Loss of Use of

- Accidental Death
- Both Hands
- Both Feet
- Speech and Hearing in Both Ears
- The entire Sight of Both Eyes
- One Hand and One Foot
- One Hand and the Entire Sight of One Eye
- One Foot and the Entire Sight of One Eye

80% of the principal sum for Loss of or Loss of Use of

- One Arm
- One Leg

70% of the principal sum for Loss of or Loss of Use of

- One Hand
- One Foot
- The Entire Sight One Eye
- Speech
- Hearing in Both Ears

35% of the principal sum for Loss of

- Thumb and Index Finger or at Least Four Fingers of One Hand
- All Toes of One Foot
- Hearing in One Ear

Two times the principal sum for total paralysis of

- Both Upper and Lower Limbs (Quadriplegia)
- Both Lower Limbs (Paraplegia)
- Both Upper and Lower Limbs on one side of the body (Hemiplegia)

Indemnity provided under this section for all losses sustained by any one Insured Person as the result of any one accident shall not exceed the Principal Sum, with the exception of quadriplegia, paraplegia and hemiplegia, where indemnity shall not exceed two times the Principal Sum.

Notwithstanding the foregoing, if loss of life due to accidental death occurs within one hundred and twenty (120) days after the date of the accident for which indemnity is payable, indemnity payable under this section shall not exceed the Principal Sum.

Aggregate Limit

The total limit for all Insured Persons in your group involved in any one aircraft accident is $5,000,000.

Beneficiary

In the event of accidental death, benefits will be paid to your designated beneficiary entered on your enrolment form. All other benefits, with the exception of the Repatriation Benefit and Occupational Training Benefit, described below, are payable to you.

Other AD&D Benefits

Repatriation benefit

In the event accidental death occurs more than 50 kilometres away from your home, the cost (up to $15,000 maximum) or preparation and shipping you to your city of permanent residence, is covered.

Rehabilitation benefit

Up to $15,000 towards the cost of special training is payable, within 3 Years of the accident, as a result of a claim which qualifies under the "Specific Loss Benefits Schedule", above.

Occupational training benefit

Should you suffer accidental death covered by this policy, up to $15,000 is payable, within 3 years of the accident, for your spouse to retrain in an occupation which he/she would not otherwise have sufficient qualifications.

Childcare benefit

Certain losses will qualify for a childcare benefit payment for children enrolled in an accredited Childcare facility and under the age of 13. This will provide up to $6,250 per year per child for up to 4 years.

Seat belt rider

In the event injury occurs while you are a driver or a passenger in a private automobile, the benefit payable will be increased by 10% if it is verified that you were wearing a properly fastened seat belt at the time of the accident.

Home modification benefit

A maximum benefit of $30,000 is provided towards the cost of alterations to your residence to make it wheelchair-accessible and habitable, in the event injury results in the loss or loss of use of both feet or both legs, quadriplegia, paraplegia or hemiplegia.

Hospital cash benefit

In the event you sustain an injury and that injury requires that you be confined to a hospital as an inpatient, while under the care of a physician or surgeon, the benefit will pay a daily amount of $50 for each day you are hospitalized, retroactive after a minimum hospital confinement of 72 hours, not to exceed more than 25 days.

Family transport and subsistence benefit

In the event injury occurs and you are confined to a hospital located not less than 250 kilometers from your residence, the benefit will pay for the return fare, economy class transportation, of one member of your immediate family, or a close friend, by the most direct route via common carrier, when the attending physician advises the necessary attendance. The benefit will also pay for the reasonable and necessary expenses incurred by your family member or friend for accommodation and meals, limited to a maximum of $300 per day inclusive, up to a maximum duration of 10 days. The maximum for the total of all transportation, accommodation and meal expenses shall not exceed a maximum of $12,500 as the result of any one accident.

Personal mobility benefit

Up to $50,000 is payable, within 2 years of the accident, for the purchase of a special vehicle with hand controls, lifts for the home or personal vehicle, electric wheelchairs, etc., which are necessary as the result of a loss payable under the "Specific Loss Benefits Schedule".

Disability fitness benefit

Up to $7,500 is payable, within 2 years of the accident, for the purchase of special fitness or athletic equipment for the disabled, that would not have been required except for an injury for which benefits are payable under the "Specific Loss Benefits Schedule".

Waiver of Premium

If you become totally disabled from performing any work you are capable of, premiums due for this coverage will be waived, after 6 months of continuous disability, until you recover, reach age 65, or the group policy is terminated.

Note: The above benefits shall only be payable under one of the policies issued by the Insurer.

Conversion Privilege

If your coverage under this group plan terminates, because you leave the employ of the company or the group policy terminates, and provided you are under the age of 75, you may convert your amount of coverage, within 31 days, to an individual policy, payable at the individual premium rates for your age, occupation and activities, as prescribed by the Insurer.

Exposure and Disappearance

Benefits are payable for losses as provided under the policy due to unavoidable exposure to the elements, when caused by an injury covered by the policy. Also, if you are not found within one year of the sinking or wrecking of the conveyance in which you were riding at the time of the accident, and under circumstances that would otherwise be covered, the Insurer will pay the Accidental Death Benefit.

Exclusions

This policy does not cover any loss, fatal or non-fatal, caused or contributed to by:

- Suicide, or intentionally self-inflicted injury;
- War, or any act of war;
- Active or full time service in the armed forces of any country;
- While flying when you have flight duties (pilot, etc.), or when flying in an aircraft owned, operated or leased by the Policyholder;
- Nuclear reaction, nuclear radiation or radioactive contamination.

Underwritten by RBC Insurance
Policy Number RBC0001291

Coverage is for the employee only

Note: All information in this section is supplied by the insurer. This is not a legal contract and payment of all claims is based solely on the group master policy or contract issued by the insurer.

Benefit Specific Definitions

The following definitions are applicable to this benefit in addition to certain definitions under the General Information section of this booklet.

Appropriate care

- you personally visit a physician as frequently as is medically required, according to generally accepted medical standards, to effectively manage and treat your disabling condition(s); and
- you are receiving and complying with the most appropriate treatment and care, which conforms with generally accepted medical standards, for your disabling condition(s) by a physician whose specialty and experience is the most appropriate for the disabling condition(s) according to generally accepted medical standards.

Appropriate care must not be limited solely to examinations or testing. Where, according to generally accepted medical standards, the appropriate form of treatment for your disabling condition(s) is surgery, hospitalization, in-patient treatment, hospital day treatment, or individual or group addiction support therapy, you must comply with such form of treatment.

Benefit offsets

Benefits or payments from the sources listed as Benefit Offsets in the policy. As indicated in the Monthly Payment Calculation in the Long Term Disability Summary of Benefits, we will subtract these other benefits or payments in order to determine your monthly payment.

Dependent

With respect to the Dependent Care Expense Benefit:

- your child(ren) under the age of 15; and
- your child(ren) over the age of 15 or a family member who requires personal care assistance.

Definition of disability

Disability and disabled (Residual Disability) means you:

- are limited from performing the material and substantial duties of your regular occupation due to your sickness or injury; and
- have a 20% or more loss in your indexed monthly earnings due to the same sickness or injury.

After 24 months of payments, disability and disabled means that due to the same sickness or injury, you are unable to perform the duties of any gainful occupation for which you are reasonably fitted by education, training or experience.

You must be under appropriate care in order to be considered disabled. Your disability must commence while you are insured under the policy.

The unavailability of employment in an occupation does not, in itself, constitute disability.

The loss of a professional or occupational licence or certification does not, in itself, constitute disability.

Disability earnings

The earnings which you receive while you are disabled and working, plus the earnings you could receive if you were working to your maximum capacity.

Eligible survivor in order of entitlement means:

1. your current spouse, if living; or
2. your former spouse, if living, where long term disability benefits under your group insurance plan are subject to a separation agreement or a judicial order that is still in effect; or
3. your children who are under age 26 at the time the Survivor Benefit is payable.

If more than one person meets the definition of eligible survivor, we will pay only one benefit, which will be paid in equal shares to the persons meeting the definition.

If any eligible survivor is a minor and there is no other person capable of giving proper discharge, we reserve the right to pay the survivor benefit to the relevant provincial trustee for the benefit of the minor or to a legal representative of the minor eligible survivor living in another jurisdiction. If we pay benefits in good faith to such person or trustee, we will be fully discharged to the extent of the payment.

Elimination period

A period of continuous disability which must be completed before you are eligible to receive benefits from us.

If you are temporarily outside of Canada and the United States of America when you become disabled, your elimination period will begin and continue to accrue, however benefits (if any) will not become payable until you return to Canada and have provided proof satisfactory to us.

Gainful occupation

An occupation that provides or can be expected to provide you with an income within 12 months of your return to work, that exceeds:

- 80% of your indexed monthly earnings, if you are working; or
- 60% of your indexed monthly earnings, if you are not working.

Gross monthly benefit

The monthly amount as determined by the Monthly Payment Calculation in the Long Term Disability Summary of Benefits, before benefit offsets are subtracted. This is the amount against which premiums for you are calculated.

Indexed monthly earnings

Your monthly earnings adjusted after each 12-month period of monthly payments. Your monthly earnings will be adjusted by the lesser of 10% or the current percentage change in the Consumer Price Index (CPI). The annual percentage change in the CPI will be determined using the calendar month that is 3 months before the calendar month in which the adjustment date occurs. Your indexed monthly earnings may increase or remain the same, but will never decrease. The resulting adjustment to your monthly earnings will be used until the next adjustment date.

The CPI is published by Statistics Canada. We reserve the right to use some other similar measurement if the Government of Canada changes or stops publishing the CPI.

Indexed post-tax monthly earnings

Your post-tax monthly earnings adjusted after each 12-month period of monthly payments. Your post-tax monthly earnings will be adjusted by the lesser of 10% or the current percentage change in the Consumer Price Index (CPI). The annual percentage change in the CPI will be determined using the calendar month that is 3 months before the calendar month in which the adjustment date occurs. Your indexed post-tax monthly earnings may increase or remain the same, but will never decrease. The resulting adjustment to your post-tax monthly earnings will be used until the next adjustment date.

The CPI is published by Statistics Canada. The Company reserves the right to use some other similar measurement if the Government of Canada changes or stops publishing the CPI.

Injury

A bodily injury that is the direct result of an accident and not related to any other cause.

Limited means that your ability is reduced.

Material and substantial duties

- are normally required for the performance of your regular occupation; and
- cannot be reasonably omitted or modified, except that if you are required to work on average in excess of 40 hours per week, we will consider you able to perform that requirement if you are working or have the capacity to work 40 hours per week.

Maximum capacity

based on your restrictions and limitations:

- during the first 24 months of disability, the greatest extent of work you are able to do in your regular occupation; and
- beyond 24 months of disability, the greatest extent of work you are able to do in any occupation, for which you are reasonably fitted by education, training or experience.

Maximum period of payment

The longest period of time we will make payments to you for any one period of disability.

Monthly earnings

Monthly earnings or "pre-tax monthly earnings" means the average monthly rate of pay, before deductions for federal and provincial taxes, received by the employee from the employer just prior to the date of disability. It includes bonuses and commissions, but not overtime pay, or any other extra compensation, or income received from sources other than the employer.

Commissions and bonuses will be averaged for the lesser of:

1. the 24 month period of employment just prior to the date of disability; or
2. the period of actual employment with the employer.

"Post-tax monthly earnings" means the average monthly rate of pay as defined above, less federal and provincial taxes.

For the purposes of any benefit calculation, monthly earnings will not be more than the amount of monthly earnings for which premiums have been paid.

Monthly payment

The monthly amount to be paid to you, as determined by the Monthly Payment Calculation in the Long Term Disability Summary of Benefits, after any benefit offsets have been subtracted but before any reduction for disability earnings.

No-evidence maximum

The amount of insurance you may obtain without providing evidence of insurability. The no-evidence maximum, until further written notice, is shown in the Long Term Disability Summary of Benefits. On any Policy Anniversary the Company may establish a new no-evidence maximum.

If your gross monthly benefit would exceed the amount of the no-evidence maximum, you must submit an evidence of insurability form. You will be covered for the gross monthly benefit in excess of the no-evidence maximum on the date the Company approves your evidence of insurability form. The amount of the no-evidence maximum and any changes to the amount of the no-evidence maximum will be communicated by the employer.

If your gross monthly benefit increases because of an increase to the no-evidence maximum, the increase to your gross monthly benefit may be limited by the Pre-Existing Condition Limitation.

Part-time basis

The ability to work and earn between 20% and 80% of your indexed monthly earnings.

Pre- tax

Prior to any deductions required by law.

Previous group policy

A policy of group insurance issued to your employer by another insurance company or by us which provided long term disability coverage to the same group, or part of the group, insured under the policy, and which terminated less than 31 days before the policy became effective.

Prudent person

A person who, with respect to his health, seeks care from an appropriate physician or medical practitioner when symptoms appear, fills prescriptions written by his physician and takes medication as prescribed by his physician.

Post-tax

After any deductions required by law. Such deductions will be limited to federal and provincial income tax (calculated using Basic Personal Exemption only).

Recurrent disability

A period of disability which is:

- caused by a worsening in your condition(s); and
- due to the same condition(s) as your prior period of disability for which a benefit was paid.

Regular occupation

The occupation you are routinely performing when your disability begins. We will look at your occupation as it is normally performed in Canada, instead of how the work tasks are performed for a specific employer or at a specific location.

Rehabilitation and return to work assistance program

A formal plan that is developed by us or our agent to assist you in the assessment of return to work potential and in returning to work. Such program may include the following services and benefits:

- medical investigation and/or treatment;
- physical rehabilitation;
- psychiatric and/or psychological rehabilitation;
- coordination with your employer to assist you to return to work;
- adaptive equipment or job accommodations to allow you to return to work;
- vocational evaluation to determine how your disability may impact on other employment options for you;

- job placement services;
- resume preparation;
- job seeking skills training;
- education and retraining expenses for a new occupation; or
- other services/activities not described above that can support the formal plan.

We shall determine, at our sole discretion, whether you are eligible for such program. If we determine that you are eligible to participate in such program, you must participate in order to continue to receive monthly payments.

Retirement plan

A defined contribution plan or a defined benefit plan. These are plans which provide retirement benefits you and are not funded entirely by employee contributions.

Sickness

Sickness means an illness or disease.

No LTD beneficiary designation allowed

No beneficiary designation for the Group Long Term Disability insurance under this policy shall be valid. You do not have the right to name a beneficiary for any amount of Long Term Disability insurance money payable under the policy.

Waiver of premium

Premium payments are not required for your insurance while you are receiving monthly payments.

Completing the elimination period

You must be continuously disabled through the elimination period shown under the Long Term Disability Summary of Benefits.

We will treat your disability as continuous if your disability ceases during the elimination period for 30 days or less.

The elimination period can be completed while you are disabled and working.

Payment of LTD benefits

Disabled and not working

For each month after the elimination period that you continue to be disabled and unable to work on a part-time basis, we will send you the monthly payment.

Disabled and working

If, after completing the elimination period, you are disabled and working, we will send you the monthly payment if you are disabled and, due to the continuing sickness or injury, your monthly disability earnings are less than 20% of your indexed monthly earnings.

If, after completing the elimination period, you are disabled and, due to your continuing sickness or injury, your monthly disability earnings are between 20% through 80% of your indexed monthly earnings we will calculate your payment as follows:

During the first 12 months of payments, while working, your monthly payment will not be reduced as long as Item 1 does not exceed Item 2, where Item 1 and Item 2 are calculated as follows:

If the monthly payment is taxable:

1. The sum of your pre-tax monthly disability earnings, plus the monthly payment, plus direct and indirect benefit offsets you are eligible to receive.
2. Your indexed monthly earnings.

If the monthly payment is non-taxable:

1. The sum of your post-tax monthly disability earnings, plus the monthly payment, plus direct and indirect benefit offsets you are eligible to receive.
2. Your indexed post-tax monthly earnings.

If Item 1 is more than Item 2, the Company will subtract the excess of Item 1 over Item 2 from your monthly payment.

After 12 months of payments, while working, you will receive payments based on your percentage of lost earnings due to your disability. To calculate your percentage of lost earnings and the amount of the payments we will:

1. Subtract your disability earnings from your indexed monthly earnings.
2. Divide the answer in Item 1 by your indexed monthly earnings. This is your percentage of lost earnings.
3. Multiply your monthly payment by the answer in Item 2.

This is the amount we will pay you each month.

If your monthly disability earnings exceed 80% of your indexed monthly earnings, we will stop sending you payments and your claim will end.

We may require you to send proof of your monthly disability earnings at least monthly. We will adjust your payment based on your monthly disability earnings.

As part of your proof of disability earnings, we can require that you send appropriate financial records which we believe are necessary to substantiate your income.

Fluctuation in disability earnings

If your disability earnings routinely fluctuate widely from month to month, we may average your disability earnings over the most recent 3 months to determine if your claim should continue.

We will not pay you for any month during which disability earnings exceed 80% of indexed monthly earnings.

If we average your disability earnings, we will not terminate your claim unless the average of your disability earnings from the most recent 3 months exceeds 80% of indexed monthly earnings.

Monthly payment-rate

After the elimination period, if you are disabled for less than 1 month, we will send you 1/30 of your monthly payment for each day of disability.

Third party claims

We may require you to provide a written statement of the circumstances that caused your disability, including any facts that may give you a legal claim against another person, organization or company that caused the disability (a "Third Party").

You must provide to us prompt notice of any legal action that you commence against a Third Party due to the circumstances that caused your disability (a “Personal Injury Action”). Once you have commenced a Personal Injury Action you must:

- execute our Personal Injury Reimbursement Agreement and Direction;
- provide us with the name and address of any lawyer pursuing the Personal Injury Action on behalf of you;
- instruct any such lawyer to pursue with due diligence your claims against the Third Party, including claims for non-pecuniary general damages, damages for past loss of income and damages for future loss of income; and
- direct, authorize and instruct any such lawyer to provide to us, free of charge:
- such reports as we may reasonably require from time to time on the status of the Personal Injury Action or any settlement negotiations;
- copies of any documents in your possession or control relating to your claims against the Third Party; and
- prompt notice of the terms of settlement or judgment in the Personal Injury Action so that we can calculate your Net Recovery.

Your Net Recovery is an amount equal to the total of all damages recovered from the Third Party (including but not limited to damages for loss of income to the date of the settlement or judgment, damages for future loss of income, all non-pecuniary general damages, interest and legal costs), minus your legal costs incurred to obtain such damages.

50% of your Net Recovery shall be designated as our Credit. You shall immediately pay to us an amount equal to the lesser of our Credit and the sum of all monthly payments paid or payable to you prior to the date of the settlement or judgment. If any portion of our Credit remains after subtracting the above amount, we may suspend further monthly payments until such time as the sum of the monthly payments which would otherwise become payable under the policy equals the remaining portion of our Credit.

We have the right to withhold or discontinue monthly payments if you refuse to sign our Personal Injury Reimbursement Agreement and Direction or fails to comply with any of its terms.

Benefit Offsets

The following gross amounts of benefits or payments are direct benefit offsets:

1. The amount that you receive or are entitled to receive under any Workers' Compensation Act or similar legislation;
2. The amount that you receive or are entitled to receive as disability payments under the Canada Pension Plan or the Quebec Pension Plan;
3. The amount that you receive as retirement payments under the Canada Pension Plan or the Quebec Pension Plan;
4. The amount that you receive or are entitled to receive as disability income payments under any automobile insurance policy or automobile accident benefit schedule;
5. The amount of any additional payments that you receive from the employer such as but not limited to any 'top-up' plan, severance pay, termination pay or vacation pay;
6. The amount that you receive under a short-term disability plan or a salary continuation or accumulated sick leave plan.

With the exception of retirement payments, we will only subtract benefit offsets which are payable as a result of the same disability. We will not subtract payments that you receive because of your spouse's retirement.

The following gross amounts of benefits or payments are indirect benefit offsets:

1. The amount that you receive or are entitled to receive as disability income payments under any:
   - compulsory benefit act or legislation;
   - other group insurance plan or policy, including any association coverage or franchise coverage; or
   - governmental retirement system as a result of your job with your employer.
2. The amount that you receive under an individual insurance policy, providing for disability benefits, that was issued to you by us pursuant to an offer made through your employer or as a result of your employment.
3. The amount that you:
   - receive or are entitled to receive as disability payments under your employer's retirement plan; or
   - receive or are entitled to receive as retirement payments under your employer's retirement plan.
4. The amount that is payable to, or on behalf of your children under the Canada Pension Plan or the Quebec Pension Plan because of your disability.

With the exception of retirement payments, we will only subtract benefit offsets which are payable as a result of the same disability. We will not subtract payments that you receive because of your spouse's retirement.

Once we have subtracted a benefit offset from the gross monthly benefit, we will not further reduce the monthly payment due to a cost of living increase from that source.

When we determine that you may be entitled to an amount under Item(s) 1 and 2 in the Direct benefit offsets section or under Item(s) 1 in the Indirect benefit offsets section, we may estimate the amount of the your entitlement to such benefit offset. If you are 65 or older, the Company may estimate the

amount of your entitlement under item 3 in the Direct Benefit Offsets section. We reserve the right to deduct the estimated amount by including it in the MONTHLY PAYMENT CALCULATION when determining your monthly payment.

We will not deduct the estimated amount under Item 1 or 2 in the Direct Offsets section, or under Item 1 in the Indirect Offsets section when determining your monthly payment if you apply for the benefit offsets, and appeal any denial to all levels we feel are necessary.

If we have deducted the estimated amount to determine your monthly payment, your monthly payment will be adjusted when we receive proof:

- of the amount awarded; or
- that benefits or payments have been denied and all appeals we feel are necessary have been completed. In this case, a lump sum refund of the estimated amount will be made to you.

If you receive any benefit offset in the form of a lump sum payment, the lump sum will be pro-rated on a monthly basis over the time period for which the sum was given. If no time period is stated, we will use a reasonable period of time.

When payments stop

We will stop sending you payments and your claim will end on the earliest of the following:

- during the first 24 months of payments, when you are able to work in your regular occupation on a part-time basis but you choose not to;
- after 24 months of payments, when you are able to work in any gainful occupation on a part-time basis but you choose not to;
- if you are working and your monthly disability earnings exceed 80% of your indexed monthly earnings, the date your disability earnings exceed 80% of your indexed monthly earnings;
- the end of the maximum period of payment;
- the date you are no longer disabled under the policy, unless you are eligible to receive benefits under our rehabilitation and return to work assistance program;
- the date you fail to cooperate with or participate in a rehabilitation and return to work assistance program;
- the date you fail to attend or participate in a medical, vocational or functional assessment required by us;
- the date you fail to attend or participate in a requested interview with an authorized representative;
- the date you fail to submit proof of continuing disability; or
- the date you die.

We will stop sending you payments after you have been outside Canada and the United States for 60 cumulative days during any 365 consecutive day period. No further payments will be made until you return to Canada and provide proof of appropriate care. If you are still disabled on your return, payments may be resumed but will not be retroactive. Although not paid, any payments attributable to any period of time beyond the 60 cumulative days during any 365 consecutive day period that you continue to be outside of Canada will be deemed to have been paid under the meaning of disability and disabled.

Recurrent Disability

If, after a period of disability for which monthly payments have been made, you experience a recurrent disability, we will treat this recurrent disability as a continuation of your previous period of disability and a new elimination period will not have to be completed, if:

- you return to continuous active employment for the period between the last date for which monthly payments were made under your prior claim and the commencement of the recurrent disability;
- you were continuously insured between the last date for which monthly payments were made under your prior claim and the commencement of the recurrent disability; and
- your recurrent disability commences within 6 months from the last date for which monthly payments were made under your prior claim.

Your recurrent disability will not be considered to be a continuation of a prior period of disability if the recurrent disability commences more than 6 months after the last date for which monthly payments were made under your prior claim. In such case, the recurrent disability will be treated as a new claim. The new claim will be subject to all of the policy provisions, including the elimination period, in force at the commencement of the new claim.

If your recurrent disability is considered to be a continuation of a prior period of disability, your recurrent disability will be subject to the same policy terms as your prior claim. The commencement date of the recurrent disability will be deemed to be original date of disability from the prior period(s) of disability. Any disability payments will be based on your monthly earnings as at the original date of disability. Monthly payments will not be made for a combined period longer than the maximum period of payment shown under Long Term Disability Summary of Benefits.

Medical examinations and claimant interviews

At our expense and discretion, and as often as is reasonably required during a claimant's continuing disability, we may require the claimant to be examined, tested or assessed by a physician, other medical practitioner or vocational or functional capacities expert of our choice.

At our expense and discretion, and as often as is reasonably required during a claimant's continuing disability, we may require the claimant to meet with and be interviewed by an authorized representative.

Pre-existing condition limitation

The policy does not cover any disability which results directly or indirectly from, or is in any manner or degree associated with or occasioned by a pre-existing condition.

However, this limitation will not apply to a disability which begins more than 12 months after your insurance began.

If, at any time, your gross monthly benefit increases because of an increase to the no-evidence maximum, the amount of the increase to your gross monthly benefit will not be payable if your disability results directly or indirectly from, or is in any manner or degree associated with or occasioned by a pre-

existing condition. However, this limitation will not apply to a disability which begins more than 12 months after the increase to your gross monthly benefit.

Pre-existing condition means any condition or symptom for which, during the 3 months just prior to the date that your insurance began:

- you consulted a physician or other healthcare provider;
- you received any health-related care, advice, treatment or services (including diagnostic measures) from or on the advice of a physician or other healthcare provider;
- you incurred any healthcare expenses;
- you took any prescribed medication; or
- a prudent person would have consulted a physician or other healthcare provider, would have filled a prescription, or would have continued to take medication previously prescribed.

If there has been an increase to your gross monthly benefit because of an increase to the no-evidence maximum, then pre-existing condition means any condition or symptom for which, during the 3 months just prior to the date of the increase to your gross monthly benefit:

- you consulted a physician or other healthcare provider;
- you received any health-related care, advice, treatment or services (including diagnostic measures) from or on the advice of a physician or other healthcare provider;
- you incurred any healthcare expenses;
- you took any prescribed medication; or
- a prudent person would have consulted a physician or other healthcare provider, would have filled a prescription, or would have continued to take medication previously prescribed.

Pre-existing condition includes any such condition or symptom whether or not such condition or symptom was diagnosed or correctly diagnosed.

Continuity of coverage

You are not eligible to be enrolled for Group Long Term Disability Insurance under the policy if you are not in active employment on the Policy Effective Date due to sickness or injury and you are receiving long term disability benefits from the insurer of a previous group policy.

- If you are not in active employment on the Policy Effective Date due to sickness or injury, you are still eligible to be enrolled for Group Long Term Disability Insurance under the policy if:
- you were properly insured for long term disability coverage under a previous group policy when that previous group policy terminated;
- your coverage under that previous group policy terminated solely because of the termination of that previous group policy;
- you would be otherwise eligible under this policy if you were in active employment; and
- the “elimination period” (or similar such period however it is named) for long term disability benefits under the previous group policy has not ended based on the date you ceased working.

If you are enrolled for Group Long Term Disability Insurance under this Continuity of Coverage provision, your coverage will terminate on the earlier of:

- the date the "elimination period" (or similar such period however it is termed) for long term disability benefits under the previous group policy would end based on the date you ceased working; or
- the date the insurer of the previous group policy accepts a claim which would qualify as a recurrent disability under the terms of the previous group policy.

If you are enrolled for coverage under this Continuity of Coverage provision you will not be covered for:

- any periods of disability which commence prior to the Policy Effective Date; or
- any periods of disability, which commence after the Policy Effective Date, but which would qualify as a recurrent disability under the terms of the previous group policy.

Subject to a change in Quebec law, if you are resident in the province of Quebec and are enrolled for coverage under this Continuity of Coverage provision you will not be covered for:

- any periods of disability which commence prior to the Policy Effective Date, unless the disability was not reported to the insurer of the previous group policy until more than 180 days after the Policy Effective Date; or
- any periods of disability, which commence after the Policy Effective Date, but which would qualify as a recurrent disability under the terms of the previous group policy, unless you have been in active employment under this policy for at least 30 days.

We will not apply Pre-Existing Condition Limitation to your long term disability claim if:

- you were insured for long term disability by the previous group policy when it terminated;
- you were in active employment on the Policy Effective Date;
- you have remained in continuous active employment since the Policy Effective Date; and
- your long term disability claim would not have been excluded by the previous group policy's pre-existing condition limitation based on:
  - the terms of the previous group policy's pre-existing condition limitation; and
  - the combined continuous time that you were insured under this policy and the previous group policy.

If, due to the above Continuity of Coverage provision, your claim is not excluded under the Pre-Existing Condition Limitation, then we will administer your claim according to the provisions of this policy. However, your payment will be the lesser of:

- the monthly payment under this policy; and
- the monthly amount which would have been paid under the previous group policy.

If, due to the above Continuity of Coverage provision, your claim is not excluded under the Pre-Existing Condition Limitation, then payments under the policy will not extend beyond the earlier of the following dates:

- the end of the maximum period of payment under this policy as shown in the Benefit Summary; or
- the date benefits would have ended under the previous group policy if it had remained in force.

Survivor Benefit

When we receive proof that you have died, we will pay your eligible survivor a lump sum benefit equal to 3 months of your gross monthly benefit if, on the date of your death:

- your disability had continued for 180 or more consecutive days; and
- you were receiving or were entitled to receive monthly payments under the policy.

However, we will first apply any Survivor Benefit payment to any overpayment which may exist on your claim for Long Term Disability Benefits.

If you have no eligible survivor, no payment will be made.

Worksite Modification Benefit

If your employer and you determine that a worksite modification may be needed to enable you to perform the material and substantial duties of your regular occupation, one of our designated professionals will assist you and your employer to identify a modification that we agree is likely to help you remain at or return to active employment.

If we agree that the worksite modification is appropriate, we will prepare a written agreement in which we, your employer and you will agree to the worksite modification in order to help you remain at or return to active employment. This agreement must be signed by us, your employer and you.

When such agreement is signed, we will reimburse your employer for the cost of the modification, up to the amount shown under the benefit summary.

This benefit is available to assist you on a one-time basis only.

Work Life Assistance Program

The policy provides you and your dependents access to a work life assistance program designed to assist them with problems of daily living.

You and/or your dependents can call and request assistance for virtually any personal or professional issue, from helping find a day care or transportation for an elderly parent, to researching possible colleges for a child, to helping to deal with the stress of the workplace. This work life program is available for everyday issues as well as crisis support.

This service is also available to your employer.

This program can be accessed by a 1-800 telephone number available 24 hours a day, 7 days a week.

Information about this program can be obtained through your employer's plan administrator.

NOTE: If such services or program are included under more than one of the applicable sections of the policy, they shall be deemed to be only one single benefit and not two benefits. Any limitations or restrictions on usage or payment (if applicable) of these services or program shall be deemed covered under one single benefit only.

Best Doctors®

RBC Insurance also offers a service called ***Best Doctors***. This service provides *eligible employees, and their eligible dependents, with a unique combination of information and access to the best medical care when it matters most. When you're affected by a serious illness or injury, managing your medical care can be confusing and intimidating. There are so many decisions to make, personal and medical details to co-ordinate and treatment options to consider. Modern health care presents a vast number of choices, and you want to feel confident that you're choosing well. Access to the right information can make the difference between merely coping with a serious illness or injury and recovering from it.

Information, Expertise, Insight

If your physician suspects you may have a covered illness or injury, or you have an unresolved medical condition, and important call to make is to Best Doctors. From identifying the latest state-of-the-art treatments to finding a physician with the expertise you need, the Best Doctors service can connect you with the right medical care, right when you need it most.

The Best Doctors service can help answer these important health questions:

- Is my diagnosis correct?
- What are my treatment options?
- Which physicians are the best to treat my condition?
- How can I access expert opinions and estimate costs?

Suite of Services

For any of the following services, you will have access to a Best Doctors personal advocate. The personal advocate – a registered nurse – is responsible for liasing with the physicians who are reviewing your case. The personal advocate keeps you informed of the progress on your case, and offers guidance and support.

The Best Doctors suite of services includes: ***InterConsultation, FindBestDoc*** *and* ***FindBestCare****.*

InterConsultation service: expert medical evaluation that gives you the findings and recommendations of world-class specialists.

This service includes a comprehensive review of your medical files to establish or confirm your diagnosis and identify effective treatment. This timely and detailed turnaround of results can reduce the possibility of serious complications resulting from a misdiagnosis.

FindBestDoc global database of physicians: a customized search for best doctors based on peer review – including specialized Canadian physicians.

Once the appropriate treatment is identified, this service can offer you a customized search of the top specialized medical experts in and outside of Canada who are identified as the "best" to treat your condition. Your personal advocate can help you understand your options and determine the best care provider for your specific medical condition.

FindBestCare preferred provider network: a comprehensive service that identifies and arranges access to top medical experts and treatment centres worldwide.

While you are receiving medical care, Best Doctors will review the necessary information provided by the medical specialists involved and will continually monitor the treatment process to help ensure your medical priorities are met.

If you opt to receive treatment outside of Canada, this service can identify and arrange access to the top medical experts and treatment centres. And, discounts on the cost of care and hospitalization are often available. Best Doctors can assist you and your family with international travel, lodging and pre0admission arrangements, medical appointments and co-ordination of patient inquires, 24 hours a day, seven days a week.

Unlimited Access

While you are insured under your employer's Group Long Term Disability Income Protection plan, you, your eligible spouse and dependents will have unlimited access to the Best Doctors service if a physician suspects any of the following covered illnesses and injuries or an unresolved medical condition.

- Aids
- Alzheimer's Disease
- Benign Brain Tumour
- Blindness
- Cancer
- Cardiovascular Conditions
- Coma
- Deafness
- Kidney Failure
- Loss of Speech
- Major Organ Transplant
- Motor Neuron Disease (ALS, Lou Gehrig's)
- Multiple Sclerosis
- Paralysis
- Parkinson's Disease
- Severe Burns
- Stroke
- Trauma

Best Doctors gives you access to the best medical information and insight available and empowers you to make the best health-care choices.

To learn more about this service, please call the Best Doctors bilingual toll-free number **1-866-611-8898**. You can also visit www.bestdoctors.com/rbc for more information on how to activate service.
For English website, enter "rbceng" as user ID and password at Member Login
For French website, enter "rbcfr" as user ID and Password at Member Login

NOTE: If such services or program are included under more than one of the applicable sections of the policy, they shall be deemed to be only one single benefit and not two benefits. Any limitations or restrictions on usage or payment (if applicable) of these services or program shall be deemed covered under one single benefit only.

Dependent Care Expense Benefit

While you are participating in a rehabilitation and return to work assistance program, we will pay you a Dependent Care Expense Benefit if you are or start incurring expenses (such as but not limited licenced day care facilities and home health care programs) to provide care for a dependent who needs personal care assistance.

Dependent Care Expense Benefit payments will begin immediately after you start to participate in a rehabilitation and return to work assistance program.

The amount of the Dependent Care Expense Benefit will be as shown under the BENEFIT SUMMARY.

You must provide satisfactory proof that he is incurring expenses that entitle you to the Dependent Care Expense Benefit.

Note: We will not recognize you or your spouse, children, parents or siblings as a program or facility providing care for a dependent who needs personal care assistance under this benefit unless such person actually owns, operates, administers or is working for such a facility or program.

Dependent Care Expense Benefits will end on the earlier of the following:

- the date you are no longer incurring expenses for your dependent;
- the date you no longer participates in the rehabilitation and return to work assistance program; or
- any other date payments would stop in accordance with the policy.

Rehabilitation And Return To Work Assistance Benefit

While you participate in a rehabilitation and return to work assistance program, we will pay an additional benefit of 10% of your gross monthly benefit to a maximum benefit shown under the Long Term Disability Summary of Benefits.

We are under no obligation to approve or continue a rehabilitation and return to work assistance program for you. Any decision about your eligibility for the program, or to approve or discontinue a rehabilitation and return to work assistance program will be made solely by us.

The final determination about your eligibility for a rehabilitation and return to work assistance program will be made solely by us. You must be medically able to engage in a rehabilitation and return to work assistance program.

In order to remain in the rehabilitation and return to work assistance program and to receive this benefit, you must actively participate in the rehabilitation and return to work assistance program.

Actively participate or actively participating means you must comply with the terms and conditions of the rehabilitation and return to work assistance program plan written specifically for you by us.

This benefit is not subject to policy provisions which would otherwise increase or reduce the benefit amount.

In addition, we will make monthly payments to you for 3 months following the date your disability ends if we determine you are no longer disabled while:

- you are actively participating in the rehabilitation and return to work assistance program; and

- you are not able to find employment.

This benefit payment may be paid in a lump sum.

Benefits for the rehabilitation and return to work assistance program will end on the earliest of the following dates:

- the date we determine that you are no longer eligible to participate in the rehabilitation and return to work assistance program;
- the date we determine that you are no longer actively participating in the rehabilitation and return to work assistance program; or
- any other date on which weekly payments would stop in accordance with the policy.

Total Benefit Cap

The total benefit payable to you on a monthly basis (including all benefits provided under the policy) will not exceed 100% of your monthly earnings, unless the excess amount is payable as a Cost of Living Adjustment. However, if you are participating in our rehabilitation and return to work assistance program, the total benefit payable to you on a monthly basis (including all benefits provided under the policy) will not exceed 110% of your monthly earnings unless the excess amount is payable as a Cost of Living Adjustment.

General limitations and exclusions:

This policy does not insure any disability which results directly or indirectly from, or is in any manner or degree associated with or occasioned by:

- your intentionally self-inflicted injuries;
- your active participation in a riot, insurrection or civil commotion;
- your service in the armed forces of any nation;
- your attempt to commit or commission of a crime, or provoking an assault, whether or not you have been charged; or
- war, declared or undeclared, or any act of war.

We will not pay a benefit for any period of disability during which you are lawfully incarcerated, confined or imprisoned.

We will not make a monthly payment for any period of disability during which you are on a statutory leave, leave of absence, temporary layoff, strike or lockout. If your coverage has been continued during a statutory leave, leave of absence, temporary layoff, strike or lockout, and you become disabled during the statutory leave, leave of absence, temporary layoff, strike or lockout the monthly payment will begin on the later of the date the elimination period ends or the date the statutory leave, leave of absence, temporary layoff, strike or lockout ends, provided you are still disabled.

NOTE: Other Exclusions or Limitations may be applicable as specified under each individual additional benefit provision.

Underwritten by Industrial Alliance
Policy Number 23101-00

Coverage is for employee and dependents

Note: All information in this section is supplied by the insurer. This is not a legal contract and payment of all claims is based solely on the group master policy or contract issued by the insurer.

Benefit

The Insurer will reimburse you for all covered expenses which are incurred by you and/or your insured dependents in an amount equal to the Benefit Percentage as outlined under the Summary of Benefits. Such amount will be subject to the Cash Deductible, if any, and the limitations and exclusions included in this Benefit. The benefits apply separately to each insured person.

Covered Expenses

This means the reasonable and customary charges for services and supplies which are incurred after the person became insured and which are furnished as a result of an injury, pregnancy or disease. These expenses do not include any benefits either provided under the Provincial Hospital or Provincial Medicare Acts of your province of residence or prohibited by such acts.

Out-of-province including out-of-country expenses are payable in excess of the benefits provided by the Provincial Acts noted above, where not prohibited by government legislation or regulation.

Hospital care

- Room and board charges made by a hospital, as shown in the Summary of Benefits.
- Hospital services and supplies furnished during a hospital confinement (not including special nursing services).

Nursing care

Private duty nursing when certified in writing by the Attending Physician as medically necessary and pre-approved by the Insurer and when performed in the patient's home by a registered graduate nurse or registered nursing assistant, who is not a relative of yours and who does not have the same legal residence.

Convalescent home care

Room and board charges made by a convalescent home which is licensed by the appropriate licensing authority, to the extent that the charges are not covered by any other plans and do not include any part of a charge exceeding $20 per day, for a maximum of 120 days during any one continuous period of confinement provided the confinement:

- Occurs within 48 hours following a hospital stay of at least 3 consecutive days,
- Is for the same cause(s) as the preceding hospital stay,
- Has been recommended and approved, in writing, by a legally licensed physician, and
- Is primarily for rehabilitation or convalescent care and not primarily for custodial care.

"Continuous period of confinement" as used above, shall include all periods of confinement in a convalescent home which are due to the same or related cause(s) except periods of confinement separated by more than (1) 30 consecutive days, with respect to you and (2) 180 consecutive days with respect to your dependent, during which you or your dependent was not so confined.

Substance abuse treatment facility

Room and board charges made by a substance abuse treatment facility which is licensed by the appropriate licensing authority, to the extent that they are not covered by any other plan and do not include any part of a charge exceeding the semi-private room rate, subject to a cumulative lifetime maximum of 60 days of confinement, provided:

- the substance abuse treatment facility is located in our province of residence;
- the confinement occurs as a result of the insured person's involvement in a substance abuse rehabilitation program and is not primarily for custodial care;
- a benefit is payable with respect to the confinement under the Provincial Hospital Act and/or Provincial Medical Act of your province of residence. This must be confirmed, in writing, by the insured person with the administrators of such Acts prior to the confinement occurring
- approval for the confinement is received from the Insurer, in writing, prior to the confinement occurring.

Ambulance, laboratory and out-patient charges

- Use of professional ambulance service in a medical emergency, for transporting the insured person to the nearest hospital equipped to provide the required treatment including where necessary, use of air ambulance and scheduled common carrier.
- X-ray examinations and other diagnostic laboratory services.
- Out-patient charges.

Prescription Drugs

The quantity of drugs and medicines which may be dispensed for any one prescription will be limited to that amount sufficient for up to a 34-day period, except in the case of drugs and medicines for long term therapy for which up to a 100 day supply is allowable.

Certain drugs will require pre-authorization by the insurer prior to the commencement of their usage. For these drugs the insured person will be required to have his attending physician provide the insurer with information describing his medical condition, previous treatment history and the medical criteria for prescribing the drug.

As part of its pre-authorization process, the Insurer may request that a drug be purchased from a preferred pharmacy network that has been approved by the Insurer. If the Insured should choose to use another pharmacy, the amount reimbursed to the Insured will be based on the amount which would have been charged by the Insurer's approved pharmacy network. The Insurer will not be responsible for

any amounts in excess of the amounts that would have been reimbursed had the Insured used the approved pharmacy network.

The Insurer reserves the right to exclude coverage of any drug where it has determined, at its sole discretion, that coverage of the drug causes or may cause a material change in the risk insured under this policy or a material change in risk for the Insurer in general.

If the drug is an original drug which has a generic equivalent, the amount payable will be based on the lowest priced interchangeable drug. However, if the physician has included the notation "Do not product select", or "No Sub." or "No Substitution", the amount payable will be based on the cost of the eligible product prescribed.

As used above, lowest priced interchangeable drug will include, but is not limited to,

a) an alternative drug to the original drug deemed interchangeable by law; or
b) a subsequent entry biologic.

- Drugs which by law or convention require a legally licensed physician's, surgeon's, or dentist's prescription.
- Insulin supplies (such as needles, syringes, and diagnostic test supplies), but excluding swabs and rubbing alcohol.
- Anaesthetics, oxygen and administration thereof.
- Blood and blood plasma and administration thereof to the extent that charges are not reduced by any blood donations.

Items not covered, whether prescribed or not, include in part:

- any drug, medication, or other health care product which may be purchased without a prescription, such as over-the-counter (OTC) products;
- serums and vaccines used in an inoculation program;
- infertility drugs;
- minerals and vitamins;
- patented medicines and G.P. products;
- first aid and surgical supplies;
- atomizers and vaporizers;
- salt and sugar substitutes;
- infant formulae;
- dietary foods and aids;
- contact lens care products;
- diagnostic aids and laboratory tests;
- contraceptives other than Oral;
- anti-obesity, anti-smoking, and other habit-breaking drugs.

Paramedical Practitioners

The following will be eligible charges to the extent that insurance of such charges is not prohibited by any government legislation or regulations.

Services performed by a licensed;

- Acupuncturist,
- Chiropodist or podiatrist;
- Chiropractor;
- Masseur;
- Naturopath;
- Osteopath
- Physiotherapist
- Registered Psychologist or Psychotherapist
- Speech therapist;

Excluding any charges in excess of the limits stated in the Summary of Benefits.

Equipment and/or Appliances

The Insurer will rent or purchase at its option the following **where medically necessary**:

- Intrauterine devices (IUD's)
- Splints excluding dental splints,
- Apnea monitors for respiratory disrhythmias,
- Canes and walkers,
- Crutches,
- Casts,
- Burn garments,

- Sleeves for lymphoedema following mastectomy,
- Support hose (calendar year maximum of $100 per insured person),
- Braces with rigid support,
- Orthopaedic shoes, which have been custom made, customized or custom molded for the insured person and which were recommended, in writing, by a legally licensed physician, up to 1 pair per calendar year,
- Artificial eyes including repair and replacement (calendar year maximum of $1,000 per insured person for repairs and replacements),
- Artificial limbs and prostheses (excluding myoelectric and electric prostheses), repairs and replacement covered up to a calendar year maximum of $2,000 per insured person,
- Wigs required as a result of chemotherapy or bodily injury (lifetime maximum of $500 per insured person),
- Back Supports,
- Stump socks,
- Shoulder harnesses,
- Head halter,
- Traction apparatus,
- Cervical collar,
- Colostomy and ileostomy apparatus and supplies,
- Catheters,
- External breast prosthesis (two per insured person in any calendar year),
- Surgical bras (two per insured person in any calendar year),
- Diabetic monitoring and administration equipment (lifetime maximum of $1,000 per insured person),
- Non-electric wheelchairs (lifetime maximum of $2,000 per insured person) or electric wheelchairs where medically necessary (lifetime maximum of $4,000 per insured person),
- Hospital beds,
- Bed rail,
- Trapeze bar,
- Transcutaneous nerve stimulator (lifetime maximum of $2,000 per insured person),
- Intermittent positive pressure breathing machine,
- Aerosol equipment, mist tents and nebulizers for cystic fibrosis, acute emphysema, chronic obstructive bronchitis or chronic asthma,
- Oxygen tent and oxygen supplies,
- Sphygmomanometers (lifetime maximum of $200 per insured person),
- Foot orthoses which have been specifically designed and constructed for the insured person and which were recommended, in writing, by a legally licensed physician or surgeon, up to a calendar year maximum of $300 per insured person.

Hearing aids

Must be obtained on a written prescription of a physician licensed as an otolaryngologist (excluding charges for batteries) up to $400 per insured person in any 5 consecutive calendar years.

Vision Care

Covered expenses up to the maximum amount payable shown in the Summary of Benefits are those incurred for:

- Ocular examination (including refraction) limited to not more than one in any continuous period of 24 months for an adult and not more than one in any continuous period of 12 months for a dependent child (unless covered under provincial legislation and regulation.)
- Cost of frames, lenses and fitting of prescription glasses and contact lenses.

Physician – In and Out of Province

The following will be eligible charges to the extent that insurance of such charges is not prohibited by any government legislation or regulations.

- Charges made by a legally licensed physician or surgeon in your province of resident, in excess of the current tariff of the relevant Medical Association, where not prohibited by any government legislation or regulations.
- Charges made by a legally licensed physician or surgeon in respect of services performed outside of your province of residence but excluding any benefit payable under the provincial government plan and where not prohibited by any government legislation or regulations.

Out of Canada Non-Emergency Referral Coverage

Charges made for non-emergency services performed outside of Canada, to a Lifetime Maximum of $50,000 (covered at Ward Level), provided that:

- the services cannot be performed in Canada,
- the services are determined to be medically necessary as certified in writing by at least two physicians practicing in Canada, one of whom regularly attends the Insured, the other who specializes in the field of medicine applicable to the injury, disease or pregnancy being treated and neither of who is the Insured himself or a member of the family.
- the services must be accepted as normal treatment for the injury, disease or pregnancy and must not be considered experimental,
- a benefit for such services will be payable under either the Provincial Hospital or Provincial Medicare Acts of the employee's province of residence. This must be confirmed, in writing, by the Insured with the administrators of such Acts prior to the services being performed.
- approval for such services is received from the Insurer, in writing, prior to the services being performed.

The amount of the charge will be converted into Canadian dollars at the exchange rate in effect on the date the claim has been approved by the Head Office of the Insurer.

Out of Canada Emergency Assistance Coverage

Charges made for services performed outside of Canada provided:

- the services are required for emergency treatment of an injury, disease or pregnancy which occurs during the first 90 days after the commencement of the individual's absence from Canada,
- the services are defined under the extended health benefit, except that any charges for hospital room and board will be limited to ward level.
- the services would have been covered if incurred in Canada.

The amount of the charges for the services will be converted into Canadian dollars at the exchange rate in effect on the date the claim has been approved by the Head Office of the Insurer.

Supplementary Out of Canada Emergency Assistance Coverage

This coverage is provided by the Insurer through CanAssistance Inc.

To make use of this coverage, simply phone the number on your TRAVEL ASSIST card and provide whatever information is requested by the co-ordinator at CanAssistance Inc.

The following charges and services will be supplied with respect to a medical or personal emergency while you and/or your insured dependents are travelling outside of Canada for the purpose of vacation or business provided the medical or personal emergency occurs during the first 90 days after the commencement of the absence from Canada. If, however, the absence is due to attendance at an accredited educational institution on a full-time basis, the medical emergency occurs during the school year for which your insured dependent is enrolled at the institution.

- Multilingual assistance by telephone or telex, 24 hours a day, 365 days a year. (This includes interpretation services in most major languages).
- Assistance in locating appropriate medical care.
- If required to obtain needed emergency medical treatment, an advancement of funds will be provided for such treatment, subject to a maximum of $5,000.
- If you or your insured dependent's medical condition requires it, transportation to a medical facility or repatriation to a hospital in Canada, under proper medical supervision, if needed, will be arranged.
- If you/or your insured dependents are travelling together and miss a pre-arranged return flight home due to the hospitalization or death of one member, economy class transportation will be arranged and paid for to the original point of departure in Canada. (If the return tickets have any redeemable value, only the additional costs necessary after applying such value to the transportation will be provided).
- If you or your insured spouse is hospitalized and as a result your insured children are left unattended, economy class transportation will be arranged and paid for to their usual home in Canada. If needed, an escort will be arranged. (If valid transportation tickets should exist only for the additional costs necessary for the return tickets after applying the value of the original tickets will be provided).
- If you or one of your insured dependents are travelling alone and are hospitalized for at least 7 consecutive days, round-trip economy class transportation will be arranged for a spouse, parent,

child, brother or sister to visit. (The visit must be considered by the attending physician to be beneficial to the patient).

- If a transportation benefit is provided under the 3 points above, charges incurred for commercial accommodation and meals will be reimbursed, up to a maximum of $150 per day for a period of up to 7 days. (For reimbursement, retain the receipts and submit them to CanAssistance Inc., upon returning to Canada).
- If you or one of your insured dependents should die while travelling outside of Canada, all necessary authorizations and arrangements will be made to return the remains to the province of usual residence. A maximum of $3,000 will be provided. (The cost of a burial coffin will be excluded).

Note: the maximum amount provided under the above 5 points, during any one travel emergency, will be $10,000.

- Assistance in replacing lost or stolen documents or tickets.
- Assistance in locating legal assistance and, if needed, arranging cash advances from credit cards, family or friends to pay bail or legal fees.
- A message centre where messages will be held for and from you, or your insured dependent who is travelling, for up to 15 days.

Limitations (supplementary travel)

The following limitations will apply to the Supplementary Out of Canada Emergency Assistance Coverage:

- You and/or your insured dependents will be responsible for any services requiring payment of $200 or less. (For these services, submit the receipts to the government body administering the Provincial Hospital or Provincial Medicare Act of your province of residence and the Insurer for reimbursement).
- Services will not be provided in (1) Canada, (2) countries designated from time to time (it is your responsibility to enquire with CanAssistance Inc., whether the services are provided in a particular country prior to you or your insured dependent's departure), and (3) any countries where the local authorities refuse to permit the providing of the services described above.

Neither the Insurer, or CanAssistance Inc. or its affiliates, will be responsible for the availability, quantity, quality or results of services requested and received under the supplementary Out of Canada Emergency Assistance Coverage or the failure of you and/or your insured dependents to receive medical services for any reason.

Emergency Dental Care

Charges by a legally licensed dentist for treatment necessitated by a traumatic injury to sound natural teeth or the surrounding tissues provided:

- The damage is not due to an object or food placed wittingly or unwittingly in the mouth.
- The injury occurs while the insured person is insured under this Benefit.
- The charges are incurred within 12 months of the injury. However, if the charges are to be incurred more than 60 days after such injury, a treatment plan must be submitted to the Insurer at its Head Office within 60 days of the injury.

- The treatment is the least expensive that will provide a professionally adequate treatment.
- No payment will be made by the Insurer for any part of the charge which exceeds the amount shown for the treatment in the Current Provincial Fee Schedule for general practitioners in your province of residence.

The total amount payable under this covered expense during the lifetime of the insured person (whether or not the insured person is continuously insured) including any amount payable for charges incurred following discontinuance of the insured person's insurance under this Benefit shall not exceed $3,000.

Extension of Benefits

If you or your insured dependent is disabled on the date your or their insurance is discontinued under this Benefit, benefits will be available during the continuance of such disability but only while this Benefit remains in force and only with respect to the charges for covered expenses which arise as a result of the disability, provided such charges are incurred within 3 months of the date of the discontinuance.

As used above, "disabled" and "disability" mean:

- With respect to you, a state of incapacity resulting from disease, injury or pregnancy by which you are unable to perform substantially all of the essential duties of any occupation or employment for which you are reasonably qualified by education, training or experience, and
- With respect to your dependent, that due to injury, disease or pregnancy, your dependent is confined to hospital or is receiving treatment by a legally licensed physician or surgeon.

Survivor Benefit

If you die while insured under this Benefit and prior to any continuance of insurance as provided under the Extension of Benefits section, insurance under this Benefit will be continued with respect to your dependents who were insured under this Benefit on the date of your death, without payment of premiums. The insurance will terminate on the earliest of:

- 2 years following the date of your death, and
- the date the dependent no longer qualifies as a dependent, and
- the date of termination of this Benefit with respect to active employees.

Coordination of Benefits

This plan includes a co-ordination of benefits provision. This operates in the event you are covered under another Group Plan, or individual insurance plan or any governmental legislated automobile insurance plan including the Quebec Automobile Insurance Plan, and ensure that payments made by all plans do not exceed the actual expenses incurred.

Exclusions

"Covered Expenses" shall not include any charge:

- for any services or benefits which are "insured services or benefits" under any government legislation or regulation and to the extent that insurance for such service is prohibited by law.
- for or in connection with general health examinations.
- for or in connection with any dental treatment except as specifically stated under the Covered Expenses section.
- for or in connection with the treatment of pre-existing dental disease or orthodontic malocclusion in order to facilitate treatment for a traumatic injury to sound natural teeth or the surrounding tissues.
- for or in connection with a surgical procedure or treatment performed for primarily cosmetic reasons, or for hospital confinement for such procedure treatment.
- for or in connection with any services or supplies which are for the sole purpose of facilitating the insurer person's participation in sports or recreational activities and not for daily living activities.
- for transportation or travel except as specifically stated under the Covered Expenses section.
- which occurs as a result of an insurrection, war or any act of war (declared or undeclared).
- which occurs as a result of participation in a riot or civil commotion.
- which results from the commission of or attempted commission of a criminal offence or the provoking of an assault.
- which results from an intentionally self-inflicted injury while sane or insane.
- for services for which the insured person is not required to make payment or where payment is received as a result of legal action or settlement.
- for any drugs, medicines, medical testing, surgical procedures and appliances considered by the Insurer to be experimental and not recognized by the Canadian Medical Association as an established standard treatment for the condition.
- for private duty nursing where:
    - services are performed by a registered graduate nurse unless such qualified individual is required to administer intravenous medication or narcotics and to continuously monitor the vital signs of the patient;
    - services are performed by a registered nursing assistant when the care could be administered by a less qualified individual.
    - no record of the nurse's daily duties are submitted as part of the proof of claim.
- for any fees charged in respect of services performed by a legally licensed physician or surgeon in your province of residence which are not included in the current tariff of the provincial government plan except as specifically stated under the Covered Expenses section.
- for any orthotic appliance which was not specifically designed and constructed for the insured person and which was not recommended, in writing, by a physician or legally licensed surgeon.
- for any emergency services provided outside of Canada if the absence from Canada was for a purpose other than business, vacation travel or attending an accredited educational institution.for any services or supplies received outside of Canada in an emergency if such services or supplies could have been delayed until the insured person had returned home without endangering the insured person's health.

- for which the insured person may apply and receive indemnity or compensation under any Worker's Compensation Act.
- for or in connection with any services received or performed outside of Canada which (1) are due to a pregnancy (includes childbirth, miscarriage or any compilations incident to a pregnancy) and which are received or performed after the 32nd week of gestation, or (2) are due to the deliberate inducement of a miscarriage.

The benefit does not cover any expenses for any care or treatment which was provided by a health care provider who, or a service provider that:

- has been charged with professional misconduct or improper practices; or
- is under investigation by an official body resulting from a law or regulation; or
- is under investigation by Industrial Alliance in regards to his professional conduct or practice; or
- is a member of a profession that is not regulated by an officially recognized federal or provincial regulatory body in the jurisdiction where the services were provided and, in the reasonable opinion of Industrial Alliance, does not meet the industry standards relevant to his profession.

Conversion Privilege

If your coverage under the Group Policy is cancelled due to termination of

- your employment; or
- your group membership,

you will be able to convert your supplementary health insurance coverage to an individual insurance contract without having to submit evidence of insurability to the insurer.

The individual insurance contract that will be provided will be in accordance with the rates and terms and conditions established by the insurer.

You must make application and pay all required premium for the individual insurance contract within 60 days of the termination date of your insurance under the Group Policy. Failure to submit the application and premium within such 60 days will prevent you from obtaining the insurance under the individual insurance contract.

Clearly Discount Program

Coverage is for employees and dependents

What this benefit offers

Johnstone's Benefits members will receive a further 15% discount off of Clearly.ca (formerly Clearly Contacts) already discounted prices. Clearly is one of the largest contact lens and eyeglass suppliers in North America. Canadian-owned and based in Vancouver, they specialize in delivering replacement contact lenses and eyeglasses directly to your door at up to 50% less than retail cost.

How the Clearly discount works

Place your order online at www.clearly.ca, or by phone (1-866-414-2326). **Don't forget to use the coupon code of "JBENEFITSCF" to receive an additional 15% discount.**

There is no limit to how often the discounts can be used. The discount is applied directly at the point of sale, so there are no additional forms to complete in order to take advantage of the savings. As this is a value-added benefit, there is no cost to use this benefit.

Note: Not valid with other coupons, discount sales, or special promotion items. The Clearly Program is subject to change or cancelation without notice.

Underwritten by Homewood Health Inc
Policy Number WB2000

Coverage is for the employee and dependents

Note: All information in this section is supplied by the insurer. This is not a legal contract and payment of all claims is based solely on the group master policy or contract issued by the insurer.

The Employee & Family Assistance Program (EAP) is a voluntary, confidential counseling, advisory and information service for you and your eligible dependents. The EAP can help with any personal problem, large or small, that affects your family life, work life or your general well-being. The EAP provides assistance for a wide range of personal issues including: couple and marital relationships, family matters, work-related and career issues, stress and anxiety, depression, childcare, aging parents, financial and legal concerns, alcohol and drugs, bereavement, cross-cultural issues.

The service is provided by Homewood Human Solutions. Their staff consists of experienced professionals including registered psychologists, and counselors.

All services provided by Homewood Human Solutions are paid for through your benefit plan with Hitachi Data Systems. If long term or specialized counseling is required, your counselor will assist you with a referral to a community resource. You could be responsible for any charges that your benefits plan or provincial health insurance do not cover. Your counselor will help you find services you can afford.

For immediate response North America-wide (24 hours a day), you can call:

English:	1-800-663-1142
French:	1-800-398-9505
TTY:	1-888-384-1152
International Access:	604-689-1717 (**call collect**)
Website:	www.homewoodhumansolutions.com/

Underwritten by Industrial Alliance
Policy Number 23101-00

Coverage is for employee and dependents

Note: All information in this section is supplied by the insurer. This is not a legal contract and payment of all claims is based solely on the group master policy or contract issued by the insurer.

The plan will reimburse you for reasonable and necessary charges, pertaining to yourself and your dependents, for the following covered items performed or prescribed by a legally licensed Doctor of Dental Surgery. Payment will be made up to the amount set for General Practitioners in the applicable Provincial Dental Association Schedule of Fees subject to the benefit percentage, any deductible, any dollar maximums shown in the Summary of Benefits and any maximums included below in the list of covered expenses.

When you or your dependents are visiting a dentist, it is important that you refer this booklet to his/her attention so that he/she may advise you if his/her prescribed services are covered by the plan.

When the course of treatment is expected to exceed $400 or when an alternative course of treatment is available, a treatment plan, prepared by the legally licensed dentist, outlining the procedures and their cost, should be submitted to the Insurer before commencement of the treatment. This will enable the Insurer to determine yours and its financial responsibilities, thus avoiding any potential misunderstanding.

Basic Services

Diagnostic

- examinations (not more than once in 3 consecutive calendar years)
- recall examinations (not more than 2 in any calendar year and no more than 1 per day)
- x-rays: complete series (not more than once in 3 consecutive calendar years); bitewings (6 films in a calendar year); panoramic film (not more than once in any 3 consecutive calendar years)
- laboratory examinations
- consultations (limited to 2 units per calendar year)

Preventive

- dental prophylaxis (not more than twice in any calendar year and excludes periodontal scaling and root planning within a six month period)
- fluoride treatment (not more than twice in any calendar year)
- other preventive: oral hygiene instruction (not more than once per family per lifetime); caries/pain control, sedative dressing; pit and fissure sealants for first tooth and each additional tooth same quadrant (limited to children under 18 years of age)

- occlusal equilibration (not in conjunction with the delivery and post insertion of (i) single restorations at the same appointment of (ii) fixed or removable prosthesis by the same dentist for a period of 3 months; limited to 2 units per calendar year)

Restorative

(services only covered if necessitated by decay or traumatic injury)

- amalgam restorations
- retentive pins
- tooth coloured composite restorations: permanent anteriors, non-acid etch/bond technique, permanent anteriors, non acid etch technique (not to be used for Veneer Applications or Diastema Closures)
- gold foil restorations (reimbursement made only to the level of the suggested fee for the similar class of restoration using amalgam or composite)
- crown-single-performed (limited to children under 18 years of age)

Minor surgical

- removal of tooth, erupted tooth (uncomplicated)
- surgical removals
- removal of residual roots
- secondary hemorrhage control

Additional services

- anaesthesia
- special visits (limited to $250 in any calendar year)
- denture repairs (limited to twice in any calendar year)
- denture rebasing and relining (limited to once every 2 years)
- space maintainers (limited to children under 18 years of age)

Endodontics

(claims for service on same tooth within 3 months of previous claim will be reduced by amount of previous benefit)

- pulp capping and pulpotomy
- root canal therapy
- apexification
- periapical services
- root amputation
- other endodontic procedures
- hemisection, canal and/or pulp chamber enlargement
- bleaching
- intentional removal, apical filling and reimplantation
- removal of root filling materials or foreign bodies

- emergency procedures

Periodontics

- non-surgical services
- surgical services
- adjunctive periodontal services: scaling and root planing (limited to 8 units per calendar year); maintenance, adjustments and repairs to appliances (limited to 2 units in any calendar year); Appliance impression, insertion and adjustment (limited to once every 4 years) and relining.

Oral surgery

- surgical exposure of tooth; transplantation of a tooth (up to a maximum of $150); surgical repositioning of a tooth (up to a maximum of $150)
- alveoloplasty
- gingivoplasty and/or stomatoplasty
- osteoplasty
- surgical excision and incision (some dental code procedures have maximums of $150)
- fractures: open reduction – mandibular (to a maximum of $750); open reduction – maxilla (to a maximum of $750)
- frenectomy
- miscellaneous
- drugs

Major Restorative

Prosthodontic - removable

- complete dentures
- partial dentures
- cast chrome cobalt (not gold)
- precision attachment of cast chrome cobalt (not gold, limited to $550 plus lab fees)
- denture adjustments (limited to twice in any calendar year)
- miscellaneous: denture/implant retained prosthesis prophylaxis and polishing (limited to once every 2 years)

Major restorative services

- restoration inlays (limited to amalgam restorations equivalent)
- onlay restorations
- retentive pins in onlays
- crowns – single restorations only (use of porcelain or acrylic facing on crowns restricted to teeth 1-6)
- other restorative services: recement/rebond, inlays, onlays, crowns and veneers (limited to once per year)

Prosthodontic services - fixed

- pontics (uses of porcelain or acrylic restricted to teeth 1-6)
- retainers – inlay, onlay
- repairs (use of porcelain or acrylic limited to teeth 1-6)
- retainers – crowns (use of porcelain or acrylic restricted to teeth 1-6): telescoping crown unit (to a maximum of $450 plus lab): precision attachments (to a maximum of $150 plus lab)
- retentive pins in abutments
- other: provisional coverage in extensive or complicated restorative dentistry (to a maximum of $50 including lab fees)

Exclusions and limitations: prosthodontic services

Covered expenses will not include any charges incurred directly for or as a result of the following:

- the replacement of an existing appliance (fixed bridgework, removable partial or complete dentures) which has been lost or stolen;
- the replacement of, or addition to an existing appliance (fixed bridgework, removable partial or complete dentures) unless (i) necessitated by the extraction of one or more additional natural teeth while insured under the policy, (ii) the existing appliance is at least 4 years old and cannot be repaired; or (iii) the existing appliance is temporary and is replaced with a permanent bridge or a permanent denture;

  If the replacement appliance is of a different type, the maximum amount payable will be limited to the current cost of the type of appliance being replaced, subject to the coverage specified in this policy.

- The initial installation of an appliance (fixed bridgework, partial or complete dentures), unless the appliance is required to replace one or more natural teeth extracted after the effective date of the insured's coverage.
- the initial provision of crowns, inlays, onlays or veneers, unless the tooth of the insured person's tooth is broken down by decay or traumatic injury and cannot be restored with an amalgam or composite restoration.
- the replacement of crowns, inlays, onlays or veneers unless:
  - the insured person's tooth is further broken down by decay or traumatic injury and cannot be resorted with an amalgam or composite restoration and,
  - a continuous period of 4 years has elapsed since the last date on which the crown, inlay, onlay or veneer was provided.
- the initial installation of an appliance (fixed bridgework, partial or complete dentures), unless the appliance is required to replace one or more natural teeth extracted. If you have not been employed with your employer for at least 12 months, the extraction of natural teeth must have occurred while insured under the policy, for the charge to be covered.

Orthodontia

Limited to dependent children under 19 years of age.

Covered expenses:

- observation and adjustment: repairs, alterations and recementations (to a maximum of $50 plus lab)
- separation
- active orthodontics – removable
- fixed or cemented – bilateral
- fixed or cemented – unilateral
- appliances to control harmful habits
- retention appliances

It should be noted that if, in the opinion of the orthodontist concerned the course of treatment is likely to extend beyond one year, the Insurer will make quarter-yearly payments only upon receipt of a completed claim form, from the orthodontist stating that the treatment plan has continued through the three months for which the payment is due.

Coordination of Benefits

This plan includes a Co-ordination of Benefits Provision. This provision operates in the event that you are covered under another Group Plan, or individual insurance plan or any government legislated automobile insurance plan including the Quebec Automobile Insurance Plan and ensures that payments made by all plans do not exceed the actual expenses incurred.

Survivor Benefit

If you die while insured under this Benefit and prior to any continuation of insurance as provided under an Extension of Benefits section, the insurance under this Benefit will be continued with respect to your dependents who are insured under this Benefit on the date of your death, without payment of premiums. The insurance will terminate on the earliest of:

- 2 years following the date of your death, and
- the date the dependent no longer qualifies as a dependent, and
- the date of termination of this Benefit with respect to active employees.

Limitations

If the date your insurance commenced is more than 31 days after the date you become eligible, covered expenses are limited to $200 for you and $200 for each of your dependents for the first 12 months of coverage, during which time full premiums must be paid.

Exclusions

The determination of “Covered Expenses” shall not include any charge:

- For services for any injury or disease due to insurrection, war, or act of war declared or undeclared, whether or not the insured person is actually participating in such insurrection or war.
- For services for any injury or disease due to participation in any riot or civil commotion.
- For services for any injury or disease due to the commission of or attempted commission of a criminal offense or provoking an assault.
- For services or examination performed by a legally licensed Dentist solely for the use of a third party.
- For intentional self-inflicted injury while sane or insane.
- For recent duplication of services by the same or a different Dentist.
- For a broken appointment
- For a full mouth reconstruction, for a vertical dimension correction, or for a correction of a temporomandibular joint dysfunction.
- For endodontics and coping with respect to over-dentures.
- For services or supplies considered by the Insurer to be experimental and not recognized by the Canadian Dental Association as an established, standard treatment for the condition.
- For the services or treatment which the insured person received while attending an accredited educational institute, college or university outside of Canada.
- For the services or treatment performed for primarily cosmetic reasons
- For services for which an insured person is not required to pay, including any expenses reimbursed, assumed or allowed under any other non-contractual plan, scheme, or arrangement.
- For treatment furnished or started before the date on which the insured person on whose account the charge was made became insured for this Dental Expense Benefit.
- For the placing of crowns to restore occlusal height or as a preventive measure.
- For the permanent splinting of teeth.
- For any treatment other than those specifically included as a “Covered Expense” mentioned in this Summary.
- For any services or treatment prohibited by law.
- For which the insured person may apply for and receive indemnity or compensation under any Workers’ Compensation Act.
- For the services or treatment which the insured person received while attending an accredited educational institute, college or university outside of Canada.
- For services for which the insured person receives payment as a result of legal action or settlement.

Conversion Privilege

If your coverage under the Group Policy is cancelled due to termination of

- your employment; or
- your group membership,

you will be able to convert your dental care insurance coverage to an individual insurance contract without having to submit evidence of insurability to the insurer, provided you are also converting your supplementary health insurance. Failure to convert your supplementary health insurance will prevent you from converting your dental care insurance.

Underwritten by myHSA
Coverage is for the employee and their dependents

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This account will reimburse any eligible expense that the CRA considers an eligible Medical Expense (as per the Income Tax Act). Any payments made from this account are made in before tax dollars. Thus, many expenses such as deductibles, vision, or dentistry that would normally be paid out of your pocket can come from this account.

Eligible Expenses

Charges for health care and dental care expenses that are:

- unpaid portions of expenses from regular health and dental plans such as deductibles, co-insurance amounts and amounts which exceed plan maximums
- expenses not covered under any other benefit plan whether group, provincial or private
- expenses listed as eligible medical expenses in the Income Tax Act, its regulations and Interpretation Bulletins. It is subject to change as the Act is amended

Canada Revenue Agency links

For information on eligible expenses you can paste the following links into the CRA website:

What medical expenses are covered?

www.cra-arc.gc.ca/tx/ndvdls/tpcs/ncm-tx/rtrn/cmpltng/ddctns/lns300-350/330-331/menu-eng.html

Authorized medical practitioners by province or territory for the purposes of claiming medical expenses

www.cra-arc.gc.ca/tx/ndvdls/tpcs/ncm-tx/rtrn/cmpltng/ddctns/lns300-350/330-331/ampp-eng.html

The Canada Revenue Agency (CRA) requires that health spending accounts be used only for the purpose they were intended—to pay for eligible medical expenses. Account balances cannot be withdrawn in cash or used for other purposes. Any unused portion of your allotment in a given year may be carried forward into the next calendar year. However, it must be used in that following year or it will be lost.

Carry forward of unused allocation

There is no carry forward, any unused portion of your allotment in a given year will be forfeited.

How to Claim

You must submit eligible claims to your primary insurer first and if applicable, your spouse's plan, before submitting to myHSA.

The Health Spending Account is only to be used for expenses or a portion of the expenses which are not covered elsewhere. For expenses of which a portion is payable under your or your spouse's group policy, you must submit the claim under those group policies first. After the benefit has been paid under those plans, you may then submit the unpaid portion of the claim for payment under your Health Spending Account (HSA).

Accumulate receipts and when reasonable reimbursement is due, submit a claim as follows:

a. New employees receive a welcome e-mail with a link to set their password.
b. Login at www.getmyhsa.com. Your username is the e-mail you were set up with. You can also download the myHSA App to access your account and submit claims at any time through your smartphone.
c. Enter your personal banking information under settings to make sure you receive payment.
d. Select “Make a Claim”, fill out the five fields, attach proof of payment, and submit.
e. Reimbursement for claims occurs within a few days when your claim is approved and sent to be paid.
f. We suggest you submit claims as soon as possible and no later than the claiming deadline as indicated in the summary of benefits.

View your Plan Details

a. On the Employee Dashboard you can see your spending account balance under “Employee Balance”
b. Under “Plan Info” you can access more information about your plan by clicking “Plan Details”.
c. To view what is eligible under your spending account, click on “List of Covered Items”.

Online Support

a. Click “Help” at any point on the system to access myHSA Live Chat. They offer technical support answers to any questions you may have.

phone: (604) 980-6227

toll free: 1 800 432-9707

www.jbenefits.com

At Johnstone's Benefits, we work with employers of all sizes to customize employee benefit and retirement plans. We have no contractual obligations to any insurers, which allows us to negotiate the most favourable premium costs, benefit provisions, and claim payment settlements for our clients and their employees.

Your Independent Employee Benefits Advisor
and Third Party Administrator