Q. How does Hydro's current group benefits compare with those provided by the Provincial Government to its employees?

A. Group benefits are part of a total compensation offering for both employers. A summary comparison of Hydro's Group Insurance Benefit Plan with that provided by the Government of Newfoundland and Labrador is provided in CA-NLH-220, Attachment 1. Hydro and the Provincial Government both have "core plus optional" plan designs. Core benefits require mandatory enrollment from eligible employees and cost-sharing arrangements apply. In both plans, employees have the option to elect and fully pay for additional coverage through optional programs. Cost sharing, eligible expenses, and coverage varies between plans.

Detail on both Group Insurance Benefit Plans is provided in CA-NLH-220, Attachment 2 and CA-NLH-220, Attachment 3.

Group Insurance Benefits - Plan Comparison (Hydro and Government of Newfoundland & Labrador)		
Description	**Newfoundland and Labrador Hydro**	**Government of Newfoundland and Labrador**
Basic Plan Design	Core plus Election of various Optional Insurance.	Core plus Election of various Optional Insurance.
Ennrollment Requirement	Mandatory for core (choice of single or family coverage).	Mandatory for core (choice of single or family coverage).
Cost Sharing Arrangement (Premium Payment)	Employer pays group health, life, AD&D, and 75% of dental. Employee pays LTD and 25% of dental. Employee pays for elected optional insurances.	50/50 per basic benefit. Employee pays for elected optional insurances (Government Plan includes long term disability as an optional insurance).
Basic Group Life Insurance	3x annual salary Part of core. 100% employer paid.	2x annual salary. Part of core. 50/50 cost sharing.
Dependent Life	Elect from $20,000 (spouse) and $10,000 (child) *or* $10,000 (spouse) and $5,000 (child). Optional. 100% employee paid.	$10,000 (spouse) and $5,000 (child). Part of core. 50/50 cost sharing.
Optional Life Insurance	Employee and Spousal plans. Max coverage: $300,000, terminates at 65. Medical evidence required. Optional. 100% employee paid.	Employee and Spousal plans. Max coverage: $300,000, terminates at 75. New employees $100,000 without medical evidence. Optional. 100% employee paid.
Accidental Death and Dismemberment Insurance (AD&D)	3x annual salary. Part of core. 100% employer paid.	2x annual salary. Part of core. 50/50 cost sharing.
Volunary (Optional) AD&D	Single or family coverage available. Max coverage: $300,000. Family coverage provides 50% benefit to spouse, 15% to child. Optional. 100% employee paid.	Single or family coverage available. Max coverage: $300,000. Family coverage provides 40% benefit to spouse, 5% to child. Optional. 100% employee paid.
Short Term Disability	Non-insured program (fully funded by employer). May be entitled to income continuance up to a maximum of 105 days. (Proof of disability to Plan Administrator required.)	Non-insured program (fully funded by employer). Non-union: Part of paid leave. Accumulating bank which includes annual, family and sick (total of 25 to 35 days of entitlement per year) with carryover and payout available (upon termination or retirement). Union: Accumulating sick leave bank available (1 day earned per month), no payout of unused credits.
Long Term Disability	Coverage: 60% regular monthly earnings. 105-day waiting period. Maximum benefit (NME): $9,000. 2 year own occupation. Expires at Earliest Unreduced Retirement date. Part of core. 100% employee paid.	Coverage: 66 2/3% regular monthly earnings. 119-day waiting period. Maximum benefit (NME): $10,000. 1 year own occupation. Expires at 65 or death. Optional. 100% employee paid.

Description	Newfoundland and Labrador Hydro	Government of Newfoundland and Labrador
Critical Care	Optional insurance. $10,000 with no medical evidence but has clause that excludes pre-existing conditions. Medical evidence required for over $10,000. Maximum available benefits: $100,000. Eligibility: Active employees under age 65. 100% employee paid.	Optional insurance. Fixed benefit coverage amounts. Employee coverage $25,000; Spouse $10,000; Dependent Child: $5000. Medical evidence of insurability required. Eligibility: Active employees under age 65. 100% employee paid.
Supplemental Health Care	Part of core. 100% employer paid.	Part of core. 50/50 cost sharing.
· **Prescription Drugs**	Pay Direct – Employee pays dispensing fee.	Co-pay (employee pays pharmacists fee plus applicable surcharge).
· **Hospital**	100% reimbursement for semi-private room.	100% reimbursement for semi-private room (daily max. of $85).
· **Vision**	Eye exam: $45 for every 24 months. Glasses/corrective lenses: 100% reimbursement every 24 months for adults (12 months for children) for glasses, contacts. Laser corrective survey: in 10 calendar years in combination with lenses, frames and/or contacts to maximum of $1000.	Eye exam: 80% reimburesement for eye exam every 2 calendar years (1 year for children). Glasses/corrective lenses: 100% reimbursement every 3 years for single lense glasses and frame up to $150 and $200 for bifocals and $250 for trifocals. Laser corrective surgery: Limited to one-time corrective laser survey, $450 maximum (no vision care payable for 6 years after).
· **Extended Health**	80% reimbursement.	80% reimbursement of eligible expenses up to $5,000; 90% over $5,000; 100% over $10,000.
- *Home Nursing Care*	$25,000 per calendar year maximum.	$10,000 maximum per disability.
- *Transportation*	Emergency transportation to and from hospital or medical facility. Non-emergency: Up to $500 maximum per calendar year.	Emergency transportation to and from hospital or medical facility. Non-emergency: Up to $300 maximum per calendar year.
- *Diabetic Supplies*	Supplies where prescribed. Glucometers (monitoring devices) up to $300 where prescribed.	Supplies where prescribed. Maximum eligible expense per calendar year $2,170. Insulin pumps up to $4,800 in a five year period for dependents under 16 and up to $2,500 in a five year period on a restricted basis. Glucometers (monitoring devices) up to $300 where prescribed.
- *Orthopedic Shoes*	One pair of customized shoes per year ($75 per calendar year for modifications).	Shoes and aid to maximum up to $200 per calendar year.
- *Paramedical*	80% reimbursement. Maximum of $250 per calendar year per practitioner except physio to a maximum of $1000 per calendar year.	Maximum of $500 per calendar year per practitioner.
- *Occupational Therapist*	Not an eligible expense.	Annual eligible expense is $500.
- *Hearing Aids*	Up to $400 per insured in any five calendar years.	One for each ear, every three consecutive calendar years. Maximum for each aid $1,000.
Group Travel	100% reimbursement for eligible expenses incurred due to accident or unexpected illness.	100% reimbursement for eligible expenses incurred due to accident or unexpected illness.

Description	Newfoundland and Labrador Hydro	Government of Newfoundland and Labrador
Dental	Core benefit, mandatory enrollment. Fee guide: Current. 25% employee/75% employer cost sharing.	Optional insurance. Fee guide: 2013. 100% employee paid.
· **Basic**	80% reimbursement (no maximum).	80% reimbursement (no maximum).
· **Major Restorative**	70% reimbursement - maximum $1,250 per calendar year.	70% reimbursement - maximum $1,250 per calendar year.
· **Orthodontics**	None.	None.

GROUP INSURANCE BENEFIT GUIDE

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GENERAL INFORMATION - GROUP INSURANCE BENEFITS

SCHEDULE OF BASIC GROUP INSURANCE BENEFITS

Employee Life Insurance Benefit

Benefit:	3 times annual earnings rounded to the next higher $1,000 (if not already a multiple) up to a maximum of $500,000.
Reduction:	Upon retirement at age 55 insured amount reduces to 1 times annual earnings and reduces to $10,000 at age 65 (effective January 1, 2007).
Cost Sharing:	100% employer paid until retirement, then 50/50
Optional Coverage:	Available for employee and/or spouse. Premium 100% employee paid.

Dependent Life

Benefit:	Opt. I: Spouse - $10,000 Opt. II: Spouse - $20,000	Each child - $5,000 Each child - $10,000
Termination:	Terminates at age 65.	Dependent child - age 25
Cost sharing:	100% employee paid	

Employee Accidental Death & Dismemberment Benefit

Benefit:	Same as Employee Life Benefit
Reduction:	Upon retirement at age 55 insured amount reduces to 1 times annual earnings and terminates at age 65.
Cost Sharing:	100% employer paid until retirement, then 50/50.
Optional Coverage:	Employees may purchase additional Optional Accidental Death and Dismemberment on an employee and family basis, the cost of which is 100% employee paid.

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Short Term Disability

Benefit: Eligible employees may be entitled to receive 100% of salary for a defined period (maximum of 105 days), if absence is due to sickness or non-occupational accident. Employees will be required to provide proof of disability satisfactory to the Plan Administrator.

Cost Sharing: 100% employer paid.

Long Term Disability

Benefit: 60 % of regular monthly earnings, plus 8% pension contribution, to a non evidence maximum of $9,000 per month (non-taxable). Pension contribution is 5% for part-time employees.

Waiting Period: 105 days

Benefit Period: To age 65.

Cost Sharing: 100% employee paid.

Extended Health Care Benefit

Prescription Drugs: Pay Direct. Employee pays dispensing fee.
Hospital Benefit: 100% reimbursement for semi-private room.
Extended Health: 80% reimbursement.
Travel: 100% reimbursement for eligible expenses incurred due to accident or unexpected illness.
Vision: 100% reimbursement to a maximum of $200.00.
Adults every 24 consecutive months.
Children every 12 consecutive months.

Cost Sharing: 100% employer paid until retirement, then 50/50.

Dental Benefits

Basic: 80% reimbursement - no maximum
Major Restorative: 70% reimbursement - maximum $1,250 per calendar year.

Fee Guide: Current Dental Fee Guide

Cost Sharing: 75% employer / 25 % employee paid.

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Critical Illness Benefit

Benefit:	Lump Sum payment from $10,000 to $100,000
Termination:	Terminates at age 65 or at time of termination of active employment or payout of principal sum amount.
Cost sharing:	100% employee paid

Eligibility

- All Regular and Full-Time Seasonal Employees are insured under the basic program from the date employment commences.

- Term and Temporary Employees are insured in accordance with their respective Collective Agreement or the Corporate Policy Manual.

The Basic Group Insurance Program consists of Group Life, Accidental Death and Dismemberment and Long Term Disability Insurance as well as Supplementary Health and Dental* benefits. In addition, you may purchase on a voluntary basis, at your own expense, additional coverage under the Optional Group Life, Optional Dependent Life, Optional Accidental Death and Dismemberment Insurance Program and/or the Critical Illness Benefit.

* Employees who were eligible for dental insurance benefits prior to November 1, 1988, and did not apply within one month of being eligible have coverage restricted during the first 12 months of coverage. For those employees, the plan will cover only dental treatment required solely as the result of an accident occurring while insured and routine treatment expenses up to a maximum of $100.00. Major treatment expenses will be covered after 12 months of coverage under the plan.

  For employees hired on or after November 1, 1988, participation in the dental plan is a condition of employment and you and your dependents will be covered automatically when you become eligible.

If you are not actively at work on the date your insurance would normally commence, it will not become effective until you return to work.

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Definition of Dependent

Spouse

- Your spouse by virtue of a legal marriage, or your common-law spouse (i.e. a person with whom you have cohabited for at least one year).

Children

- Your unmarried, natural, adopted foster or step-child who is under age 21, or 21 years or over if a full-time student wholly dependent on you for support or incapable of self-sustaining employment by reason of mental or physical handicap and chiefly dependent on you for support. Notwithstanding the foregoing, Dependent Life benefits terminate at age 25.

Changes in Insurance Benefits

Changes in benefits because of plan amendment or change in employee status (e.g. earnings, dependent status) become effective:

- On the effective date of the change or status provided you are actively at work on that date.

- If you are not actively at work on the date of the change in plan or status, on the date of your return to work.

Change of Beneficiary

You may change your beneficiary designation at any time subject to any legal requirements. For further information, please contact the Human Resources Department.

NOTE: This summary outlines the benefits for which you and your dependents are eligible but does not create or confer any contractual or other rights. All rights with respect to the specific insurance coverage will be governed solely by the master policy issued by the respective insurer. Further information may be obtained from the Human Resources Department.

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BASIC GROUP LIFE INSURANCE

Benefit Payable

In the event of your death from any cause whatsoever, a life insurance benefit equal to three (3) times your annual earnings, rounded to the next higher $1,000, if not already a multiple thereof, will be paid to the beneficiary named by you or to your estate.

Reduction Clause

The intent of group life insurance is to provide a significant level of coverage to employees during their active employment years when their personal responsibilities and liabilities are the greatest. As such, life insurance coverage reduces to one times annual earnings should you elect retirement after age 55 but prior to your attaining age 65. At age 65, coverage reduces to $10,000 (effective January 1, 2007) and continues in force throughout your lifetime.

Continuation of Coverage in the Event of Disability

Should you, while insured under the plan, become disabled from engaging in any occupation for which you are or may become qualified by education, training or experience, your group life insurance may be continued in force for the duration of such disability. At age 65, coverage reduces in accordance with the reduction clause.

Beneficiary Designation

In the event of your death, the group life insurance benefit is payable to the beneficiary you have appointed on your application card.

Termination of Coverage

Your group life insurance terminates on termination of employment, other than retirement.

Conversion Privilege

If your insurance reduces and/or terminates on or prior to age 65, you may be entitled to convert the cancelled amount of basic group life insurance to an individual policy of the type then being offered by the insurer to conversion applicants within 31 days of the termination or reduction date, and no medical evidence of insurability would be required. The premium rate would be based on your age and class of risk at that time. For further information, please contact the Human Resources Department.

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BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Benefit Payable

The plan provides accidental death and dismemberment insurance coverage in an amount equal to your basic group life insurance. Coverage is provided 24 hours per day, anywhere in the world, for any accident resulting in death, dismemberment, paralysis, loss of use, or loss of speech or hearing. Your Loss of Life benefit shall be payable to the beneficiary designated under your Basic Group Life Insurance Program, or if there is no such beneficiary designation, the benefit shall be payable to your Estate.

All other indemnities payable will be payable to you, with the exception of indemnities payable under the following sections:

Education
Day-Care
Occupational Training
Identification

Specific Loss Accident Indemnity

When injury results in any of the following losses within 365 days after the date of the accident, the insurer will pay:

For Loss of	
Life	The Principal Sum
The Entire Sight of One Eye	Two-Thirds of the Principal Sum
Speech	Two-Thirds of the Principal Sum
Hearing in One Ear	One-third of the Principal Sum
All Toes of One Foot	One-Quarter of the Principal Sum

For the Loss or Loss of Use of	
One Arm	Three-Fourths of the Principal Sum
One Leg	Three-Fourths of the principal Sum
One Hand	Two-Thirds of the Principal Sum
One Foot	Two-Thirds of the Principal Sum
Thumb and Index Finger or at Least Four Fingers of One Hand	One-Third of the Principal Sum

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For Total Paralysis of

Both Upper and Lower Limbs (Quadriplegia)	Two Times the Principal Sum
Both Lower Limbs (Paraplegia)	Two Times the Principal Sum
Upper and Lower Limbs of One Side of Body (Hemiplegia)	Two Times the Principal Sum

"Loss" as used above with reference to:

hand or foot: means the complete severance through or above the wrist or ankle joint, but below the elbow or knee joint;

arm or leg: means the complete severance through or above the elbow or knee joint;

thumb: means the complete severance of one entire phalanx of the thumb;

finger: means the complete severance of two entire phalanges of the finger;

toe: means the complete severance of one entire phalanx of the big toe and all phalanges of the other toes;

eye: means the irrecoverable loss of the entire sight thereof;

speech: means the complete and irrecoverable loss of the ability to utter intelligible sounds;

hearing: means the complete and irrecoverable loss of hearing;

quadriplegia, paraplegia, and hemiplegia: means the complete and irreversible paralysis of such limbs;

loss of use: means the total and irrecoverable loss of use, provided the loss is continuous for 12 consecutive months and such loss of use is determined to be permanent at the end of such period.

Indemnity provided under this section will not be paid under any circumstances for more than one of the losses, the greatest, sustained for multiple injuries to the same limb by any one Insured Person as the result of any one accident.

Indemnity provided under this section for all Losses sustained by any one Insured Person as the result of any one accident will not exceed the following:

a) with the exception of quadriplegia, paraplegia and hemiplegia, the Principal Sum.

b) with respect to quadriplegia, paraplegia and hemiplegia, Two Times the Principal Sum, or the Principal Sum if Loss of Life occurs within 90 days after the date of the accident.

In no event will indemnity provided under this section exceed Two Times the Principal Sum for all Losses sustained by an Insured Person as the result of the same accident.
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Definitions Applicable to the Basic AD&D Benefit

"Injury" means bodily injury caused by an accident occurring while your coverage is in force under the Policy, and resulting directly and independently of all other causes in Loss covered by the Policy, 24 hours a day, anywhere in the world.

"Insured Person" means an Employee insured under the Policy.

"Member of the Immediate Family", means a person at least 18 years of age, who is your spouse, son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law, (all of the above include natural, adopted or step relationship), grandson, granddaughter, grandfather or grandmother.

"Hospital" means an institution licensed as a hospital, which is open at all times for the care and treatment of sick and injured persons, has a staff of one (1) or more Physicians available at all times and which continuously provides twenty-four (24) hour nursing service by graduate registered nurses. It provides organized facilities for diagnostics and surgery, is an active treatment hospital and not primarily a clinic, rest home, nursing home, convalescent hospital or similar establishment. For the purposes of this definition, hospital will include a facility or part of a facility used for rehabilitative care.

"Regular Care and attendance" means observation and treatment to the extent necessary under existing standards of medical practice for the condition causing the confinement.

"Physician" means a doctor of medicine (other than the Insured Person or a Member of the Immediate Family) who is licensed to practice medicine by:

1) a recognized medical licensing organization in the locale where the treatment is rendered, provided he is a member in good standing of such licensing body, or

2) a governmental agency having jurisdiction over such licensing in the locale where the treatment is rendered.

"Accommodation" means lodging in the vicinity of the Hospital where the Insured Person is confined.

The male pronoun will be construed as the feminine when the person is a female.

Repatriation*

If you sustain accidental Loss of Life not less than 50 kilometers from your normal place of residence and indemnity for such Loss becomes payable under this program, we will pay the reasonable and

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customary expenses actually incurred for the transportation of your body to the first resting place (including but not limited to a funeral home or the place of interment) in proximity to your normal place of residence. The repatriation benefit up to $10,000 will be paid for expenses incurred for the return home of your body (including charges for the preparation of the body for such transportation).

Education**

If you sustain accidental Loss of Life for which an amount of Principal Sum becomes payable under the Policy, up to 5% of your Principal Sum (maximum $5,000) is payable for each of your Insured Dependent Children already enrolled full-time

1) in an institution for higher learning above the secondary school level; or

2) at the secondary school level but who will enroll as a full-time student in an Institution for higher learning within 365 days after your death.

The benefit is equal to the reasonable and necessary expenses actually incurred and payable annually for each year (up to 4 consecutive years) that the Insured Dependent Child continues his education in an Institution for higher learning, but payment is not made for expenses incurred prior to your death, nor for room, board or other ordinary living, travelling or clothing expenses.

If none of your Insured Dependent Children satisfy either the above requirements or the requirements as shown under the section entitled "Day-Care", then an amount equal to 5% of Your Principal Sum or $2,500, whichever is less, is payable to your beneficiary.

"Institution for higher learning" includes any university, college, CEGEP or trade school.

"Dependent Children" mean persons that are either legitimate or illegitimate children, adopted children, step-children or children who are in a parent-child relationship with the Insured Person. The children are single under 25 years of age and dependent upon the Insured Person for maintenance and support.

Day-Care**

If you sustain accidental Loss of Life for which an amount of Principal Sum becomes payable under the Policy, up to 5% of your Principal Sum (maximum $5,000) is payable for each of your Insured Dependent Children under 13 years of age, who

1) are enrolled in a Day-Care Centre on the date of your death; or

2) will enroll in a Day-Care Centre within 365 days after your death.

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The benefit is equal to the reasonable and necessary expenses actually incurred and payable annually for each year (up to 4 consecutive years) that the Insured Dependent Child is enrolled in a Day-Care Centre but payment is not made for expenses incurred prior to your death, nor for room, board or other ordinary living, travelling or clothing expenses.

If none of your Insured Dependent Children satisfy either the above requirements or the requirements as shown under the section entitled "Education", then an amount equal to 5% of your Principal Sum or $2,500, whichever is less, is payable to your beneficiary.

"Day-Care Centre" means a facility which is operated according to law, including laws and regulations applicable to day-care facilities and which provides care and supervision for children in a group setting on a regular basis. Day-Care Centre will neither include a hospital, the child's home, care provided during normal school hours while a child is attending grades 1 through 12 nor any other day-care facility which does not charge a fee for services rendered.

"Dependent Children" mean persons that are either legitimate or illegitimate children, adopted children, step-children or children who are in a parent-child relationship with the Insured Person. The children are under 13 years of age and dependent upon the Insured Person for maintenance and support.

Rehabilitation*

If you sustain any Loss which becomes payable under the program and such Loss requires you to participate in a rehabilitation program in order to qualify to engage in an occupation in which you would not have engaged except for such Loss, the Insurer will pay the reasonable and necessary expenses actually incurred within 3 years from the date of the accident to a maximum of $10,000. No payment will be made for room, board or other ordinary living, traveling or clothing expenses.

Occupational Training*

If you sustain accidental Loss of Life which becomes payable under the program, this benefit will refund expenses incurred for your spouse to engage in a formal occupational training program in order to upgrade his/her employment qualifications, to a maximum of $10,000 within 3 years from the date of the accident. No payment will be made for room, board or other ordinary living, traveling or clothing expenses.

Permanent Total Disability

The Principal Sum is payable in a lump sum, less any other amounts paid or payable under the Specific Loss Accident Indemnity as a result of the same accident, if you, become totally disabled and the following conditions are met:

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1) The disability results from an Injury occurring prior to age 65.

2) The disability commences within 365 days of the accident.

3) The disability prevents you from engaging in each and every occupation or employment for compensation or profit for which you are reasonably qualified by education, training or experience.

4) The disability has continued for 12 consecutive months, remains total and is deemed to be permanent at the end of such period.

Family Transportation*

If any Specific Loss covered under the Specific Loss Accident Indemnity confines you to a hospital or if any other Injury confines you to a hospital for 4 days and such hospital is located at least 150 kilometers from your residence, this benefit will refund expenses incurred by any Members of your Immediate Family for hotel accommodation and transportation (via the most direct route) to your bedside, to a maximum of $1,000. Private transportation expenses are limited to $0.20 per kilometer travelled.

Payment is not made for board or other ordinary living, travelling or clothing expenses.

Identification*

If you sustain accidental Loss of Life, and the police require the identification of the body by a Member of the Immediate Family, and indemnity for Loss of Life subsequently becomes payable under the Policy, we will refund expenses incurred by such family member for:

1) accommodation and board (up to a maximum of 3 consecutive nights) while en route and/or during the stay in the city or town where the body is located, and

2) transportation via the most direct route to this location,

provided this location is not less than 150 km from the family member's usual residence.

Private transportation expenses are limited to $0.20 per km traveled and the total maximum refundable for all expenses is limited to $5,000.

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Seat Belt**

If, at the time of the accident, you were wearing a properly fastened seat belt and driving or riding in a "vehicle" driven by a driver who has a valid driver's license and was neither "intoxicated" nor "under the influence of drugs" (unless taken as prescribed by a physician), and a Loss becomes payable under the program, the applicable amount of Principal Sum will be increased by 10% for those wearing a seat belt, subject to a maximum of $25,000, which maximum is in combination with the Seat Belt Benefit maximum provided under any other policy issued to the Policyholder by the Insurer.

"Intoxicated" and being "under the influence of drugs" is as defined by the jurisdiction in which the accident occurs.

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

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

Home Alteration and/or Vehicle Modification*

If you sustain the Loss of or Loss of Use of Both Feet or Legs or becomes Quadriplegic, Paraplegic or Hemiplegic, for which indemnity becomes payable under the Policy, and you subsequently requires the use of a wheelchair to be ambulatory, We will refund the reasonable and necessary expenses actually incurred during the 3 year period following the accident, to a maximum of $10,000, for the cost of alterations to your principal residence and/or the cost of modifications to 1 motor vehicle utilized by yourself, when such modifications are approved by licensing authorities where required, for the purpose of making them wheelchair accessible.

Hospital Indemnity**

If any Loss covered under the Specific Loss Accident Indemnity section of the Policy confines an Insured Person to a hospital and such person is under the regular care and attendance of a physician, you will receive a daily benefit of 1/30th of 1% of your Principal Sum from the 1st day of hospitalization, up to a maximum of $2,500 per month and for a maximum duration of 365 days per accident.

Hospitalization required for treatment of any Injury other than for a Specific Loss is also covered in accordance with the above terms, provided such hospitalization begins within 365 days of the date of the accident which caused the Injury and insurance is in force. The daily benefit is payable from the 1st day of hospitalization if the Insured Person is hospitalized for at least 4 days.

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Hospitalization is either a single uninterrupted confinement in a hospital or several successive confinements in a hospital as a result of the same accident, provided each such confinement is separated by a period of less than 90 consecutive days. All confinements must occur within 730 days of the date of the accident.

Only one hospitalization, as defined above, will be payable for all Injuries sustained by the Insured Person as the result of the same accident.

Cosmetic Disfigurement

If you suffer cosmetic disfigurement due to a burn, the Insurer will pay the Cosmetic Disfigurement benefit provided that such burn is classified as a third degree burn.

The amount of benefit payable under this section is based on the percentage of the Principal Sum, as shown in the Cosmetic Burn Schedule below, which is determined by the Area Classification factor times the percentage of body surface actually burned.

Maximum allowable percentage for body surface burned, as shown in the following Cosmetic Burn Schedule, is based on 100% of the specific body part being burned. The attending physician will determine the actual percentage applicable to each burn.

If you suffer burns to more than one body part as a result of any one accident, benefits payable for all such burns will not exceed 100% of the Principal Sum.

Cosmetic Burn Schedule

Body Part	Area Classification Factor	Maximum Allowable % for Body Surface Burned	Maximum % of Principal Sum Payable
Face, Neck, Head	11	9.0%	99.9%
Hand & Forearm (Right)	5	4.5%	22.5%
Hand & Forearm (Left)	5	4.5%	22.5%
Upper Arm (Right)	3	4.5%	13.5%
Upper Arm (Left)	3	4.5%	13.5%
Torso (Front)	2	18.0%	36.0%
Torso (Back)	2	18.0%	36.0%
Thigh (Right)	1	9.0%	9.0%
Thigh (Left)	1	9.0%	9.0%
Lower Leg - below knee	3	9.0%	27.0%

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In the event benefits are payable under this section and the sections entitled Specific Loss Accident Indemnity or Permanent Total Disability, the total benefits payable will not exceed 100% of the Principal Sum (or 200% for Paralysis).

Note: Benefits marked with an asterisk (*) are only payable under one of the policies issued to the employer by AXA Assurances Inc..

Benefits marked with 2 asterisks (**) are payable under all other policies with similar benefits issued to the Employer by AXA Assurances Inc. subject to the maximum amount stated in the policies.

Exposure and Disappearance

If, by reason of an accident covered by this program, you are unavoidably exposed to the elements and such exposure results in a covered Loss, such Loss will be covered.

If you are not found within one year of the disappearance, sinking or wrecking of a conveyance in which you were riding at the time of the accident, it will be presumed you have suffered Loss of Life resulting from bodily Injury caused by an accident.

Reduction and Termination of Coverage

Coverage reduces on early retirement (prior to age 65) in accordance with the basic group life insurance schedule and terminates at age 65.

Waiver of Premium

Should you become totally disabled prior to age 65, your basic accidental death and dismemberment insurance coverage may be continued in accordance with the benefit schedule, without further premium payment, to the earlier of recovery, death or attainment of age 65.

Notwithstanding anything contained to the contrary in the Policy, benefits payable for any Loss which occurs while this clause is in effect cannot exceed the amount of insurance payable on the date of your disability.

Aggregate Limit

The Basic AD&D policy contains a $5,000,000 aggregate limit of indemnity for all losses arising out of any one aircraft accident. If this amount is insufficient to pay the full amount of indemnity for each Insured Person, then the amount payable for each Insured Person is proportionately reduced so that the total amount of indemnity payable equals $5,000,000.

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The aggregate limit of indemnity only applies to losses payable under the Specific Loss Accident Indemnity section of the Policy

Exclusions

The program does not cover any Loss, fatal or non-fatal, caused or contributed to by:

1) intentionally self-inflicted Injury while sane or self-inflicted Injury while insane;

2) declared or undeclared war or any act thereof;

3) active full-time service in the armed forces of any country;

4) riding as a passenger or otherwise in any vehicle or device for aerial navigation not certified as airworthy and/or piloted by a person not licensed to pilot such a vehicle or device.

Critical Illness

When the Insured Person suffers a Critical Illness, the Insurer shall pay the Benefit Amount, subject to the survival by the Insured Person of a Survival Period. No Benefit Amount is payable if the Insured Person does not survive the Survival Period.

"**Critical Illness**" means:

a) Heart Attack;
b) Coronary Artery Bypass Graft;
c) Stroke;
d) Cancer;

"**Heart Attack**" means the Diagnosis of the death of a portion of the heart muscle, resulting from blockage of one or more coronary arteries. The Diagnosis must be based on both a) new electrocardiographic (ECG) changes which support the diagnosis of a heart attack and b) elevations of cardiac enzyme.

"**Coronary Artery Bypass Graft**" means the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts. The surgery must be recommended by a cardiologist licensed and practicing in Canada.

Non-surgical procedures **not** covered by this definition include:
Balloon angioplasty;
Laser embolectomy; or
Other non-by pass techniques.

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"**Stroke**" means the Diagnosis of a cerebrovascular incident causing infarction of brain tissue due to thrombosis, embolism or hemorrhage and producing a measurable functional neurological deficit persisting for at least thirty(30) days following the occurrence of the stroke. This definition excludes Transient Ischemic Attacks (TIA's).

"**Cancer**" means the Diagnosis of a malignancy which is characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue.

Benefit will not be payable under this definition if within ninety (90) days following the effective date of coverage of the Insured Person a) a Diagnosis of Cancer is made or b) any symptoms or medical problems commenced and initiated investigations leading to the Diagnosis of any cancer.

The conditions **not** covered by this definition include:

- Early prostate cancer, Diagnosed as T1A or T1B N0 M0 or equivalent staging;
- Non-invasive cancer (in situ);
- Pre-malignant lesions, benign tumors or polyps;
- Any skin cancer other than invasive malignant melanoma greater than 0.75 mm.;
- Any tumor in the presence of the Human Immunodeficiency Virus (HIV).

"**Survival Period**" means thirty (30) days following the date Diagnosis becomes effective or the date of the surgery for Coronary Artery Bypass Graft or Major Organ Transplant.

"**Diagnosis**" means the certified diagnosis of a Critical Illness by a medical practitioner or specialist who is licensed and practicing medicine in Canada, other than the Insured Person, a business associate or a relative.

"**Benefit Amount**": $1,000.

Conditions for Payment

Benefit will be payable for new Diagnosis made while the policy is in force as to Insured Person whose Critical Illness is the basis of claim.

Benefit Payment

The Benefit Amount payable in the event of a Critical Illness will be payable to the Insured Person or the Insured Person's Estate.

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Exclusions

The Principal Sum will not be paid if a Critical Illness results directly or indirectly from any one or more of the following causes:

a) Within ninety (90) days following the effective date of coverage of the Insured Person a) Diagnosis of Cancer is made, or b) any symptoms or medical problems commenced and initiated investigations leading to the Diagnosis of Cancer.
b) An intentionally self-inflicted injury or sickness, whether the Insured Person is sane or insane.
c) The use of illicit drugs other than as prescribed and administered by or in accordance with the instruction of a legally licensed medical practitioner.
d) From a pre-existing condition as specified under the Pre-existing Conditions Exclusion.

Pre-existing Conditions Exclusion

The Benefit Amount will not be paid for Critical Illness which results directly and indirectly from any conditions for which the Insured Person, during twenty-four (24) months prior to his coverage came into force:

1. incurred medical expenses;
2. received medical treatment;
3. took prescribed drugs or medicine; or
4. consulted a physician.

However, no claim for Critical Illness beginning after two (2) years from the date the Insured Person's coverage came into force will be reduced or denied under this exclusion unless it is excluded by name or specific description.

If this policy directly replaces one with another Insurer providing similar benefits, an Insured Person who has satisfied the time period of pre-existing conditions limitation in a prior policy will be deemed to have satisfied the time period in this policy, but only to the extent of the benefit amount and Critical Illnesses covered in the prior policy. The prior policy must be cancelled within thirty-one (31) days prior to the date this policy came into force.

An Insured Person who has not satisfied the time period of pre-existing conditions limitation in a prior policy will be allowed to apply any amount of time satisfied under the pre-existing conditions limitation of the prior policy toward the satisfaction of the time period requirement of this pre-existing conditions exclusion, but only to the extent of the benefit amount and Critical Illnesses covered in the prior policy. Any additional benefit amount provided in this policy will be subject to the terms of this exclusion. The prior policy must be cancelled within thirty-one (31) days prior to the date this policy came into force.

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Area of Diagnosis

Should a Critical Illness occur or be diagnosed outside of Canada, payment of the Benefit Amount may be considered upon the Insured Person's return to Canada for medical assessment and confirmation of the Diagnosis of a Critical Illness.

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OPTIONAL DEPENDENT LIFE INSURANCE

Death Benefits

In the event of the death of your spouse or dependent child from any cause whatsoever, the Insurance Company will pay you an amount depending on the option selected as outlined below:

Opt I: Spouse - $10,000	Each dependent child - $5,000
Opt II: Spouse - $20,000	Each dependent child - $10,000

Continuation of Coverage in the Event of Disability

Should you become totally disabled while insured under the plan, your dependent life insurance may be continued in force for the duration of such disability up to the attainment of age 65.

Termination of Coverage

Dependent life insurance coverage terminates on termination of employment (other than early retirement) or, in respect of dependent children, on the earlier of the date they are no longer eligible, as outlined in the General Information Section, or on your attainment of age 65.

Coverage may be continued during early retirement (prior to age 65) terminating at age 65.

Conversion Privilege (Spouse Only)

If your dependent life insurance terminates on or prior to your spouse having attained age 65, your spouse may be entitled to convert the amount of dependent life insurance to an individual policy of the type then being offered by the insurer to conversion applicants within 31 days of this period, without submission of evidence of health. The premium rate will be determined from your spouse's age and class of risk at the time of conversion. For further information, please contact the Human Resources Department.

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SHORT TERM DISABILITY

Subject to providing Hydro with satisfactory evidence of disability, all permanent, term and full-time seasonal employees are eligible to receive 100% of salary for the first 105 days of absence, if absence is due to sickness or non-occupational accident.

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LONG TERM DISABILITY INSURANCE (LTD)

This benefit provides a certain level of income in the event that you should be unable to work due to total disability.

Commencing with the date you are first absent from work and during the first 27 months of disability, disability is defined as your inability to perform the duties of your own job. Thereafter, long term disability benefits will be continued as long as you are unable to engage in gainful employment:

- the duties of which you are medically able to perform and for which you have at least the minimum qualifications, and,
- that provides income of at least 60% of your pre-disability monthly earnings,
- that exists in the province or territory where you worked when you became disabled or where you currently live. It is important to note that availability of work is not considered in assessing disability.

Note: A benefit period will normally not continue past a person's 65th birthday unless he has been entitled to benefits for less than 24 months. In that event, the benefit period will continue until the end of the 24 months.

Benefit Payable

The monthly long term disability benefit payable will be 60% of your regular monthly earnings at the date of disability plus 8% of earnings which is contributed on your behalf to the Public Service Pension Plan while you are disabled. The total maximum benefit payable is $9,000 per month (non-taxable).

Payments under the LTD plan will be offset by other income or benefits received during disability. Your monthly benefit will be reduced by benefits to which you are entitled on your own behalf under:

- Workplace Health, Safety & Compensation Commission
- the Canada Pension Plan or the Quebec Pension Plan or,
- a plan in another country for which there is a reciprocal agreement with the Canada or Quebec Pension Plan.

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Further, benefits under the LTD Plan will be co-ordinated with other income so that total income does not exceed 90% of take-home pay. Under this "co-ordination provision" your LTD benefit will be reduced by the amount by which your total income exceeds 90% of take-home pay. The sources of income which will be included in the co-ordination provision are :

- Benefits to which another family member is entitled, on the basis of the employee's disability, under the Canada or Quebec Pension Plan or a plan in another country for which there is a reciprocal agreement with the Canada or Quebec Pension Plan,

- Loss of income benefits available through legislation on the basis of disability, including automobile insurance benefits if permitted by law.

- Disability benefits under a plan of insurance as a result of membership in an association.

- Employment, disability or retirement income related to any employment except:

  * retirement benefits from a plan to which an employer has not contributed.

  * any amount related to employment other than with Hydro that was payable for each of the 12 months before a disability period.

  * income from an approved rehabilitation plan or program.

Note: Once benefits commence, your income will not be further reduced by cost-of-living adjustments under the Canada or Quebec Pension Plans.

Rehabilitation Benefit

Rehabilitation involves a training strategy or work related activity which is recommended or approved by Great West Life and which can be expected to facilitate a disabled person's return to his job or other gainful employment.

Great West Life distinguishes between a Comprehensive Rehabilitation Program and a Rehabilitation Plan on the basis of their different goals:

A Comprehensive Rehabilitation Program must have as its goal:

- to return the person to work in a different job that requires extensive training or to return the person to work in a self-employed capacity.

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A Rehabilitation Plan must have as its goal:

- to return the person to work in the same job; or a modified job with the same employer or,
- to return the person to work in a different job that capitalizes on transferable skills.

Rehabilitation Incentive Provision

Earnings received from an approved rehabilitation plan or program, are not used to reduce LTD benefits unless those earnings, the LTD benefits and income from sources such as Canada Pension exceed 100% of the employee's take-home pay. If total income does exceed 100% of take-home pay, the LTD benefit will be reduced by the amount in excess of 100%.

Recurrence of Disability

After the waiting period, a disability is considered a recurrence if it arises from the same disease or injury and starts:

- within six months after the previous disability ended,
- within 24 months after the end of an approved comprehensive rehabilitation program.

Other Benefit Provisions and Limitations

To qualify for LTD benefits, you need not be confined to your home, but you must be under the continuous care and personal attention of a physician.

While you are receiving LTD benefits, you are not required to pay LTD premiums.

Since you pay 100% of the premium cost of your LTD insurance, the monthly benefit is non-taxable.

Claims for disability due to pregnancy will be eligible for payment. However, no long term disability benefits will be payable during the period of receipt of E.I. maternity benefits or during the period of maternity leave of absence.

The plan does not provide benefits for disability resulting from war, from intentionally self-inflicted injury, or injury sustained while working for another employer. Further, LTD insurance does not cover illness or injury due to alcoholism, drug addiction or the use of any hallucinogen, unless the condition is specifically documented as being an organic condition or the employee is undergoing a program of rehabilitation treatment approved by the insurance company.

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No benefits are payable for a disability that begins while you are on approved leave of absence, approved sabbatical or temporary or seasonal layoff until the date you are scheduled to return to work.

Termination of Coverage

Long term disability insurance coverage terminates when eligible for an unreduced pension, on attainment of age 65 or termination of employment, whichever is earlier.

Conversion Privilege

If you change jobs, you may apply for an individual long term disability insurance policy (one of the standard conversion policies offered by the insurer), without taking a medical examination. You must apply within one month of the date you start your new job, however, and you must start your new job within six months of the date you leave your present one.

Termination of Benefits

LTD benefits are payable to the earlier of recovery, death, eligibility for unreduced pension or attainment of age 65.

In the event of death while benefits are payable, a survivor benefit equal to three times the income benefit is payable to the claimants' named beneficiary or the estate.

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SUPPLEMENTARY HEALTH BENEFIT

In addition to the benefits available under the Government Medical Care and Hospitalization Plans, supplementary health coverage is provided to you and your dependents as outlined below. There is no deductible applicable to this plan and there is no overall annual or lifetime maximum. Payment will be based on the reasonable and customary charges for the eligible expenses in accordance with the co-insurance and applicable benefit maximums.

Hospital and Ambulance Coverage

Coverage is provided at 100% of the eligible expenses for:

Hospital Room - the difference between standard ward accommodation and semi-private room accommodation in or outside of Canada. This benefit includes any in-patient hospital admittance charges where permitted by law.

Out-patient Services - out-patient and diagnostic services of a hospital or private facility approved by the insurer. This benefit does not provide coverage for out-patient user fees.

Ancillary Services - ancillary services where such services are not fully covered under a Government Health Program.

Ambulance Services - transportation to and from a hospital or medical clinic qualified to render essential medical treatment certified as immediately necessary by the attending physician. Eligible charges include transportation by a licensed ground ambulance, air ambulance, regularly scheduled airline or other public transportation.

Prescription Drug Coverage

Drugs may be purchased on a pay direct basis with a co-pay equal to the dispensing fee. You will be covered for those drugs and medicines which, by law, can only be obtained with written prescription from a physician or dentist and dispensed by a licensed pharmacist. These items include prescription drugs, insulin and oral contraceptives. The plan also covers certain other drugs requiring a doctor's prescription that are considered medically necessary for the treatment of specific medical conditions and authorized by the insurer. The plan does not cover cough/cold medications, prescribed or otherwise, neither does it cover antihistamines. Other than certain preparations, necessary to sustain life, medications which are available over the counter (i.e. do not require prescription) are not covered.

Please Note: This benefit includes payment of the Government user fee applicable to prescription drugs for participants age 65 and over.

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Extended Health Benefits

This portion of the plan covers 80% of the following eligible expenses:

Private Nursing Duty - home nursing care by an R.N., V.O.N., R.N.A., or C.N.A. (but not an employee of the hospital nor a relative), when recommended by the attending physician, to a maximum eligible expense of $25,000 per person in any calendar year period. You must obtain prior approval of your doctor and have your doctor sign a special nursing care authorization form certifying approval of the services.

Services and Supplies - charges incurred at home or in-hospital for the following:

(1) rental of a wheelchair, hospital bed, or similar equipment for temporary therapeutic use when prescribed by a licensed physician, or purchase if approved;

(2) oxygen and equipment for its administration when prescribed by a licensed physician;

(3) injectable drugs, including the HIB vaccine, when administered by a physician;

(4) disposable syringes; and

(5) insulin injectors.

Prosthetic Appliances - remedial appliances or supplies including artificial eyes or limbs, crutches, splints, casts, trusses and braces and any other prosthetic device required for a medical condition which has been arrested or corrected by surgery. Mastectomy brassieres are an eligible expense following breast surgery, limited to one in any 18 month period. Wigs to replace hair lost through chemotherapy are eligible to a maximum payable of $500 per lifetime.

Orthopaedic shoes - charges for one pair of orthopaedic shoes in a calendar year.

Orthopaedic shoe modification supplies, such as moulded arch supports, lifts, etc., up to a maximum eligible expense of $75 per person in a calendar year, when prescribed by an orthopaedic surgeon, physiatrist, rheumatologist or the attending physician.

Physician Services - charges outside your province of residence in excess of the allowance under a Government health plan.

Psychologist - charges of a licensed psychologist or a licensed social worker paid at 50% of the charges up to $20 per visit to a maximum of 50 visits per participant in a calendar year.

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Accidental Dental - dental treatment when natural teeth have been damaged by a direct accidental blow to the mouth or jaw. Services must be rendered or reported and approved for payment by the insurer within 180 days of the accident.

Oral Surgery - charges of a licensed dentist or oral surgeon payable at the dentist's usual and customary fee up to the "dental fee guide" for general practitioners in effect where services are rendered for the following oral surgical procedures:

- alveoplasty or alveolectomy (area occupied by not less than six teeth per jaw);
- treatment of cellulitis;
- excision of tori;
- excision of benign hard tumor (osteoma), radicular closure of oro-antral fistula;
- removal of salivary stone from duct or gland;
- therapeutic nerve block with alcohol or other sclerosing solution; and
- surgical removal of impacted teeth;

Convalescent Hospital - charges for room and board in a licensed convalescent hospital up to $20 per day; this being defined as an extended health care facility, such as a sanatorium, skilled nursing home, or a special wing or ward of a hospital, which has a transfer agreement with a hospital.

Physiotherapy - charges for physiotherapy treatment by a duly licensed physiotherapist (not a relative) to a maximum of $1,000 per calendar year per insured person.

Surgical Stockings - charges for surgical stockings prescribed by a doctor and purchased through a surgical supply dealer, up to $20 in a calendar year.

Diagnostic Services - charges for diagnostic laboratory procedures rendered out of hospital (excluding tests performed in a drug store).

Hearing Aids - hearing aids when prescribed by an otologist, clinical audiologist and/or otolaryngologist subject to a maximum eligible expense of $500 per person in any five consecutive calendar year period (batteries excluded).

Other Practitioners - treatment by a licensed Chiropractor, Massage Therapist, Acupuncturist, Osteopath, Podiatrist, Speech Pathologist, Naturopath or Christian Science Practitioner (not a relative) to a maximum eligible expense of $250.00 per calendar year per practitioner.
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Diabetic Supplies - charges for diabetic supplies when prescribed by a physician including swabs, test tapes and lancets.

Glucometer - charges for a glucometer or any similar glucose monitoring machine when prescribed by a physician limited to $300 in any three consecutive calendar years. Also covered are the supplies used with the machine.

Ostomy Supplies - charges for essential ostomy supplies (including tracheotomy supplies)

Burn Garments - when ordered by a physician for the treatment of burn scars, post surgery edema, or lymphedema.

Vision Care Insurance

The plan provides for 100% reimbursement of the cost of the following:

Eye examinations - eye examinations performed by a licensed Optometrist or Ophthalmologist to a maximum of $45 in any 24 consecutive month period for adults or any 12 consecutive month period for dependent children.

Lenses and Frames - charges for the cost of one pair of spectacle lenses and frames prescribed by a registered, licensed Optometrist or Ophthalmologist to a maximum of $200 in any 24 consecutive month period for adults and any 12 consecutive month period for dependent children. (Safety glasses are to be paid for in the same manner as regular glasses under this benefit, but not in addition to regular glasses). Tinting, photograying and hardening of lenses is included. Sunglasses or eyeglasses for cosmetic or aesthetic purposes are not included as a benefit.

Contact Lenses - charges for contact lenses which are issued for either of the following reasons, to a maximum eligible expense of $250 in any 24 consecutive month period for adults and any 12 consecutive month period for dependent children.

(1) the visual acuity in the better eye can be improved to 20/40 with contact lenses and this level of visual acuity cannot be attained with lenses for eyeglasses; or

(2) the contact lenses are prescribed by a doctor following cataract surgery.

Contact elected in lieu of eyeglasses is payable up to $200 per person once in the benefit period.

Laser Eye Surgery – Eligible for a one-time maximum payment of $1,000. However, if an employee claims this benefit, they will not be eligible to claim any amount for frames and/or lens for 10 years from the date of the laser correction surgery.
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Treatment of the Eye - Charges for:

(a) treatment of the eyes for accidental injury to, or disease of, the eye if not otherwise provided for under this contract;

(b) diagnostic services for suspected eye diseases; and

(c) services for visual training or remedial exercises payable at 50%, up to a maximum of $120 during your lifetime.

Non-emergency Transportation Benefit

Payable at 80% under the extended health care benefit.

Transportation expenses incurred for non-emergency service to and from the nearest medical facility which can provide necessary services, including x-rays or examinations, not readily available in the local area to a maximum expense of $500 in respect of all such claims in a calendar year. Expenses for an escort, including a parent if the person incurring such expense is under 18 years of age, up to $500 in each calendar year.

Benefits for transportation expenses shall be paid only if:

(1) Written confirmation is received from the physician who prescribed the treatment and the physician or medical facility that rendered the treatment, that such treatment was actually rendered;

(2) The nearest hospital or medical facility able to provide the necessary treatment was at least 100 kilometres, or 200 kilometres round trip by the most direct route, from the insured's place of residence; and

The amount payable will be $0.20 per km. Also, up to $25 per person required to travel will be payable for meals; accommodation expenses will be paid to an overall maximum of $75 per day (receipts are required). An allowance of $15 per day is payable if staying with family/friends. (All expenses subject to overall $500 maximum.)

The following are excluded:

(1) Services not prescribed by a physician or surgeon; and
(2) Services which are provided for cosmetic purposes.

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Additional coverage may be available through the Non-emergency Medical Transportation Assistance Program provided by the Department of Health, Government of Newfoundland. The Government plan will reimburse 50% of eligible expenses incurred for travel, meals and accommodations exceeding $500 in any 12 month period.

Co-ordination of Benefits

In the event that benefits may be claimed under more than one section of the health care plan, the claim will be assessed under that portion of the contract which provides the greatest benefit amount to you.

Benefit payments will be co-ordinated with any other plan or arrangement so that the total amount received from all sources will not be greater than the actual expense incurred.

Exceptions and Limitations

Health care benefits will not be payable for charges in connection with the following:

- convalescent, custodial or rehabilitation services;
- conditions not detrimental to health;
- services or supplies normally provided without cost or at nominal cost by your government health plan;
- services or supplies not included as a benefit in the contract;
- benefits you receive or are entitled to receive from Workers' Compensation;
- mileage or delivery charges;
- insurrection or war; or
- participation in the commission or attempted commission of a criminal offence.

Termination of Coverage

Coverage terminates on termination of employment, but may be continued during retirement.

Conversion Privilege

If you should terminate employment, you may convert to an individual Health Plan currently issued by the insurer, provided application is made within 31 days following your date of termination. This conversion privilege is also available to the surviving spouse and/or dependents in the event of your death.

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GROUP TRAVEL PLAN

The group travel plan covers a wide range of benefits which may be required as a result of an accident or unexpected illness incurred while on business or vacation outside the province. Subject to the maximum amounts indicated below, the plan pays 100% of the eligible expenses with no overall maximum less the amount allowed under any Government health plan.

Eligibility

You and your dependents, if you have elected family coverage under the supplementary health insurance plan, are covered for the following group travel benefits.

Eligible Expenses

Hospital Charges - room accommodation (not a suite) and medically necessary in-patient/out-patient services.

Physicians and Surgeons - customary charges by physicians and surgeons for services rendered.

Ambulance - licensed ambulance service, including air ambulance, to and from the nearest hospital able to provide essential care to the patient.

Coming Home - extra costs of return economy fare by the most direct route (air, bus, train) when an illness is such that the patient must return home and be accompanied by a qualified medical attendant (not a relative). Written authorization is required from the attending physician. If returning on a commercial aircraft, this coverage is included:

- two economy seats by the most direct route to the patients home city in Canada, one for the covered patient and one round trip fare for a medical attendant; or

- the number of economy seats required to accommodate the patient if on a stretcher and one round trip for a medical attendant.

Private Duty Nursing - Registered Nurses' care ordered by a physician, excluding an employee of the hospital or a relative of a patient.

Diagnostics and X-rays - laboratory services for diagnostics and x-rays.

Accidental Dental - dental treatment when natural teeth have been damaged by a direct accidental blow to the mouth or jaw. The maximum eligible expense is $1,000. Dental treatment must be rendered or reported and payment approved by the insurer within 180 days of the accident.

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Other Services - treatment by a licensed chiropractor, chiropodist, osteopath, podiatrist and physiotherapist (not a relative) excluding the cost of x-rays.

Equipment Rental - charges for the rental, when ordered by a physician, (or purchase if approved by the insurer) of a wheelchair, crutches, canes or other medical appliances.

Prescription Drugs - charges for drugs, serums and injectibles in a quantity sufficient for the period of travel purchased on a written prescription of a physician and dispensed by a pharmacist, physician or hospital located outside the patient's province of residence.

Return of Vehicle Allowance - an allowance of up to $500 payable to a commercial agency for the return of a private vehicle to your place of residence or in the event of a rental vehicle, to the nearest rental agency. Authorization must be obtained from a physician stating that you are unable to drive the vehicle.

Homeward Carriage - an eligible expense of up to $3,000 towards the actual cost incurred for transporting the remains of a deceased insured person (excluding the cost of a coffin) to the point of departure in Canada by the most direct route.

Meals and Accommodations - up to $700 Canadian ($100 per day for seven days) per trip for extra costs of commercial accommodations and meals incurred by you or by a covered dependent remaining with a travelling companion when the trip is delayed due to illness or accident to a travelling companion or a covered person. This must be verified by the attending physician and supported with receipts from commercial organizations.

Transportation to Visit the Covered Person - return economy fare by the most direct route for transportation costs (air, bus, train) when the covered person has been confined to hospital for seven days or more or has died and the attending physician advised the necessary attendance of a family member or close friend of the covered person.

Emergency and Payment Assistance

Emergency Hotline - the services of a 24-hour emergency hotline are available to participants who need assistance while travelling. By telephoning the appropriate number on the back of your "Blue Cross Identification Card" when a medical emergency occurs, coverage will be confirmed to the hospital or physician. Payment of medical expenses will be arranged or co-ordinated on behalf of the participant.

Medical Assistance - the patient may call for a list of hospitals or medical facilities and arrangements will be made for:

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- advice from a qualified physician
- medical follow-up of the patients condition and communication with the subscriber and family
- return home or transfer of patient if medically permissible
- transport of a family member to the patient's bedside or to identify the deceased.

Non-Medical Assistance - the patient may call to obtain:

- an emergency response in any major language
- emergency assistance in contacting the family or business
- referral to legal counsel

Benefit Period

The benefits of this plan shall become effective on the latest of:

- the time of crossing the provincial border (if travelling by air, at the time of take-off);
- the effective date of the group travel health plan; or
- the effective date of your coverage

Benefits terminate on the earliest of:

- the time of crossing the provincial border on the return trip home (if travelling by air, at the time of landing in the province of residence);
- 12:00 midnight on your termination date; or
- 12:00 midnight on the termination date of the group travel plan.

Exclusions

(1) No benefits are available under the plan for residents travelling outside their province of residence primarily, or incidentally, to seek medical advice or treatment, even if the trip is on the recommendation of a physician.

(2)

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(2) No benefits are available under the plan for elective (non-emergency) treatment or surgery. This is defined as treatment or surgery:

(a) not required for the immediate relief of acute pain and suffering;

(b) which reasonably could be delayed until the covered person has returned to Canada; or

(c) which the covered person elects to have rendered or performed outside of Canada following emergency treatment for, or diagnosis of, a medical condition which (on medical evidence) would not prevent the covered person from returning to Canada prior to such treatment or surgery.

(3) Benefits under the plan shall not be paid if the covered person receives the same from a third party.

(4) No benefits will be paid for expenses incurred as the result of abuse of medications, drugs or alcohol, suicide or attempted suicide, criminal acts, war or other hostilities.

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DENTAL BENEFIT

Dental coverage has been designed to help you pay for your family's dental expenses, both for routine care and for expensive and unforeseen treatment.

To be considered as a "covered expense", the charge for a particular service must be reasonable and customary for the service provided in the area where the expense is incurred and will be limited to the maximum fee level of the Current Newfoundland Dental Association Fee Guide.

The plan covers necessary dental treatment by a dentist, physician and other qualified personnel under the direct supervision of the dental or medical profession (e.g. dental assistants and dental hygienists) and will also cover services rendered by specialists, dental mechanics, denturologists, denture therapists, etc. where permitted by law to deal directly with the public. If there is no fee schedule for these practitioners in your province, payment will be based on the appropriate General Practitioners' schedule.

The insurance company pays 80% of routine treatment expenses and 70% of major treatment expenses.

There is no maximum on the amount the plan will pay for covered routine treatment dental expenses in any one calendar year for any one person.

The maximum amount that the plan will pay for covered major treatment dental expenses in any one calendar year is $1,250 for any one person.

Treatment Plan

It is suggested you submit a treatment plan to the insurance company before treatment starts for any routine or major treatment expected to cost more than $200. A pre-determination of the benefits payable for the proposed treatment will then be calculated, so you know in advance the portion of the cost you will have to pay. Any predetermination of benefits is only valid for 90 days from its date of issue. Your dentist will prepare a treatment plan upon request.

Covered Expenses

The following items are considered covered expenses under this dental benefit:

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Routine Treatment

- oral examinations, cleaning and scaling, topical applications of fluoride solutions twice in any calendar year but not more than once in any five month period;
- bitewing, occlusal and extraoral x-rays, four of each type twice in any calendar year but not more than once in any five month period;
- oral hygiene instruction;
- full mouth series of x-rays once every 24 months;
- extractions and alveolectomy at the time of tooth extraction;
- dental surgery
- general anaesthesia and diagnostic x-ray and laboratory procedures required in relation to dental surgery;
- amalgam, silicate, acrylic and composite fillings;
- pit and fissure sealants;
- necessary treatment for relief of dental pain;
- cost of medication and it's administration when provided by injection in the dentist's office;
- space maintainers for missing primary teeth and habit-breaking appliances ;
- consultations required by the attending dentist;
- denture rebasing and lining (once in 24 months);
- endodontics (root canal therapy);
- periodontal treatment; and
- repairs to existing partial or complete dentures or to fixed bridge restorations; and
- adjustments to an initial or replacement partial or complete denture or to a fixed bridge restoration after the three month post-insertion care period (care during the three month post-insertion period is included in the initial expense).

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Major Treatment

- crowns and fixed bridge restorations;

- partial or complete dentures including denture replacements; and

- treatment involving the use of gold when such treatment cannot be rendered at a lower cost by means of a reasonable substitute consistent with generally accepted dental practice.

Exclusions

Covered dental expenses do not include and no payment is made for:

- treatment furnished without charge or paid for directly or indirectly by any Government or for which a Government prohibits payment of benefits;

- experimental treatment, dietary planning, congenial or development malformation;

- treatment received from a dental or medical department maintained by the employer, a mutual benefit association, labour union, trustee or similar type of group;

- replacement of existing dentures or bridgework unless:

  (a) they are required because of the extraction of one or more natural teeth before or after initial installation of the appliance and the existing appliance cannot be made serviceable;

  (b) the existing denture or bridgework is at least five years old and cannot be made serviceable;

  (c) the existing denture or bridgework was temporarily installed after the effective date of coverage for the individual and is replaced by a permanent appliance;

  (d) the replacement denture or bridgework is made necessary as the result of initial placement of an opposing denture while insured;

  (e) the replacement denture or bridgework is made necessary as the result of an accidental bodily injury while insured;

- expenses of dentures which have been lost, mislaid or stolen;

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- expenses of dental treatment required as a result of any self-inflicted injury, war or engaging in a riot or insurrection;

- charges made by a dentist for broken appointments or for completion of claim forms required by the insurance company;

- orthodontic treatment;

- charges for dental treatment involving the use of gold which are in excess of the charges that would have been made if a reasonable substitute could have been used;

- services or supplies for full mouth reconstructions, for vertical dimension correction of temporal mandibular joint dysfunction;

- expenses for accidental injury to natural teeth incurred more than 12 months after the accident;

- any portion of your dental expenses for which you or your dependents are covered under Workers' Compensation or similar program;

- aesthetic surgery (cosmetic surgery for beautification purposes); and

- service, including part-time or temporary service, in the armed forces of any country.

Termination of Coverage

Coverage terminates on termination of employment, but may be continued during retirement.

Continuation of Dental Benefits

If your dental coverage terminates due to termination of this dental benefit, any benefits payable under this plan for accidental injuries to natural teeth will continue after termination as long as the accident occurred while the dental benefit was still in force.

Co-ordination of Benefits

In addition to the benefits payable under this plan, sometimes an employee or dependent is entitled to benefits for the same expenses under an automobile insurance plan or other group insurance plan. Should this type of duplication occur, the benefits under this plan will be co-ordinated so that the total benefits from all plans will not exceed the expenses actually incurred.

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OPTIONAL GROUP LIFE INSURANCE

Amount of Insurance

Your basic group life insurance covers you for three times your current salary. However, you may feel you would like to have additional group life insurance over and above what you are covered for under the basic plan. The Optional Group Life Insurance Program allows you to choose on behalf of yourself and/or your spouse, additional group life insurance from $10,000 up to $300,000 in units of $10,000. You would pay the full cost of this additional coverage. All amounts of optional group life insurance are subject to evidence of insurability satisfactory to the Insurance Company. Your coverage, or increase in coverage, will not become effective until it has been approved by the Insurance Company.

Payment of Benefits

You and/or your spouse are covered 24 hours a day, on and off the job. Benefits are paid as the result of death from any cause whatsoever except if death is due to suicide within the first two years of initial and/or increased coverage, benefits will be limited to the amount of premium paid in respect of such insurance.

Beneficiary Designation

You may appoint any beneficiary you want to receive the benefits you have selected. You are automatically the beneficiary of any coverage selected for your spouse.

Waiver of Premium

If you become totally disabled for a period of at least six consecutive months, prior to age 65, further premiums will be waived during continuation of such disability. Coverage will remain in force until the earlier or recovery, death or attainment of age 65.

Termination of Coverage

Your and/or your spouse's coverage terminates on the earlier of your termination of employment (other than early retirement) or the insured person's attainment of age 65; however, in no event will spousal coverage extend beyond your attainment of age 65.

You may elect to continue your and/or your spouse's coverage during early retirement (after age 55 but prior to attaining age 65), the amount frozen at the date of retirement.

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Conversion Privilege

If any or all of your insurance terminates on or prior to your 65th birthday and/or your spouse's insurance terminates on or prior to the spouse's 65th birthday, you and your spouse may be able to convert the cancelled amount to an individual policy within 31 days, without submission of health. The premium rate will be determined from your/or your spouse's age and class of risk at the time of conversion. For further information, please contact the Human Resources Department.

Applying for Coverage

In order to apply for coverage or subsequent increases in coverage, you/your spouse must complete a medical questionnaire. Premium deductions will commence the first of the month coincident with or next following date of approval. If additional medical information is required, you will be notified accordingly.

The premium you pay is dependent on your age and the sex and smoking status of the insured person (you/your spouse) in accordance with the following schedule:

	Monthly Rate Per $10,000 of Coverage			
Age of Employee	Male Smoker	Male Non-smoker	Female Smoker	Female Non-smoker
	$	$	$	$
Under age 35	0.90	0.50	0.60	0.40
35-39	1.10	0.60	0.90	0.60
40-44	1.70	0.90	1.20	0.80
45-49	3.00	1.60	2.20	1.20
50-54	5.10	2.70	3.50	2.10
55-59	8.90	4.80	5.30	3.40
60-64	11.60	6.70	6.40	4.40

The applicable premium rate will change on January 1st coincident with or next following the date you enter into a new age bracket.

Example

Shown below is the monthly premium for a male employee, age 40, who selects $100,000 coverage for himself and $100,000 coverage for his spouse; both are non-smokers.

Employee	- $100,000 x 0.90 per $10,000	=	$9.00
Spouse	- $100,000 x 0.80 per $10,000	=	$8.00
Total Monthly Premium			$17.00

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OPTIONAL ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Amount of Insurance

This plan provides additional accidental death and dismemberment insurance for you, your spouse and dependent children, if desired, on an employee-pay-all basis. You are covered 24 hours a day, 365 days a year, on or off the job, while travelling or at home.

You may select coverage for yourself alone or for yourself and your family by choosing one of the following plans:

(A) Employee Only Plan

You may purchase, in units of $10,000, any amount of coverage between $10,000 and $300,000.

(B) Family Plan

You may purchase, in units of $10,000, any amount of coverage between $10,000 and $300,000. You are insured for the amount selected.

In addition, your spouse is insured for 50% of the benefit you have selected and each dependent child is insured for 15% of the selected amount.

In the event there are no dependent children, your spouse will be insured for 60% of the benefit you have selected.

Where there is no spouse, each dependent child will be covered for 20% of the selected amount.

Payment of Benefits

Your accidental death benefit will be paid to the beneficiary designated on your application card. If there is no such beneficiary designation, such benefit will be paid to your Estate.

All other indemnities payable, will be payable to the Insured Person (including those payable for the dependents), with the exception of indemnities payable under the following sections:

Education
Day-Care
Occupational Training
Common Disaster
Identification
Extension of Family Coverage

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Specific Loss Accident Indemnity

When Injury results in any of the following losses within 365 days after the date of the accident, the insurer will pay:

For Loss of	
Life	The Principal Sum
The Entire Sight of One Eye	Two-Thirds of the Principal Sum
Speech	Two-Thirds of the Principal Sum
Hearing in One Ear	One-third of the Principal Sum
All Toes of One Foot	One-Quarter of the Principal Sum

For the Loss or Loss of Use of	
One Arm	Three-Fourths of the Principal Sum
One Leg	Three-Fourths of the principal Sum
One Hand	Two-Thirds of the Principal Sum
One Foot	Two-Thirds of the Principal Sum
Thumb and Index Finger or at Least Four Fingers of One Hand	One-Third of the Principal Sum

For Total Paralysis of	
Both Upper and Lower Limbs (Quadriplegia)	Two Times the Principal Sum
Both Lower Limbs (Paraplegia)	Two Times the Principal Sum
Upper and Lower Limbs of One Side of Body (Hemiplegia)	Two Times the Principal Sum

"Loss" as used above with reference to:

hand or foot: means the complete severance through or above the wrist or ankle joint, but below the elbow or knee joint;

arm or leg: means the complete severance through or above the elbow or knee joint;

thumb: means the complete severance of one entire phalanx of the thumb;

finger: means the complete severance of two entire phalanges of the finger;

toe: means the complete severance of one entire phalanx of the big toe and all phalanges of the other toes;

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eye: means the irrecoverable loss of the entire sight thereof;

speech: means the complete and irrecoverable loss of the ability to utter intelligible sounds;

hearing: means the complete and irrecoverable loss of hearing;

quadriplegia, paraplegia, and hemiplegia: means the complete and irreversible paralysis of such limbs;

loss of use: means the total and irrecoverable loss of use, provided the loss is continuous for 12 consecutive months and such loss of use is determined to be permanent at the end of such period.

Indemnity provided under this section will not be paid under any circumstances for more than one of the losses, the greatest, sustained for multiple injuries to the same limb by any one Insured Person as the result of any one accident.

Indemnity provided under this section for all Losses sustained by any one Insured Person as the result of any one accident will not exceed the following:

a) with the exception of quadriplegia, paraplegia and hemiplegia, the Principal Sum.

b) with respect to quadriplegia, paraplegia and hemiplegia, Two Times the Principal Sum, or the Principal Sum if Loss of Life occurs within 90 days after the date of the accident.

In no event will indemnity payable for all losses under this section exceed, in the aggregate, two times the principal sum as the result of the same accident.

Definitions Applicable to the Voluntary AD&D Benefit

"Injury" means bodily Injury caused by an accident occurring while your coverage is in force under the Policy, and resulting directly and independently of all other causes in Loss covered by the Policy, 24 hours a day, anywhere in the world.

"Principal Sum", when referring to you, means the amount indicated on your application card which you have completed and filed with the Policyholder.

"Principal Sum", when referring to your Insured Dependents, means the percentages outlined under the Family Plan.

"Insured Person" means an Employee and his/her Dependent(s) insured under the Policy.

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"Member of the Immediate Family" means a person at least 18 years of age, who is your spouse, son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law, (all of the above include natural, adopted or step relationship), grandson, granddaughter, grandfather or grandmother.

"Hospital" means an institution licensed as a hospital, which is open at all times for the care and treatment of sick and injured persons, has a staff of one (1) or more Physicians available at all times and which continuously provides twenty-four (24) hour nursing service by graduate registered nurses. It provides organized facilities for diagnostics and surgery, is an active treatment hospital and not primarily a clinic, rest home, nursing home, convalescent hospital or similar establishment. For the purposes of this definition, hospital will include a facility or part of a facility used for rehabilitative care.

"Regular Care and attendance" means observation and treatment to the extent necessary under existing standards of medical practice for the condition causing the confinement.

"Physician" means a doctor of medicine (other than the Insured Person or a Member of the Immediate Family) who is licensed to practise medicine by:

1) a recognized medical licensing organization in the locale where the treatment is rendered, provided he is a member in good standing of such licensing body, or

2) a governmental agency having jurisdiction over such licensing in the locale where the treatment is rendered.

"Accommodation" means lodging in the vicinity of the Hospital where the Insured Person is confined.

The male pronoun will be construed as the feminine when the person is a female.

Repatriation*

If you or your Insured Dependent(s) sustain accidental Loss of Life not less than 50 kilometres from the Insured Person's normal place of residence and indemnity for such Loss becomes payable under the program, we will pay the reasonable and customary expenses actually incurred for the transportation of the body to the first resting place (including but not limited to a funeral home or the place of interment) in proximity to the Insured Person's normal place of residence. The repatriation benefit up to $10,000 will be paid for expenses incurred for the return home of the body (including charges for the preparation of the body for such transportation).

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Education**

If you sustain accidental Loss of Life for which an amount of Principal Sum becomes payable under the Policy, up to 5% of your Principal Sum (maximum $5,000) is payable for each of your Insured Dependent Children already enrolled full-time

1) in an institution for higher learning above the secondary school level; or

2) at the secondary school level but who will enrol as a full-time student in an Institution for higher learning within 365 days after your death.

The benefit is equal to the reasonable and necessary expenses actually incurred and payable annually for each year (up to 4 consecutive years) that the Insured Dependent Child continues his education in an Institution for higher learning, but payment is not made for expenses incurred prior to your death, nor for room, board or other ordinary living, travelling or clothing expenses.

If none of your Insured Dependent Children satisfy either the above requirements or the requirements as shown under the section entitled "Day-Care", then an amount equal to 5% of your Principal Sum or $2,500, whichever is less, is payable to your beneficiary.

"Institution for higher learning" includes any university, college, CEGEP or trade school.

"Dependent Children" mean persons that are either legitimate or illegitimate children, adopted children, step-children or children who are in a parent-child relationship with the Insured Person. The children are single under 25 years of age and dependent upon the Insured Person for maintenance and support.

Day-Care**

If you sustain accidental Loss of Life for which an amount of Principal Sum becomes payable under the Policy, up to 5% of your Principal Sum (maximum $5,000) is payable for each of your Insured Dependent Children under 13 years of age, who

1) are enrolled in a Day-Care Centre on the date of your death; or

2) will enrol in a Day-Care Centre within 365 days after your death.

The benefit is equal to the reasonable and necessary expenses actually incurred and payable annually for each year (up to 4 consecutive years) that the Insured Dependent Child is enrolled in a Day-Care Centre but payment is not made for expenses incurred prior to your death, nor for room, board or other ordinary living, travelling or clothing expenses.

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If none of your Insured Dependent Children satisfy either the above requirements or the requirements as shown under the section entitled "Education", then an amount equal to 5% of your Principal Sum or $2,500, whichever is less, is payable to your beneficiary.

"Day-Care Centre" means a facility which is operated according to law, including laws and regulations applicable to day-care facilities and which provides care and supervision for children in a group setting on a regular basis. Day-Care Centre will neither include a hospital, the child's home, care provided during normal school hours while a child is attending grades 1 through 12 nor any other day-care facility which does not charge a fee for services rendered.

"Dependent Children" mean persons that are either legitimate or illegitimate children, adopted children, step-children or children who are in a parent-child relationship with the Insured Person. The children are under 13 years of age and dependent upon the Insured Person for maintenance and support.

Rehabilitation*

If you sustain any Loss which becomes payable under the program and such Loss requires you to participate in a rehabilitation program in order to qualify to engage in an occupation in which you would not have engaged except for such Loss, the Insurer will pay the reasonable and necessary expenses actually incurred within 3 years from the date of the accident to a maximum of $10,000. No payment will be made for room, board or other ordinary living, travelling or clothing expenses.

Occupational Training*

If you sustain accidental Loss of Life for which an amount becomes payable under the program, this benefit will refund expenses incurred for your Spouse to engage in a formal occupational training program in order to upgrade his/her employment qualifications, to a maximum of $10,000 within 3 years from the date of the accident. No payment will be made for room, board or other ordinary living, traveling or clothing expenses.

Child Enhancement

With the exception of Loss of Life, the benefit amounts shown under the Specific Loss Accident Indemnity are doubled with respect to your Insured Dependent Children.

This provision is not applicable if Loss of Life occurs within 90 days after the date of the accident.

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Permanent Total Disability

The Principal Sum is payable in a lump sum, less any other amounts paid or payable under the Specific Loss Accident Indemnity as a result of the same accident, if you, become totally disabled and the following conditions are met:

1) The disability results from an Injury occurring prior to age 65.

2) The disability commences within 365 days of the accident.

3) The disability prevents you from engaging in each and every occupation or employment for compensation or profit for which you are reasonably qualified by education, training or experience.

4) The disability has continued for 12 consecutive months, remains total and is deemed to be permanent at the end of such period.

Family Transportation*

If any Loss covered under the Specific Loss Accident Indemnity confines you to a hospital or if any Injury confines you to a hospital for a period of at least 4 days, and such hospital is located more than 150 km from normal residence, this benefit will refund expenses incurred by any Members of your Immediate Family for hotel accommodation and transportation (via the most direct route) to the hospital bedside, up to a maximum of $1,000. Private transportation expenses are limited to $0.20 per km travelled.

Payment is not made for board or other ordinary living, travelling or clothing expenses.

Identification*

If you or an Insured Dependent sustain accidental Loss of Life, and the police require the identification of the body by a Member of the Immediate Family, and indemnity for Loss of Life subsequently becomes payable under the Policy, we will refund expenses incurred by such family member for:

1) accommodation and board (up to a maximum of 3 consecutive nights) while en route and/or during the stay in the city or town where the body is located, and

2) transportation via the most direct route to this location,

provided this location is not less than 150 km from the family member's usual residence.

Private transportation expenses are limited to $0.20 per km travelled and the total maximum refundable for all expenses is limited to $5,000.

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Common Disaster

If you and your Insured Spouse both sustain accidental Loss of Life which becomes payable under the program as the result of a "Common Accident", your Spouse's amount of coverage will be increased to the same level as yours to a combined program maximum of $1,000,000.

"Common Accident" means the same accident or separate accidents occurring within the same 24 hour period.

Escalation

In the event you sustain an Injury which results in the benefit being payable under either Specific Loss Accident Indemnity or Permanent Total Disability, the Insurer will pay an Escalation benefit which is equal to 1% of the amount of benefit payable, for each year your insurance remains in force without interruption, subject to a maximum of 5%.

For benefit calculation purposes, the anniversary date of this benefit or your effective date of insurance, whichever occurs last, is used and each subsequent anniversary date thereafter.

If you discontinue your coverage and subsequently re-apply, you are considered as a person becoming insured for the 1st time in the year you re-apply for coverage.

Seat Belt**

If, at the time of the accident, you or your Insured Dependent(s) were wearing a properly fastened seat belt and driving or riding in a "vehicle" driven by a driver who has a valid driver's license and who was neither "intoxicated" nor under the "influence of drugs" (unless taken as prescribed by a physician), and a Loss becomes payable under the Specific Loss Accident Indemnity, the applicable amount of Principal Sum will be increased by 10% for those wearing a seat belt, subject to a maximum of $25,000, which maximum is in combination with the Seat Belt benefit maximum provided under any other policy issued to the Policyholder by the Insurer.

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

"Intoxicated" and "being under the influence of drugs" is as defined by the jurisdiction in which the accident occurs.

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

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Home Alteration and/or Vehicle Modification*

If an Insured Person sustains the Loss of or Loss of Use of Both Feet or Legs or becomes Quadriplegic, Paraplegic or Hemiplegic, for which indemnity becomes payable under the Policy, and he subsequently requires the use of a wheelchair to be ambulatory, we will refund the reasonable and necessary expenses actually incurred during the 3 year period following the accident, to a maximum of $10,000, for the cost of alterations to the Insured Person's principal residence and/or the cost of modifications to 1 motor vehicle utilized by the Insured Person, when such modifications are approved by licensing authorities where required, for the purpose of making them wheelchair accessible.

Hospital Indemnity**

If any Loss covered under the Specific Loss Accident Indemnity section of the policy confines you, your Insured Spouse or Insured Dependent Child to a hospital and such person is under the regular care and attendance of a physician, you will receive a daily benefit of 1/30th of 1% of your, your Insured Spouse's or Insured Dependent Child's Principal Sum from the 1st day of hospitalization, up to a maximum of $2,500 per month and for a maximum duration of 365 days per accident.

Hospitalization required for treatment of any Injury other than for a Specific Loss is also covered in accordance with the above terms, provided such hospitalization begins within 365 days of the date of the accident which caused the Injury and insurance is in force. The daily benefit is payable from the 1st day of hospitalization if the Insured Person is hospitalized for at least 4 days.

Hospitalization is either a single uninterrupted confinement in a Hospital or several successive confinements in a Hospital as a result of the same accident, provided each such confinement is separated by a period of less than 90 consecutive days. All confinements must occur within 730 days of the date of the accident.

Only one hospitalization, as defined above, will be payable for all Injuries sustained by the Insured Person as the result of the same accident.

Note: Benefits marked with an asterisk (*) are only payable under one of the policies issued to the employer by AXA Assurances Inc..

Benefits marked with 2 asterisks (**) are payable under all other policies with similar benefits issued to the employer by AXA Assurances Inc. subject to the maximum amount stated in the policies.

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Exposure and Disappearance

If, by reason of an accident covered by this program, you or your Insured Dependent(s) are unavoidably exposed to the elements and such exposure results in a covered Loss, such Loss will be covered.

If you or your Insured Dependent(s) are not found within one year of the disappearance, sinking or wrecking of a conveyance in which you or your Insured Dependent(s) were riding at the time of the accident, it will be presumed you or your Insured Dependent(s) have suffered Loss of Life resulting from bodily Injury caused by an accident.

Waiver of Premium

If you become disabled prior to age 65, following six months of total disability further premiums will be waived for the continuation of your disability and coverage will continue up to the earlier of recovery, death or attainment of age 65.

Notwithstanding anything contained to the contrary in the Policy, benefits payable for any Loss which occurs while this clause is in effect cannot exceed the amount of insurance payable on the date of your disability.

Extension of Family Coverage

In the event of your death from any cause, coverage for your Insured Dependent(s) will be continued without payment of premium for a period of 6 months.

Exclusions

The Program does not cover any Loss, fatal or non-fatal, caused or contributed to by:

1) intentionally self-inflicted Injury while sane or self-inflicted Injury while insane;

2) declared or undeclared war or any act thereof;

3) active full-time service in the armed forces of any country;

4) riding as a passenger or otherwise in any vehicle or device for aerial navigation, not certified as airworthy and/or piloted by a person not licensed to pilot such vehicle or device.

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Aggregate Limit

The Policy contains a $4,000,000 aggregate limit of indemnity for all Losses arising out of any one aircraft accident. If this amount is insufficient to pay the full amount of indemnity for each Insured Person, then the amount payable for each Insured Person is proportionately reduced so that the total amount of indemnity payable equals $4,000,000.

The aggregate limit of indemnity only applies to Losses payable under the Specific Loss Accident Indemnity section of the policy.

Termination of Coverage

Your optional accidental death and dismemberment insurance coverage terminates on the earlier of termination of employment (other than early retirement), on the attainment of age 65, or on the date your employer receives a written request for cancellation from you.

Coverage on your insured dependents terminates on the earlier of your insurance termination or when they cease to be eligible.

You may elect to continue your coverage during early retirement (after age 55 but prior to your attaining age 65). The benefit amount is frozen at the date of retirement.

Applying for Coverage

You may elect coverage for yourself alone or for yourself and your family by completing the application section on the voluntary accidental death and dismemberment insurance application. Your coverage becomes effective on the date the completed application is received by your employer but in no event prior to the commencement of active, regular employment.

The applicable monthly premium rates are as follows:

Employee Only Plan:	$0.32 per $10,000 of coverage
Family Plan:	$0.46 per $10,000 of coverage

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Examples of Monthly Premium:

Amount of Principal Sum	Employee Only	Family Plan
$	$	$
10,000	0.32	0.46
50,000	1.60	2.30
100,000	3.20	4.60
200,000	6.40	9.20
250,000	8.00	11.50

For example, if you select $100,000 under the family plan, you would be insured for the amount selected (i.e. $100,000). In addition, your spouse would be insured for $50,000 and each dependent child for $15,000. Where there are no dependent children, your spouse would be insured for $60,000. In absence of a spouse, each dependent child would be covered for $20,000.

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CRITICAL ILLNESS BENEFIT

Critical Choice Care is designed to provide a lump sum payment from $10,000 to $100,000 should you be diagnosed with one of the specified conditions. Critical Illness insurance may provide the funds and the means to preserve your quality of life, protect personal assets, and provide the freedom to choose the kind of health care you want.

Eligibility

You may enroll in the program if you are an active full time employee and you are under the age of 65.

Your spouse may also apply for coverage if he/she is under the age of 65.

Coverage

The Critical Choice Care benefit is payable if one of the following conditions is diagnosed:

Heart Attack	Multiple Sclerosis
Stroke	Paralysis
Cancer	Blindness
Alzheimer's Disease	Deafness
Kidney Failure	Loss of Speech
Parkinson's	Coronary Artery Bypass Graft

Note: Payment of the benefit is subject to your survival of a 30 day period. This period consists of 30 days following the date of diagnosis or surgery.

The principal sum payable in the event of a Critical Illness will be payable to the Insured Person or the Insured Person's Estate.

Definitions

Heart Attack
means the Diagnosis of the death of a portion of the heart muscle, resulting from blockage of one or more coronary arteries. The Diagnosis must be based on both a) new electrocardiographic (ECG) changes which support the diagnosis of a heart attack and b) elevations of cardiac enzyme.

Coronary Artery Bypass Graft
means the undergoing of heart surgery to correct narrowing or blockage of one or more coronary

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arteries with bypass grafts. The surgery must be recommended by a cardiologist licensed and practicing in Canada.

Non-surgical procedures **not** covered by this definition include:

- Balloon angioplasty;
- Laser embolectomy; or
- Other non-bypass techniques.

Stroke
means the Diagnosis of a cerebrovascular incident causing infarction of brain tissue due to thrombosis, embolism or hemorrhage and producing a measurable functional neurological deficit persisting for at least thirty (30) days following the occurrence of the stroke. This definition excludes Transient Ischemic Attacks (TIA's).

Cancer
means the Diagnosis of a malignancy which is characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue.

Benefit will not be payable under this definition if within ninety (90) days following the effective date of coverage of the Insured Person a a) Diagnosis of Cancer is made or b) any symptoms or medical problems commenced and initiated investigations leading to the Diagnosis of any cancer.

The conditions **not** covered by this definition include:

- Early prostate cancer, Diagnosed as T1A or T1B N0 M0 or equivalent staging;
- Non invasive cancer (in situ);
- Pre-malignant lesions, benign tumours or polyps;
- Any skin cancer other than invasive malignant melanoma greater than 0.75mm.;
- Any tumour in the presence of the Human Immunodeficiency Virus (HIV)

Parkinson's
means the Diagnosis by a neurologist of primary idiopathic Parkinson's Disease which is characterized by two or more of the following clinical manifestations: (a) tremour; (b) rigidity; (c) Bradykinesis. All other types of Parkinsonism are excluded.

Alzehimer's Disease
means a progressive degenerative disease of the brain. The Diagnosis of Alzheimer's Disease must be made by a neurologist. The insured must exhibit loss of intellectual capacity involving impairment of memory and judgement which results in significant reduction in mental and social functioning such that the insured requires supervision for daily living. All other dementing organic brain disorders and psychiatric illnesses are excluded.
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Multiple Sclerosis
means an unequivocal Diagnosis by a neurologist of at least two (2) episodes of well defined neurological abnormalities lasting for a continuous period of at least six (6) months and confirmed by modern imaging techniques.

Kidney Failure
means the Diagnosis of an irreversible failure of both kidneys which necessitates treatment by regular dialysis or kidney transplantation.

Paralysis
means the Diagnosis of complete and permanent loss of use of two or more limbs through paralysis for a continuous period of one hundred-eighty (180) days as confirmed by a physician.

Blindness
means the Diagnosis of permanent loss of sight in both eyes, as confirmed by an ophthalmologist. The corrected visual acuity must be worse than 20/200 in both eyes or the field of vision must be less than twenty (20) degrees in both eyes.

Deafness
means the Diagnosis of permanent loss of hearing in both ears with an auditory threshold of more than ninety decibels (90db), as confirmed by an otolaryngologist.

Loss of Speech
means the Diagnosis of total, permanent and irreversible loss of the ability to speak for a continuous period of six (6) months due to physical injury or physical disease, as confirmed by an appropriate specialist.

Survival Period
means thirty (30) days following the date Diagnosis becomes effective or the date of the surgery for Coronary Artery Bypass Graft.

Diagnosis
means the certified diagnosis of a Critical Illness by a medical practitioner or specialist who is licensed and practicing medicine in Canada, other than the Insured Person, a business associate or a relative.

Insured Person
means you and/or your spouse by virtue of a legal marriage or your common-law spouse (i.e., a person with whom you have cohabitated for at least one year).

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Principal Sum
means the amount stated on the Insured Person's most recently signed individual application on file with your employer.

Conditions for Payment

Benefit will be payable for new Diagnosis made while the policy is in force as to Insured Person whose Critical Illness is the basis of claim.

Pre-existing Conditions Exclusion

This pre-existing conditions exclusion applies only to the guarantee issue amount. However, if the Insured Person applied and was approved for a higher amount than the guarantee issue limit, this pre-existing conditions exclusion will not apply to such Insured Person.

The Principal Sum will not be paid for Critical Illness which results directly and indirectly from any conditions for which the Insured Person, during twenty-four (24) months prior to his coverage came into force:

1. incurred medical expenses;
2. received medical treatment;
3. took prescribed drugs or medicine; or
4. consulted a physician.

However, no claim for Critical Illness beginning after two (2) years from the date the Insured Person's coverage came into force will be reduced or denied under this exclusion unless it is excluded by name or specific description.

If this policy directly replaces one with another insurer providing similar benefits, an Insured Person who has satisfied the time period of pre-existing conditions limitation in a prior policy will be deemed to have satisfied the time period in this policy, but only to the extent of the benefit amount and only with respect to the Critical Illnesses covered in the prior policy. The prior policy must be cancelled within thirty-one (31) days prior to the date this policy came into force.

An Insured Person who has not satisfied the time period of pre-existing conditions limitation in a prior policy will be allowed to apply any amount of time satisfied under the pre-existing conditions limitation of the prior policy toward the satisfaction of the time period requirement of this pre-existing conditions exclusion, but only to the extent of the benefit amount and only with respect to the Critical Illnesses covered in the prior policy. Any additional benefit amount provided in this policy will be subject to the terms of this exclusion. The prior policy must be cancelled within thirty-one (31) days prior to the date this policy came into force.

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Benefit Amount

Employees and eligible spouses have the option to buy any amount of Principal Sum in units of $10,000, up to a maximum of $100,000.

Eligible spouses may participate without the employee joining the plan.

How to Enroll

You and your Spouse may enroll and purchase $10,000 of coverage each:

- By completing an enrollment card and returning it to your employer. You and your Spouse are guaranteed to be accepted for $10,000 without submitting proof of insurability. However, a pre-existing condition exclusion applies to all persons insured for the guaranteed benefit.

For amounts exceeding $10,000:

- Evidence of insurability is required and application may be made by completing a copy of the medical questionnaire and returning it to your employer.

Note: Please ensure that the questionnaire is completed in its entirety. Omissions may result in delays in processing your application and confirming coverage.

Cost

Monthly Rates per $10,000 of Principal Sum

	Male		Female	
Age	**Non-smoker**	**Smoker**	**Non-Smoker**	**Smoker**
<20	0.73	.083	.062	.062
20-24	0.73	0.83	0.62	0.62
25-29	1.24	1.45	1.24	1.45
30-34	1.35	1.76	1.66	2.18
35-39	1.66	2.39	2.07	3.21
40-44	2.39	4.14	2.90	5.38
45-49	4.25	9.22	4.14	8.90
50-54	7.04	17.18	5.59	12.63
55-59	11.59	30.02	7.77	17.29
60-64	19.98	51.03	11.08	22.98

Any misrepresentation of smoker status on your or your spouse's application will be deemed fraudulent and coverage will become void.

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Calculating Your Monthly Premium

Age, gender and smoker status determine the unit rates that apply to you and your spouse. Multiply the applicable unit rate by the number of $10,000 units of insurance selected for you and your spouse.

Example: If both you and your spouse should participate and each of you select $50,000 of Principal Sum the following would be your premium:

	Principal Sum	**Cost**
Female Employee Age 32 Non-Smoker	$50,000	$8.30
Male Spouse Age 31 Non-Smoker	$50,000	$6.75
Total Monthly Premium		**$15.05**

Your premiums are paid through Payroll Deduction.

Effective Date of Coverage

Insurance for employees and spouses, who have completed an application and have been approved by the Insurer, shall take effect on the 1st of the month following approval by the Insurer.

The guaranteed benefit amount shall take effect on the 1st of the month following receipt of your application by your employer.

You will be notified within 30 days from the date your application is received by the Insurer whether or not you have been accepted by the Insurer as well as the amount of Principal Sum**.**

Employees must be actively at work for coverage to begin.

Termination of Coverage

You and/or your spouse's insurance coverage will stop on the earliest of the following dates:

- on the date this policy is terminated;

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- on the premium due date if your employer fails to pay the required premium, except as the result of an inadvertent error;

- on the premium due date next following the date you give notice of cancellation to your employer;

- on the premium due date next following the date you or your spouse reach sixty-five (65) years of age;

- on the premium due date next following the date you cease to be an active employee on account of resignation, dismissal or retirement;

- on the premium due date next following the date your spouse ceases to be an eligible person; or

- on the date the principal sum payment has been paid.

Continuation of Coverage

Coverage under this policy will be continued for you and/or your spouse during any approved leave of absence, temporary lay-off, maternity leave or disability leave of the employee to a maximum of 1 year, provided payment of premium is continued.

Limitations/Exclusions

The program does not cover a condition resulting directly or indirectly from any one or more of the following:

- from a pre-existing condition unless the Critical Illness is diagnosed after 24 consecutive months after the Insured person's effective date of coverage. This pre-existing condition exclusion does not apply if the Insured Person was approved for insurance hereunder based on a medical questionnaire;

- diagnosis of any life threatening cancer made within 90 days following the Insured Person's effective date;

- an intentionally self-inflicted injury or sickness, or attempted suicide, while sane or insane; or

- the use of any illicit drug other than as prescribed and administered by or in accordance with the instruction of a legally licensed medical practitioner.

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GROUP INSURANCE COVERAGE AT RETIREMENT

You are considered an early retiree if you retire after the age of 55 but prior to attaining age 65.

As an early retiree you can continue coverage under all group insurance benefits with the exception of long term disability insurance and Critical Illness Benefit.

Provided the coverage was continued during early retirement, group life, supplementary health and dental insurance benefits can be extended beyond age 65. All other benefits cancel on attainment of age 65.

Provided below is a schedule of the benefits available to all retired employees.

Basic Group Life Insurance

The intent of group life insurance is to provide a sufficient level of coverage to employees during their active employment years when their personal responsibilities and liabilities are the greatest. Therefore, life insurance converge reduces to one times annual earnings on retirement after age 55 but prior to your attaining age 65. At age 65, a reduced amount of $10,000 of coverage (effective January 1, 2007) is provided through the Group Life Insurance Policy which remains in force throughout your lifetime.

Basic Accidental Death & Dismemberment Insurance

Coverage reduces on early retirement (prior to age 65) in accordance with the basic group life insurance schedule and terminates at age 65.

Optional Dependent Life Insurance

Coverage may be continued during early retirement (prior to age 65) and terminates on your attainment of age 65.

Supplementary Health Benefit*

Supplementary health insurance coverage may be continued during your retirement.

Dental Care*

Dental insurance coverage may be continued during your retirement.

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Survivor Coverage

In the event of your death, supplementary health and dental coverage can be continued for your eligible dependents until your spouse's death.

Group Travel Health Plan

The group travel plan covers a wide range of benefits which may be required as a result of an accident or unexpected illness incurred while on business or vacation outside the province. Subject to individual benefit maximums, the plan pays 100% of the eligible expenses with no overall maximum less the amount allowed under any Government health plan.

Optional Group Life Insurance

You may continue your and/or your spouse's optional life insurance coverage during early retirement (prior to age 65). The amount of insurance may not be increased after the date of retirement. However, the premium rate will change when you enter into a new age bracket.

Optional Life coverage terminates on the insured person's attainment of age 65; however, in no event will spousal coverage extend beyond your attainment of age 65.

Optional Accidental Death and Dismemberment Insurance

Optional Accidental Death and Dismemberment Insurance may be continued during early retirement (prior to age 65); however, the amount may not be increased after the date of retirement. Coverage cancels on attainment of age 65.

Cost-Sharing

All benefits are cost shared on a 50/50 basis with the exception of the dental coverage for which you pay 25% and the Hydro Group contributes 75% and the following which are 100% retiree cost: Optional Dependent Life, Optional Group Life, Optional Accidental Death and Dismemberment. Survivor coverage for health and dental is paid 100% by the survivor.

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HOW TO SUBMIT CLAIMS

Basic Group Life, Optional Dependent Life and Optional Life Insurance
(underwritten by Great-West Life Assurance Company)

Waiver of Premium:

- Contact the Human Resources Department

Death Claims:

- In the event of your death, your employer will explain the claim requirements to your beneficiary. For dependent death claims, contact the Human Resources Department for claim forms and procedures.

Basic and Optional Accidental Death and Dismemberment Insurance
(underwritten by AXA Assurances Inc.)

Waiver of Premium:

- Contact the Human Resources Department for claim forms and procedures.

Death, Dismemberment or Loss of Use Claims:

- In the event of your accidental death, your employer will explain the claim requirements to your beneficiary. For other than death claims or for claims in respect of your spouse or dependent children, contact the Human Resources Department for claim forms and procedures.

Critical Illness Benefit
(underwritten by AXA Assurances Inc.)

- The Human Resources Department should be contacted immediately.

- Written notice of claim must be given to AXA Assurances Inc. within thirty (30) days after the date of the diagnosis and written proof must be submitted ninety (90) days after the date of diagnosis.

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Long Term Disability Insurance
(underwritten by Great-West Life Assurance Company)

- If it appears that you will be off work for a period extending beyond the short term income continuance plan, you should contact the Human Resources Department for the applicable claim forms and procedures.

- Even if benefits are payable from Workers' Compensation, which may totally offset the long term disability benefit initially, application should be made for long term disability benefits.

Supplementary Health Benefit
(administered by Medavie Blue Cross Care)

Medical expenses other than drugs must be submitted with a Claims Submission Form.

All particulars regarding the expense must be attached to the claim form.

Please ensure you have included the following on the claim form:

- Your name is clearly identified as the employee, particularly when the claim is for one of your dependents;
- Your full home address is included;
- Your Blue Cross identification number and Group Number is included;
- All questions are fully answered with regard to coverage under another plan; and
- The claim form must be signed by you, the employee.

Claim forms may be submitted to:

Medavie Blue Cross Care
Claims Office
Board of Trade Building, Suite 102
66 Kenmount Road
St. John's, NL
A1B 3V7

Policy number: 6320 (Active) 6321 (Retired) 6328 (Temps)
Phone: 1-800-667-4511

Additional supplies may be obtained from your Regional Office.

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Dental Care Benefit
(administered by Medavie Blue Cross Care)

1. A dental claim form must be obtained form your dentist who will complete the expense section of the form.

2. Please ensure you have included the following on the claim form:

- Your name is clearly identified as the employee, particularly when the claim is for one of your dependents;
- Your full home address is included;
- Your Blue Cross identification number and Group Number is included;
- All questions are fully answered with regard to coverage under another plan; and
- The claim form must be signed by you, the employee.

Claim forms may be submitted to:

Medavie Blue Cross Care
Claims Office
Board of Trade Building, Suite 102
66 Kenmount Road
St. John's, NL
A1B 3V7

Policy number: 6320 (Active) 6321 (Retired) 6328 (Temps)
Phone: 1-800-667-4511

Additional supplies may be obtained from your Regional Office.

Group Travel Plan
(administered by Medavie Blue Cross Care)

In the event of a medical emergency due to sickness or accident when traveling outside of Canada, you may call Blue Cross directly to verify your insurance coverage.

1-800-563-4444
This number is applicable to Canada and the United States.

If you are traveling elsewhere in the world, please call: (506) 854-2222 (call collect)

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Payment of medical expenses will be arranged or co-ordinated on your behalf.

For identification purposes, Blue Cross will require your Group Number as well as your Blue Cross identification number.

Note: There is a time limit for submission of all claims. All receipts should be submitted within four months of the date the expense was incurred, if reasonably possible.

TRAVEL ACCIDENT INSURANCE

In addition to the Basic and Optional Accidental Death and Dismemberment Insurance, further accidental death and dismemberment insurance is provided in the event you sustain accidental injury while traveling on company business. This additional protection is provided by the employer at no cost to you. This coverage applies to travel outside your normal operating territory.

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Employee/Retiree Benefits

The information in this booklet/website is a summary of the insurance benefits for the information of employees. This should not be used to determine entitlement to coverage, which is solely governed by the express terms of the group insurance policy. Where there is any conflict between this summary and the express terms of the group insurance policy, the express terms of the group insurance policy shall apply. Employees who wish to review the current group insurance policy may do so upon written request to the Director of Insurance, Department of Finance.

Employee/Retiree Responsibility

Employees/Retirees should note that they also have responsibilities to fulfill.

- You are responsible for ensuring that you have applied for the coverage you wish to have for yourself on your enrolment forms and your dependents within the appropriate time frames.
- You are responsible to change your coverage from single to family within the appropriate time frame. If the coverage is not changed within 31 days of acquiring your first eligible dependent an Evidence of Insurability on Dependents is required for approval.
- You are responsible to add a spouse to this plan in the event that he or she loses coverage under another plan within a 31 day period following the loss of coverage to avoid having to provide medical evidence.
- You are responsible for examining payroll deductions for all group insurance benefits. This will ensure accuracy and allow for corrections on a timely basis.
- You are responsible for amending your coverage to delete any coverage you no longer require. Contributions which you have paid are not refundable if they were consistent with the application on file.
- You are responsible for effecting conversion of the coverage eligible to be converted upon the earlier of termination of employment or at age 65.
- You are responsible for completing the necessary forms required for continuing benefits while on maternity leave, sick leave, special leave without pay, retirement, etc. It is extremely important these arrangements be made prior to commencing eligible leave. For continuation of group life and health insurance while on temporary lay-off or on unpaid leave you are responsible for the payment of the full premium amount and failure to remit on the required monthly basis will result in termination of coverage.
- You are responsible for providing appropriate claim information necessary to process LTD and/or Waiver of Premium claims as well as to ensure notice of claim/proof of claim where necessary has been provided within appropriate time frames as required under the contract.

- You are responsible for completing appropriate forms necessary for such things as change of address, addition of new dependent, and other significant matters that can change or otherwise affect your coverage.
- You are also responsible to register overage student dependents between age 21 and 25 at the beginning of each school year. Failure to do so may impact coverage.
- In situations where a refund or recovery of premiums are being considered due to error, a case-by-case analysis will be performed, however the standard policy is that the maximum amount of time for a refund or recovery of premium will be 12 months from the date of the error.

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Summary of Your Benefit Program

The following summarizes the various benefits which are available for the security and well being of you and your family, while you are an employee, upon your retirement and in the event of your death before or after retirement. Please note as this is a "summary" of your benefits, if any discrepancies arise, the wording in the Insurance Contract will prevail.

The benefits are explained in greater detail in this booklet.

Eligibility for Group Insurance

- All full-time, active employees, including part-time employees who work 50% of the regular work week, are required to participate in the group insurance program from their first day of employment. All retired employees who are receiving a pension from either the Public Service Pension Plan, the Uniformed Services Pension Plan, the Members of the House of Assembly Pension Plan, or the Provincial Court Judges' Pension Plan may elect to continue coverage.

- All temporary employees, if hired for a period of more than three months, are covered under the program from the first day of employment. Employees who are hired for a period of less than three months, who receive notice of extension exceeding three months, are required to participate from the date of notification.

- Seasonal, recurring employees are covered under the plan during their term of active employment. During periods of lay-off, provided they do not work for another employer during such lay-off, employees have the option to continue coverage. ***However, coverage will not continue unless a "Continuation of Coverage" form is completed, signed and given to your Administrator prior to your leaving.***

- All elected members of the Legislature are covered under the program on a voluntary basis.
- Casuals/hourly employees are eligible once they meet policy criteria of having worked 50% or more of previous years total hours.

MANDATORY BENEFITS

Basic Group Life Insurance
In the event of your death, an amount of life insurance equal to that described in this booklet on basic group life insurance is payable to the beneficiary you have appointed on your Group Enrollment Card.

Dependent Life Insurance
In the event of the death of your insured spouse or dependent child, an amount of life insurance is payable to you as outlined in this booklet on dependent life insurance.

Accidental Death and Dismemberment Insurance
In the event of an accidental death, accidental dismemberment, loss of use, paralysis or loss of speech or hearing, within 365 days of an accident, a benefit is payable in accordance with the details outlined in this booklet.

Supplementary Health Insurance
This plan provides benefits not covered under the Provincial medical services and hospital insurance programs, for you and your insured dependents including:

Semi Private Hospital Benefit
Extended Health Benefit
Prescription Drug Benefit
Emergency Ambulance Benefit
Out-of-Province Benefit
Non-Emergency Transportation Benefit
Vision Care Benefit

Group Travel Insurance
This plan covers a wide range of benefits which may be required as a result of an accident or unexpected illness incurred outside the province while traveling on business or vacation.

OPTIONAL BENEFITS

Optional Long Term Disability Insurance
This plan is available to you on an optional and employee-pay-all basis. Long term disability insurance may provide disability benefits for periods of total disability which exceed 119 days. To be eligible for this program, you must be a member of either the Public Service Pension Plan, the Uniformed Services Pension Plan, the Members of the House of Assembly Pension Plan, or the Provincial Court Judges' Pension Plan. To avoid the underwriting process and medical evidence, LTD must be applied for within thirty-one (31) days of your eligibility to the group insurance plan.

Optional Dental Care Insurance
This plan is available to you and your insured dependents on an optional and employee-pay-all basis and must be applied for within thirty-one (31) days of eligibility to the group insurance plan to avoid the "late applicant" status (see dental plan).

Optional Group Life Insurance
This plan is available on an optional, employee-pay-all basis and you may apply to purchase additional group life insurance coverage for you and /or your spouse. Coverage is available from a minimum of $10,000 to a maximum of $300,000 in increments of $10,000 and must be applied for within thirty-one (31) days of eligibility to the group insurance plan, or otherwise during open enrollment periods wherein there may be some implications regarding medical evidence requirements.

Optional Accidental Death and Dismemberment Insurance
This plan is available on an optional, employee-pay-all basis and enables you to purchase additional amounts of accidental death and dismemberment insurance on an employee and/or family plan basis. Coverage is available from a minimum of $10,000 to a maximum of $300,000 in increments of $10,000 and must be applied for within thirty-one (31) days of eligibility to the group insurance plan, or otherwise during open enrollment periods.

Optional Critical Illness Insurance
This plan is available on an optional, employee-pay all basis and enables you to purchase coverage for yourself and your family which will provide a lump sum payment in the event of a "Critical Condition" and you meet the necessary Criteria. Maximum Benefit $25,000 (Employee), $10,000 (Spouse), and $5,000 (Dependent Child). Medical evidence is required.

Change of Beneficiary
You may change your designated beneficiary(ies) at any time subject to any legal requirements affecting such right. For further information, please contact your Administrator.

Continuation of Benefits
Please note that for any employee who retires or is granted a leave of absence, such as maternity leave, education leave, continued absence following exhaustion of sick leave credits, or is suspended for any reason, group insurance coverage ***will not continue unless a "continuation of coverage" form is completed, signed and given to the Administrator or department head, prior to your leaving***, in order that they may arrange for your premium payments during your absence.

Note: If you are granted an unpaid leave of absence and are engaged in any occupation or employment (self employed included) you are not eligible to continue group insurance coverage.

The information contained in this booklet is important to you and we suggest it be kept in a safe place.
When your insurance terminates you must return your identification card(s) to your Administrator.

Definition of Dependent
For the purpose of the group insurance program, the following definitions of dependents are applicable:

Spouse means a person of the opposite or same sex,

- who is legally married to the participant, or
- who is not legally married to the participant (including partners of the same sex) but who has continuously resided with the participant for not less than one full year having been represented as husband, wife or partner, and where there is a mutual agreement between such persons that the relationship is a permanent relationship exclusive of all other such relationships. Discontinuance of cohabitation with the participant will terminate coverage of the "common -law" spouse.

If the participant is legally married but is also cohabitating with an individual of the opposite/same sex, the Spouse will be the individual to whom the participant is legally married, unless the participant has given written notice that the common-law Spouse is to be covered as the Spouse.

At any one time, only one person may be insured as a Spouse of the participant.

Child means an unmarried person who is the participant's natural, adopted, foster or step-child (including any child of a minor, unmarried child provided they meet dependent eligibility) who is dependent upon the participant for financial support and maintenance. Such Child must be

- under age 21, or
- under age 25, attending an accredited educational institution, college or university on a full-time basis. A Child who is working more than 30 hours per week will not be eligible for coverage unless the Child is a full-time student, or
- age 21 or older who, by reason of a mental or physical disability is incapable of self sustaining employment provided such Child became Totally Disabled while insured under this policy and prior to attaining age 21, and who have been continuously disabled since that time. Children who became Totally Disabled while attending an accredited educational institution, college or university on a full-time basis prior to their attaining age 25 and have been continuously so disabled since that time are also eligible.

A Child of the participant's Spouse is also eligible provided the Spouse is living with the participant and has custody of the Child.

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Supplementary Health Insurance

In addition to the benefits available under the provincial government programs, supplementary health insurance is provided to you and your insured dependents as outlined below.

Hospital Benefit
If you or any of your insured dependents are confined in a hospital on the recommendation of a physician, coverage is provided for **semi-private hospital room**, 100%, to a daily maximum of $85.00

Prescription Drug Benefit
The program will pay the ingredient cost of eligible drugs (including oral contraceptives and insulin), and the employee/retiree will pay the co-pay, which will be the equivalent of the pharmacists professional fee plus any applicable surcharge.

The drug plan provides coverage for most drugs which require a prescription by law, however, some drugs may require special authorization, but does not provide coverage for over-the-counter drugs, cough or cold preparations, nicotine products, etc. Details of the special authorization process are outlined in this booklet.

Disclaimer: The Government of Newfoundland and Labrador, through a consultation process with the insurer and drug experts, determines the drugs that are covered under the plan, and typically follows the recommendations of The Canadian Expert Drug Advisory Committee. There is no guarantee or obligation expressed or implied that all drugs recommended by physicians will be covered by the plan. The addition or deletion of drugs from the plan is at the sole discretion of government.

Extended Health Benefit

This portion of the program includes coverage for the following. It is important to note that reimbursement under the extended health care benefit is made at 80% of covered eligible expenses up to $5,000; expenses over $5,000 and less than $10,000 are reimbursed at 90%, and expenses over $10,000 are reimbursed at 100% in any calendar year. Eligible expenses are as stated below. Where no maximum eligible expense is noted , reasonable and customary rates will apply.

- Services of a Registered Nurse, Licensed Practical Nurse and Registered Nursing Assistant, including Home Health Care Services (excluding a relative), in your home to a maximum covered eligible expense of $10,000 per disability. Service must be for active medical care and reimbursement will not be made when the services are custodial in nature. **Pre-approval is required;**
- Services of a qualified physiotherapist, massage therapist (requires physician referral stating medical reason), osteopath, chiropodist, chiropractor, naturopath and podiatrist to an annual covered eligible expense of $500 per practitioner (excluding a relative);
- Acupuncture service is covered to an annual eligible expense of $500.
- Purchase of wheelchair cushions to an annual covered eligible expense of $300;
- Casts, trusses, braces, crutches, canes, walkers and splints (excluding dental splints);
- Hearing aids are eligible, one for each ear every three consecutive calendar years. The maximum eligible expense for each hearing aid is $1,000.
- Artificial limbs, including myoelectrical limbs, along with eyes and other prosthetic appliances including repair and replacement are reimbursed at the usual and customary charges;
- Rental or purchase of a wheelchair (every five years), hospital bed, iron lung or other durable equipment. Pre-approval is required;
- Rental or purchase of transcutaneous electrical nerve stimulator (TENS);
- Jobst burn garments, Jobst sleeves for lymphoedema following mastectomy and Jobst support hose and surgical stockings;
- Stump socks;
- Colostomy and ileostomy apparatus;
- External breast prosthesis, once per calendar year, post mastectomy;
- Surgical Brassieres, post mastectomy are added as an eligible benefit providing 80% of a maximum eligible expense of $100 per brassiere. The contract will allow up to two brassieres per calendar year.
- Treatment by x-ray, radium and radioactive isotopes;
- Oxygen, plasma or blood transfusions;
- Up to a covered eligible expense of $20 per day for room and board for active treatment or convalescent care in a licensed nursing home supervised by a Registered Nurse on a 24-hour basis. Confinement in the nursing home must be for rehabilitation or convalescent care and not for custodial care;
- Services of a dental surgeon including dental prosthesis required for treatment of a fractured jaw or for treatment of accidental injuries to natural teeth if reported within six months of the accident where the injury was caused by external, violent and accidental means;
- Injectable drugs when administered by a physician, (Excludes Vaccines);
- Insulin syringes and home chemical testing supplies for diabetics including glucometer and supplies. (Note: Insulin is covered under the prescription drugs benefits portion of the plan). Maximum eligible expense per calendar year is $2,170.
- Insulin pumps are an eligible benefit with effect April 1, 2004, for insured 16 years of age or less. The program will allow 80% reimbursement to a maximum payable of $4,800 in a five year period.
- Insulin pumps are an eligible benefit with effect April 1, 2010, for adults (17yrs and over) on restricted circumstances with a maximum reimbursement of $2,500 every sixty (60) months.

- The requirement for a Psychiatrist referral will be replaced with a General Medical Practitioner referral. Effective April 1, 2010, the access to a Psychologist with the referral by a General Practitioner will be introduced with a maximum eligible amount per visit of $65 and an annual eligible maximum of $325.
- Up to a covered eligible expense of $500 per year for the services of a speech therapist on the written prescription of a Medical Specialist; and
- Orthopedic shoes and orthopedic aids to a maximum covered eligible expense of $200 every calendar year.
- Services of a qualified Occupational Therapist to an annual eligible covered expense of $500.

Emergency Ambulance Benefit
Emergency Ambulance Benefit is amended for professional ambulance service, including licensed air ambulance services when certified as immediately necessary by the attending physician. Reimbursement covers transportation to and from the nearest hospital or licensed medical facility able to provide treatment for bodily injury or sickness subject to 80% of a covered eligible expense of $1,000 outside the province and $500 within the province. For employees who are residents of Labrador, the benefit is 80% of a covered eligible expense of $500 outside the province and $1,000 within the province. Further, all eligible amounts are now subject to 80% of the maximum eligible expense applicable per person per calendar year.

Non-Emergency Transportation Benefit

- Transportation expenses incurred, for non-emergency service on the referral of a physician, to and from the nearest hospital or medical facility which can provide necessary services, including x-rays or examinations, not readily available in the local area to 80% of a covered eligible expense of $300 in respect of all such claims in a calendar year;
- Expenses for an escort, including the parent if the person requiring treatment is under 15 years of age, up to 80% of a covered eligible expense of $300 for each calendar year;
- Services must be prescribed by a physician or surgeon. No benefit is payable for aesthetic surgery (cosmetic surgery for beautification purposes); and
- Any expenses incurred for meals or accommodations will not be considered as eligible expenses.

Note

Benefits for transportation expenses shall be paid only if:

a. written documentation and confirmation is received from the physician who prescribed the treatment and the hospital or medical facility that rendered the treatment, that such treatment was actually rendered.
b. the nearest hospital or medical facility able to provide the necessary treatment was at least 80 kilometres or 160 kilometres round trip by the most direct route, from your residence; and
c. the most economical means of transportation available was used or the physician provides written documentation that an alternate, more expensive means was necessary due to the patient's medical condition. Where a private vehicle is used, a maximum of $0.125 per kilometre would be paid, but in no event shall this exceed the cost of the most economical means available.

Vision Care Benefit
You and your insured dependents are covered for the following vision care expenses:

a. Up to 80% of charges for eye examinations performed by an Ophthalmologist or Optometrist where the Medicare plan does not cover such services, limited to one such expense in a calendar year for dependent children under age 18 and once in two calendar years for all other insured persons;
b. Up to 100% of eligible expenses to a maximum of $150 for single lenses and frames and 100% of eligible expenses to a maximum of $200 for bifocal lenses and frames limited to one expense in every three calendar years. Up to 100% of eligible expenses to a maximum of $250 for trifocal lenses and frames limited to one expense in every three calendar years. Once in a calendar year for dependent children under age 18 if a change in the strength of the prescription is required. Please note that expenses for contact lenses will be reimbursed at the same level as for eyeglasses. Coverage is not provided for sunglasses, safety glasses, or repairs and maintenance.
c. Coverage for "laser eye surgery" to a one time maximum amount of $450. If a claim is made for this benefit, no further vision care will be payable for six (6) years.

d. Up to 100% of eligible expenses to a maximum of $250 in two calendar years for the purchase of contact lenses prescribed for severe corneal scarring, keratoconus or aphakia, provided vision can be improved to at least a 20/40 level by contact lenses, but cannot be improved to the level by spectacle lenses. If contact lenses are selected for cosmetic reasons, you will be eligible for up to the eyeglasses maximum once in any two calendar years. Dependent children will be eligible for this benefit once in any calendar year, provided that a change in the strength of the prescription is required;
e. One pair of eyeglasses when prescribed by an Ophthalmologist following surgery, to 100% of a lifetime covered eligible expense of $200; and
f. 50% of the cost of visual training or remedial therapy.

Out-of Province Benefit
Coverage is provided for 80% of expenses incurred outside your home province when the required medical treatment is not readily available in your home province.

If the medical treatment is readily available elsewhere in Canada but you seek treatment outside Canada, benefits will be limited to the reasonable and customary charges of the nearest Canadian medical centre equipped to provide the necessary treatment. It is suggested that you submit a treatment plan so the insurer can advise you of the amount payable before you incur the expense.

Coverage is provided for the following:

- semi-private hospital accommodation;
- hospital out-patient services;
- physicians' fees;
- laboratory tests and x-rays; and
- other eligible expenses that would have been covered in your home province.

Co-ordination of Benefits
Should similar benefits be provided by more than one section of the policy, any claim for these benefits will be assessed by the Insurance Company in a manner which provides the greatest benefit to the participant.

Where compensation for benefits covered under this plan is available to a participant under any other prepaid health service contract or insurance policy, the amount payable under this plan shall be coordinated with such other coverages in accordance with the Canadian Life and Health Insurance Association (CLHIA) Guidelines so that the total benefits from all plans will not exceed the expenses actually incurred.

Effective April 1, 2010, Co-ordination of Benefits will be allowed between spouses insured under the Plan.

If the other plan does not contain a coordination of benefits provision, then that plan shall be considered first payer.

Conversion Privilege
If you should terminate employment prior to age 65, you may convert to an individual health plan currently offered by the insurer, provided that application is made within 31 days following your date of termination. After 31 days following your date of termination, medical evidence of insurability will be required.

Services not Covered Under the Supplementary Health Insurance Program

You and/or your dependents are not covered for medical expenses incurred as a result of any of the following:

- injury or illness due to war or engaging in a riot or insurrection;
- aesthetic surgery (cosmetic surgery for beautification purposes)
  - services required due to an intentional self-inflicted injury;
- delivery charges;
- hearing tests;
- pregnancy tests;
- injury or illness for which you or your dependents are covered under Worker's Compensation or a similar program;

- services or supplies received from a dental or medical department maintained by your employers, a mutual benefit association, labour union, trustee or similar type group;
- services or supplies which are covered under a government hospital plan, a government health plan or any other government plan;
- expenses for contraceptives other than oral contraceptives;
- expenses for vitamins (except injectables), minerals, and protein supplements (other than expenses than would qualify for reimbursement under Eligible Expenses under the Drug Benefit);
- expenses for diets and dietary supplements, infant foods and sugar or salt substitutes;
- lifestyle-related expenses such as for smoking cessation or weightloss;
- expenses for drugs which are used for a condition or conditions not recommended by the manufacturer of the drugs;
- expenses for MRIs, X-rays and other diagnostic services;
- experimental products or treatments for which substantial evidence provided through objective clinical testing of the product's a treatment's safety and effectiveness for the purpose and under the conditions of the use recommended does not exist to the satisfaction of the administrator; and
- expenses for lozenges, mouth washes, non-medicated shampoos, contact lens care products and skin cleaners, protectives, or emollients.

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Special Authorization Drug Claims

The Special Authorization process has been developed to ensure you have access to a wide range of prescription drug benefits, when you need them. This section has been designed to familiarize you with the Special Authorization process.

How does Special Authorization apply to my prescription drug program?
Your prescription drug program provides you with immediate access to more than 3,000 prescription drugs. Certain other medications require Special Authorization before your prescription is eligible for coverage.

How does Special Authorization affect me?
This new process applies to you if a medication you require falls under the Special Authorization category. It is important to familiarize yourself with these medications and discuss the process with your doctor. Special Authorization is designed to provide you with your required medications as quickly as possible.

Will I need to pay for my prescription myself?
You will only need to pay for your prescription yourself if you purchase the medication prior to receiving Special Authorization approval, or if your request for Special Authorization is denied

How do I apply for Special Authorization?

1. If you are currently taking a medication that requires Special Authorization, you should begin the Special Authorization process before your prescription runs out.
2. Request a Special Authorization form from your Group Administrator or nearest from your pharmacist. This form requires the prescribing physician's signature.
3. If your current medication, or new prescription, requires Special Authorization, have your doctor complete the form. Any costs associated with completing the form are the responsibility of the patient/subscriber.
4. Send your completed form to:

   Desjardins Financial Security, Special Authorization Unit
   430 Topsail Road, Box 97
   St. John's, NL
   A1E 4N1

   or **FAX** your form to Desjardins Financial at 1-855-838-2814, our secured facsimiled location which ensures

confidentiality. Desjardins offices may be contacted during regular business hours: Monday to Friday, 8:00 a.m. to 5:00 p.m. Tel: 1-877-838-7763.

What happens to my Special Authorization request once I have sent it to the Insurance Company?
Your request will be confidentially reviewed by an medical consultant, after which you will receive written notification of the decision. Normal turnaround for assessment is seven to ten working days.

In cases where a doctor requires an urgent response due to medical condition, every effort will be made to respond the same day. The patient/subscriber may also wish to purchase the prescription before applying for Special Authorization, recognizing that there is no guarantee that Special Authorization will be granted. If information is incomplete and more details are required, turnaround may be delayed.

If your request is approved, the approval will indicate the specified period of time. You will not be required to apply for Special Authorization each time your prescription is filled within that specified time period. Please check your form carefully for the effective and termination date.

How are Special Authorization claims reimbursed?
Once your request has been approved, have your prescription filled. In the unlikely event your pharmacist will not submit your claim to the insurance company, you will need to forward the Special Authorization approval form and your paid-in-full receipts directly to the insurance company. Reimbursement will be mailed to you directly.

Claims for prescription drugs requiring Special Authorization can be paid either through Pharmacies that are on Point of Sale or through Desjardins Financial Security Claims office in the Customer Service Centre at 430 Topsail Road (Village Mall),
P. O. Box 97, St. John's, A1E 4N1, or you may forward your claims to the Toronto head office (See #4 above).

If you have further questions about Special Authorization, please call the Desjardins Financial Security customer service centre at **1-877-838-7763.**

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Group Travel Insurance

The group travel insurance plan covers a wide range of benefits which may be required as a result of an accident or unexpected illness incurred outside the province or country while traveling on business or vacation (some restrictions may apply). The plan provides coverage for a period of 90 days per trip for travel within Canada and 30 days per trip for travel outside Canada. Proof of departure and return date from province of residence is required.

It is important to note that coverage is provided for emergencies only related to accidents or unexpected illness while traveling outside your province of residence. If you have an existing medical condition, the condition must be stable before traveling to have coverage for that condition. Stable means that in the last 3 months before leaving, there has been no hospitalization, no increase or modification in treatment or prescribed medication dosage or no symptom for which a reasonably prudent person would consult a physician. Stable dosage does not apply if you are a diabetic.

The insurer will pay 100% of the reasonable and customary charges (subject to any benefit maximums) for the following eligible expenses:

a. Charges of a public general hospital, less the amount allowed under the provincial government health plan for (a) room accommodation (not a suite of rooms), and (b) medically necessary in-patient and out-patient services.
b. Customary charges by physicians and surgeons for services rendered, less the amount allowed under the provincial government health plan.
c. Rental of wheelchairs, crutches and canes when required as a result of sickness or accident. This benefit will be payable only when the sickness or accident occurs outside the insured person's province of residence. Rental expenses must be incurred outside the province of residence and ordered by a physician.
d. Private duty nursing when ordered by a physician at the usual and customary fee. registered nurses providing the service must not be a relative of the patient or an employee of the hospital.

e. Charges for normal ambulance service to and from the nearest hospital able to provide the type of care essential to the patient.
f. Extra costs of return economy fare by the most direct route (air, bus, train) when an illness is such that the patient must return home and be accompanied by a qualified medical attendant (not a relative). Written authorization is required from the attending physician. If returning on a commercial aircraft, this coverage includes:
    - two economy seats by most direct route to the patient's home city in Canada, one for the covered patient and one round trip fare for a medical attendant;
    - the number of economy seats required to accommodate the covered patient if on a stretcher and one round trip fare for a medical attendant.
g. The cost of diagnostic laboratory and x-ray services, less the amount allowed under the provincial government health plan, when ordered by the attending physician.
h. The cost of services provided by Chiropractors, Osteopaths, Chiropodist/Podiatrist and Physiotherapist (not a relative) in excess of payment by a provincial government health plan, excluding charges for x-rays.
i. Charges for prescription drugs in a quantity sufficient for the period of travel. Payment of eligible drug expenses will be made only when proof of purchase is supplied in the form of an account from a pharmacist, physician or hospital located outside the insured person's province of residence, showing the name of the preparation, date of purchase, quantity, strength and total cost.
j. Charges for dental treatment to a maximum of $1,000 in all, when, as the result of accidental injury (direct accidental blow to the mouth), natural teeth have been damaged or a fractured or dislocated jaw requires setting. Such dental treatment must be rendered or reported and approved for payment by the insurer within 180 days of the accident and be supported by proper certification. When such dental treatment must be deferred because of the age of the patient, or other factors which are justified in the opinion of the insurer within 180 days of the accident, complete details of the required services from the dentist and reason for deferment.
k. An allowance of up to $500 Canadian for the cost of driving the patient's vehicle, either private or rental, by commercial agency to the patient's residence or nearest appropriate vehicle rental agency when the patient is unable to return it due to sickness or accident.
l. Up to $3,000 Canadian towards the cost of preparation and homeward transportation of the deceased (excluding the cost of a coffin) to the point of departure in Canada by the most direct route in the event of the insured person's death.
m. Up to $700 Canadian ($100 per day for seven days) per trip for extra costs of commercial accommodation and meals incurred by the insured person, or by an insured dependent remaining with you or a traveling companion. This must be verified by the attending physician and supported with receipts from commercial organizations.
n. Return economy fare by the most direct route for transportation costs (air, bus, train) when the insured person has been confined to hospital for seven days or more, or has died and the attending physician has advised the necessary attendance of a family member or close friend.
o. The services of a 24-hour emergency hotline are available to insured persons who need assistance while traveling. By telephoning the appropriate number shown on your Identification Card "Voyage Assistance" when a medical emergency occurs, coverage will be confirmed to the hospital or physician. Payment of medical expenses will be arranged or co-ordinated on behalf of the insured person.
p. The patient may call for a list of hospitals or medical facilities and arrangements will be made for:
    - advice from a qualified physician;
    - medical follow-up of the patient's condition and communication with the insured person's family;
    - return home or transfer of patient if medically permissible; and
    - transportation of a family member to the patient's bedside or to identify the deceased.
q. The patient may call to obtain:
    - An emergency response in any major language;
    - emergency assistance in contacting the family or business; and
    - referral to legal counsel.

Co-ordination of Benefits

Should similar benefits be provided by more than one section of the policy, any claim for these benefits will be assessed by insurance company in a manner which provides the greatest benefit to the participant.

Where compensation for benefits covered under this plan is available to a participant under any other prepaid health service contract or insurance policy, the amount payable under this plan shall be coordinated with such other coverages in accordance with the Canadian Life and Health Insurance Association (CLHIA) Guidelines so that the total benefits from all plans will not exceed the expenses actually incurred.

Effective April 1, 2010, Co-ordination of Benefits will be allowed between spouses insured under the Plan.

If the other plan does not contain a coordination of benefits provision, then that plan shall be considered first payer.

Limitations and Exclusions
No benefits are payable under the plan for expenses in connection with:

- Traveling outside the province of residence primarily or incidentally to seek medical advice or treatment, even if such a trip is on the recommendation of a physician;
- Elective (non-emergency) treatment or surgery;
- Benefits received from a third party;
- The abuse of medications, drugs or alcohol;
- Suicide or attempted suicide; and
- Criminal acts, wars or other hostilities.

The insurer, in consultation with the attending physician, reserves the right to return the patient to Canada. If any patient is (on medical evidence) able to return to Canada following the diagnosis of, or the emergency treatment for, a medical condition which requires continuing medical services, treatment or surgery, and the insured person elects to have such treatment or services rendered or surgery performed outside of Canada, the expense of such continuing medical services, treatment or surgery will not be covered by this plan.

Coverage is available to all insured employees/retirees as long as they are insured under provincial Medicare programs.

Termination of Coverage
Your Group Health Insurance Coverage terminates on the earlier of termination of employment or on the attainment of age 75. Coverage may be continued during retirement provided you are in receipt of a pension from either the Public Service Pension Plan, the Uniformed Services Pension Plan, the Members of the House of Assembly Pension Plan, or the Provincial Court Judges' Pension Plan.

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Basic Group Life Insurance

Life Insurance for Employee
You are insured for a life insurance benefit equal to two times your current annual salary for active employee's, and two times your current annual pension for retiree's up to age 65, rounded to the next higher $1,000, if not already a multiple thereof, subject to a minimum of $10,000 and a maximum of $1,000,000.

Reduction Clause
In the event you have been insured under this program for a period of five consecutive years immediately prior to your 65th birthday, you may be eligible for a reduced paid-up life insurance policy on the first of the month following attainment of age 65 which will remain in force throughout your lifetime.

Waiver of Premium
While insured under the plan, should you become disabled from engaging in your own occupation, your group life insurance may be continued in force following four (4) months of continuous disability for the duration of such disability without further premium payment up to your attainment of age 65, recovery or death. At age 65, coverage reduces in accordance with the reduction clause. Application must be made in accordance with the group insurance policy.

Beneficiary Designation
In the event of your death, the group life insurance benefit is payable to the beneficiary(ies) you have appointed on your Group Enrollment Card.

Termination of Coverage
Your group life insurance terminates on the earlier of termination of employment or on the attainment of age 75.

Conversion Privilege
If your insurance reduces and/or terminates on or prior to age 65, you may be entitled to convert up to the cancelled amount of basic group life insurance to an individual policy of the type then being offered by the insurer to conversion applicants. Application for conversion must be made within 31 days of the termination or reduction date, and no medical evidence of insurability would be required. The premium rate would be based on your age and class of risk at that time. For further information, please contact your Administrator.

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Dependent Life Insurance

Life Insurance for Dependents (Only applicable with Dependent Medical Coverage)

In the event of the death of your spouse or dependent child from any cause whatsoever while you are insured under the plan, the insurance company will pay you $10,000 in respect of your spouse and $5,000 in respect of each insured dependent child. (See page showing ***Summary of Your Benefit Program*** for definition of eligible dependents.)

Waiver of Premium
While insured under the plan, should you become disabled from engaging in your own occupation, your dependent life insurance may be continued in force following four (4) months of continuous disability for the duration of such disability without further premium payment up to your attainment of age 65, recovery or death.

Termination of Coverage
Dependent life insurance coverage terminates upon termination of employment. In respect of dependent children, coverage terminates on the earlier of the date they are no longer eligible, as outlined in the Summary of Benefits, or on your attainment of age 75.

In the event of your death while insured under the plan, if your spouse qualifies for a pension from either the Public Service Pension plan, the Uniformed Services Pension Plan, the Members of the House of Assembly Pension Plan, or the Provincial Court Judges' Pension Plan insurance in respect of your spouse may be continued, at the spouse's option, until the spouse's 65th birthday.

Conversion Privilege
If your dependent life insurance terminates on or prior to your spouse having attained age 65, your spouse (does not apply to dependent children) may be entitled to convert up to the amount of dependent life insurance to an individual policy of the type then being offered by the insurer to conversion applicants within 31 days of termination, without submission of evidence of health. The premium rate will be determined from your spouse's age and class of risk at the time of conversion. For further information, please contact your Administrator.

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Basic Accidental Death and Dismemberment Insurance

The plan provides accidental death and dismemberment insurance coverage in an amount equal to your basic group life insurance (two times your current annual salary to a maximum of $1,000,000). Coverage is provided 24 hours per day, anywhere in the world, for any accident resulting in death, dismemberment, paralysis, loss of use of, or loss of speech or hearing.

In order to be covered by this benefit, all losses must result directly and independently of all other causes from bodily injuries suffered by accidental, external and violent means. Death caused by accidental drowning shall also be covered. Death or loss must occur within 365 days from the date of the accident causing such loss. In the case of accidental death, the benefit will be paid to the beneficiary you have named to receive your group life insurance benefits.

The amount payable shall be the following percentage of the amount of Accidental Death and Dismemberment Insurance for which you are insured on the date of the injury. The maximum amount payable for all losses sustained as a result of the same accident shall not exceed 100% of the amount of insurance. Only one amount, the largest applicable, will be payable for injuries to the same limb resulting from any one accident.

- Loss of life - 100%
- Loss of both hands or both feet - 100%
- Loss of one hand and one foot - 100%
- Loss of the entire sight of both eyes - 100%
- Loss of one hand and the entire sight of one eye - 100%
- Loss of one foot and the entire sight of one eye - 100%
- Loss of use of both arms or both legs or both hands - 100%
- Loss of speech and loss of hearing in both ears - 100%
- Quadriplegia - 200%
- Parapelgia - 200%
- Hemiplegia - 200%
- Loss of or loss of use of one arm or one leg - 100%
- Loss of or loss of use of one hand or one foot - 100%
- Loss of the entire sight of one eye - 100%
- Loss of speech or loss of hearing in both ears - 100%
- Loss of thumb and index finger on one hand - 66 2/3%
- Loss of four fingers on one hand 66 2/3%
- Loss of hearing in one ear - 66 2/3%
- Loss of all the toes on one foot - 33 1/3%

Loss of a hand or foot means severance at or above the wrist or ankle joint but below the elbow or knee joint. Loss of an arm or leg means severance at or above the elbow or knee joint. Loss of a finger or thumb means severance at or above the metatarsophalangeal joint. Loss of a toe means severance at or above the sophalangeal joint. Severance is defined as the permanent and complete detachment of the affected area.

Loss of use means, with regard to arms, hands and legs, the total loss of ability to perform each and every action and service the arm, hand, or leg was able to perform before the accidental occurred. Loss of use must be total and irrecoverable and beyond remedy by surgical or other means.

Loss of entire sight means that it is total and irrecoverable. Loss of entire sight is also deemed to have occurred if sight cannot be restored to better than 20/20 vision by surgical or other means (i.e. spectacles).

Loss of speech means irrecoverable loss which does not allow audible communication through surgical or other means.

Loss of hearing means irrecoverable loss which cannot be corrected through surgical treatment, hearing aid or device.

Quadriplegia means total paralysis or both the upper and lower limbs. Hemiplegia means total paralysis of the upper and lower limbs on one side of the body. Paraplegia means total paralysis of both lower limbs.

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Additional Benefits

Exposure and Disappearance
Benefits are payable if, due to an accident, you are exposed to the elements and suffer an insured loss under the policy within 365 days of the accident.

The plan also will pay for a loss of life benefit if due to accidental wrecking, sinking or disappearance of a conveyance in which the insured is riding and the body is not found within 365 days of the accident and will be presumed dead after one year.

Air Travel Accidents
If you are traveling as a passenger or as a crew member in an aircraft properly licensed and flown by a pilot properly certified to fly such aircraft, you are entitled to the benefits described herein.

Repatriation Benefit
When injury results in your loss of life more than 50 kilometers from your normal place of residence and the death benefit becomes payable under the policy, the actual expenses incurred for the preparation and transportation of the body to the place of burial, in proximity to the normal place of residence, will be paid to a maximum of $20,000 (excluding the cost of a coffin).

Rehabilitation Benefit
In the event you sustain an injury which results in a loss payable under the policy and such injury requires that you undergo special training in order to engage in an occupation in which you would not have engaged except for such injury, the reasonable and necessary expenses actually incurred by you for such training will be paid to a maximum of $20,000 as a result of any one accident. No payment will be made for any expense incurred more than three years after the date of the accident, nor for room, board or other living, traveling or clothing expenses.

Education Benefit
In the event of your accidental death, the insurer will pay an education benefit for each dependent child enrolled in a school for a higher learning, or who enrolls in a school for higher learning within 365 days after your death. The benefit is equal to the reasonable and necessary expenses actually incurred, subject to the lesser of a maximum of 5% of your principal sum or $5,000 for each year the dependent child continues their education on a full-time basis, not to exceed five consecutive years per child. Payment will not be made for room, board or other living, traveling or clothing expenses.

If you have no dependents eligible for the education benefit, the insurer shall pay an additional amount of $1,000 to the designated beneficiary.

Spousal Retraining Benefit
In the event of your accidental death, the insurer will pay the reasonable and necessary expenses to a maximum of $20,000 actually incurred by your spouse who engages in a formal occupational training program in order to become qualified for employment in an occupation for which they would not otherwise have sufficient qualifications. Payments will not be made for room, board or other living, traveling or clothing expenses.

Seat Belt Benefit
Benefits will be increased by 25% to a maximum of $25,000 if your injury or death results while you were a passenger or driver of an automobile and your seat belt was properly fastened. Seat belt use must be certified by the investigating officer or verified on the official accident report.

In-Hospital Indemnity
The plan 1% of the benefit payable, up to $2,500 per month, if you are hospitalized for at least four days as a result of injury occurring in a covered accident. The benefit is payable for a maximum of 12 months for confinement due to any one accident. This benefit is reduced by the amount by which this benefit, plus benefits payable under the Government of Newfoundland and Labrador optional long term disability insurance plan, exceed 100% of pre-disability net monthly earnings.

Benefit in the Event of Coma
In the event that you suffer an accidental injury which directly results in a state of coma, the benefit payable will be equal to the amount for which you are insured on the date of the accident.

Family Travel
If an insured Employee suffers a loss covered under the accidental death and dismemberment provision and is hospital confined, or suffers from an illness or injury other than as specified in the schedule of losses which requires hospital confinement of at least four days, and such confinement occurs more than 100 kilometers from his normal place of residence, the plan will pay for the reasonable and necessary traveling expenses or one or more family members to the insured Employee's place of confinement. The total amount will be $10,000 for hotel accommodation and transportation cost combined. If personal transportation is used in lieu of public conveyance, a rate of $0.20 per kilometer will apply.

Day-Care Benefit
In the event accidental Loss of Life is sustained by an insured person and indemnity for such Loss becomes payable, the plan will pay the Day-Care Benefit below for each of the insured person's dependent children who:

1. are enrolled in a day-care centre on the date of such Loss; or
2. enroll in a legally licensed day-care centre within 365 days after the date of death of the insured Employee; and
3. is age 12 or younger

The Day-Care Benefit is equal to the reasonable and necessary expenses actually incurred, subject to the lesser of a maximum of 5% of the insured person's Principal Sum or $5,000, which maximum is in combination with the Day-Care Benefit maximum provided under any other policy issued to the Policy holder by the insurer, for each year the dependent child described above is enrolled in a legally licensed day-care, but not to exceed four years, which must run consecutively, with respect to any one dependent child.

The benefit will be paid each year immediately upon receipt of satisfactory proof that the child is enrolled in a legally license day-care centre, but payment will not be made for expenses incurred prior to the death of the insured person, nor for room, board or other ordinary living, traveling or clothing expenses.

In the event the insured person's dependent child does satisfy the requirement indicated above, the Day-Care Benefit will be payable to the surviving spouse if the spouse has custody of the child. If there is no surviving spouse or the child does not reside with the spouse, benefits payable under this provision will then be paid to the child's legally appointed guardian. If none of the insured person's dependent children satisfy the above requirements, the insurer will pay an amount of $2,500 under one of the policies issued to the Policyholder by the insurer to the insured person's beneficiary.

"Day-Care Center" means a facility which is run according to law, including laws and regulations applicable to day-care facilities and which provides care and supervision for children in a group setting on a regular basis. Day-Care Centre will not include a hospital, the child's home or care provided during normal school hours while a child is attending grades one through 12.

Home Alteration and Vehicle Modification Benefit
In the event an insured person sustains the Loss of or Loss of Use of Both Feet or Legs or becomes Quadriplegic, Paraplegic of Hemiplegic, for which indemnity is payable in accordance with the terms of the policy, and he/she subsequently requires the use of a wheelchair to be ambulatory, the plan will pay the reasonable and necessary expenses actually incurred within three years of the date of the accident causing such loss for:

a. the cost of alterations to the insured person's principal residence and/or
b. the cost of modifications to one motor vehicle utilized by the insured person, when such modifications are approved by licensing authorities where required, for the purpose of making them wheelchair accessible.

The total of all expenses incurred by or for any insured person will not exceed $20,000 in three (3) years as the result of any one accident, nor will this benefit be payable under more than one of the policies issued to the policyholder.

Waiver of Premium
While insured under the plan, should you become disabled from engaging in your own occupation, your accidental death and dismemberment insurance may be continued in force following four (4) months of continuous disability.

For the duration of such disability without further premium payment up to your attainment of age 65, recovery or death. Application must be made in accordance with the group insurance policy.

Termination of Coverage
Your accidental death and dismemberment insurance coverage terminates on the earlier of termination of employment or on the attainment of age 75. Coverage may be continued during early retirement provided you are in receipt of a pension from either the Public Service Pension Plan, the Uniformed Services Pension Plan or the Members of the House of Assembly Pension Plan, or the Provincial Court Judges' Pension Plan but not beyond your 65th Birthday.

Conversion Privilege
If your insurance reduces and /or terminates on or prior to age 65, you may be entitled to convert up to $100,000 of basic

accidental death and dismemberment insurance to an individual policy of the type then being offered by the insurer to conversion applicants. Application for conversion must be made within 31 days of the termination or reduction date, and no medical evidence of insurability will be required. The premium rate will be based on your age and class of risk at that time. For further information, please contact your Administrator.

Exclusions
Benefits are not payable if loss results from or was associated with:

- suicide or self-destruction or any attempt thereat while sane or insane;
- declared or undeclared war, insurrection or participation in a riot;
- active full-time service in the armed forces of any country; and
- air travel in any aircraft not properly licensed or flown by a pilot not properly certified.

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Benefits for Retired Employees

If you are a retiree and are receiving benefits from either the Public Service Pension Plan, the Uniformed Services Pension Plan, the Members of the House of Assembly Pension Plan, or the Provincial Court Judges' Pension Plan and have elected to continue your group insurance benefit, you are eligible for benefits as outlined below.

Retirees under age 65
If you retire early and are in receipt of a pension from one of the pension plans outlined above, you will be given a one time option at your retirement date to continue your group insurance coverage, without evidence of good health.

If you elect to continue benefits, **all** basic group insurance benefits must be continued, i.e. group life, accidental death and dismemberment, dependent life, supplementary health and group travel insurance.

The level of benefits will be identical to those offered to active employees, with the exception of the basic group life and basic accidental death and dismemberment insurance benefits, which will each be two times your annual pension rounded to the next higher $1,000, if not already a multiple thereof, subject to a minimum of $10,000 and a maximum of $1,000,000.

Premiums for the basic group insurance benefits will continue to be cost-shared 50/50 with the Government. You may also elect to continue optional dental care, optional group life and optional accidental death and dismemberment insurance during early retirement provided you pay 100% of the premiums. Optional long term disability insurance may not be continued.

Note: If you elect to continue your group insurance coverage during early retirement, a Continuation of Coverage Form must be completed and given to your Administrator prior to your retirement or last day worked.

If you elect a deferred pension, no benefits are available other than those continued through the conversion during the period of deferment. A continuation form must be completed prior to leaving your place of employment for benefits to commence when you are eligible to receive pension.

Retirees over Age 65
In the event you have been insured under this program for a period of five consecutive years immediately prior to your 65th birthday, you can be eligible for a reduced insurance policy with no further premium payment on the first of the month following attainment of age 65, which will remain in force throughout your lifetime.

You are also eligible to continue your supplementary health and group travel insurance plans on a 50/50 cost-shared basis. The supplementary health and group travel insurance plans are identical to those offered to active employees. Dental insurance may also be continued during retirement.

In the event of your death, your surviving spouse, who on the date of your death was insured under the plan, will be given the option of continuing in the group health insurance program if in receipt of a survivor pension.

Pensioners should note that certain provisions may vary; however, any questions should be forwarded to:

Insurance Division
Department of Finance
P. O. Box 8700
Confederation Building, East Block
St. John's, NL A1B 4J6
Telephone: (709) 729-2310
Fax: (709) 729-2156

Note: In all correspondence, please indicate your name, address and Identification Number.

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Optional Dental Care Insurance

Dental care insurance is available to all active and retired employees and their eligible dependents (see ***Summary of Your Benefit Program***) on an optional and employee-pay-all basis. In order to be insured for this benefit, you must also be insured under the basic group insurance program.

Coverage will be based on the 2013 Newfoundland and Labrador Dental Association Fee Guide for general practitioners and specialists in accordance with the following:

Basic Benefits
Eligible expenses will be reimbursed at 80%; there is no annual or overall maximum applicable.

Diagnostic Services

- Clinical oral examinations (one recall examination every *calendar year* for adults; every five months for a dependent child age 13 to 17 inclusive)
- X-ray examinations - full mouth or panoramic films (one set of each in a *calendar year*) single films (up to ten), occlusal, posterior bitewing or extraoral films (four of each type in five months); and
- Tests, laboratory examinations and treatment planning.

Preventative Services
Cleaning and polishing, fluoride treatments (once a*calendar year* for adults; every five months for a dependent child age 13 to 17 inclusive) nutritional counseling, oral hygiene instruction, pit and fissure sealants, space maintainers and protective athletic appliances (one in 12 months).

Restorative Services
Fillings, recementing inlays and crowns, removal of inlays and crowns and cement restorations.

Endodontic Services
Diagnosis and treatment of the pulp (nerve) and tissue which supports the end of the root, root canal therapy and emergency procedures.

Periodontic Services
Diagnosis and treatment of disease which affects the supporting tissue of the teeth, such as the gums and bones surrounding the teeth.

Prosthodontic Services - Removable
Denture repairs, denture rebasing and relining (once in 24 months) and tissue conditioning.

Surgical Services
Extraction of teeth

Adjunctive General Services
Emergency treatment of pain, local anaesthetic or conscious sedation and consultation with another dentist.

Major Restorative Benefits
Eligible expenses will be reimbursed at 70% to a maximum of $1,250.00 per insured person per calendar year.

Extensive Restoratives
Major repairs and restorations, including inlays, onlays and crowns

Prosthodontic Services
Complete dentures, partial dentures, denture adjustments and repairs, pontics, retainers, abutments, crowns and fixed bridges.

This program excludes:

- replacement of the denture, unless it is at least five years old and cannot be made serviceable; and
- the replacement of dentures that have been lost, mislaid or stolen.

Major Surgical Procedures
Surgical exposure of the tooth, surgical repositioning or transplantation, cutting of bone to aid in removal of teeth or to permit insertion of a denture, surgical shaping of gum or tissue in order to support teeth and treatment of tumors and cysts.

Note
If you do not apply for optional dental coverage within 31 days of being eligible, you will be considered a late applicant.

Late applicants, provided they are not eligible for coverage under their spouse's dental program, will be limited to an eligible expense of $100.00 per individual during the first 12 months of coverage.

Termination of Coverage
Your dental insurance coverage terminates on the termination of employment. Coverage may be continued during early retirement provided you are in receipt of a pension from either the Public Service Pension Plan, the Uniformed Services Pension Plan, the Members of the House of Assembly, or the Provincial Court Judges' Pension Plan.

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Optional Long Term Disability Insurance

In order to be insured under this benefit, you must also be insured under the basic group insurance program and be a member of either the Public Service Pension Plan, Uniformed Services Pension Plan, the Members of the House of Assembly Pension Plan, or the Provincial Court Judges' Pension Plan.

This plan is intended to provide a level of income while you are unable to work due to total disability resulting from accident or illness which continues beyond the elimination period of 119 consecutive days. It is not required that you exhaust your accumulated sick leave, however at your option, the elimination period may be extended to the expiration of accumulated sick leave (maximum accumulation 480 days). Benefits are payable through to your recovery, attainment of age 65 or death, whichever occurs first. Regular medical examinations and reports are required throughout your entire period of disability.

Benefits Payable
The monthly income benefit payable will be 66 2/3% of your regular monthly salary at the date of disability, to a maximum monthly benefit of $10,000 on a non-taxable basis.

Definition of Disability
Benefits are payable for the first 12 months **following initial receipt of benefits** if sickness or accident prevents you from doing your own job. You will be considered disabled if there is no combination of duties you can perform that regularly took at least 60% of your time at work to complete.

After 12 months, benefits continue to be payable if disease or injury prevents you from being gainfully employed in any occupation. Gainful employment is work you are medically able to perform, for which you have at least the minimum

qualifications and which provides you with an income of at least 60% of your pre-disability monthly earnings, adjusted for inflation. The availability of work will not be considered in assessing disability.

Recurrence of Disability

Successive periods of Total Disability occurring while this benefit is in force will be considered to be one period of Total Disability if :

- They result from the same or related causes, and are separated by at least 2 consecutive weeks of active full-time employment during the Elimination Period, or
- They result from the same or related causes, and are separated by an interval of less than six months during which the employee was actively at work on a full time basis following a period of Total Disability for which Long Term Disability benefits were paid under this benefit, or
- They result from entirely unrelated causes, unless they are separated by at least 1 day of active full-time employment

If a period of total disability is considered under this provision to be a continuation of a previous Total Disability, then benefits will be resumed based on the original benefit period and for the same amount of monthly benefit, but without the application of another elimination period.

Rehabilitation

Provision has been made in the plan to assist you in undertaking rehabilitative employment, however, it is necessary to have the approval of the insurance company prior to commencing rehabilitative employment. The plan allows you to receive increased income in connection with work performed in an approved rehabilitative program, in that your long term disability benefit will be reduced by only the amount of your rehabilitative earnings and other income as outlined below exceed 100% of your pre-disability net earnings.

A Participant who refuses to participate or co-operation in rehabilitative employment considered appropriate by the Insurer will no longer be eligible for monthly benefits payable under this benefit.

Benefit Reduction

Your monthly long term disability benefit will be directly reduced by any amount payable under:

- Workers' Compensation
- Canada Pension Plan (excluding any payments for your dependents); or
- Pension benefits from the Public Service Pension Plan, Uniformed Services Pension Plan, the Members of the House of Assembly Pension Plan, or the Provincial Court Judges' Pension Plan payable due to the disability. Benefits are automatically assumed to commence after 24 months of disability unless written notice of proof is received confirming benefits were denied.

Long term disability benefits will only be further reduced if your total disability income from all sources, as outlined below, exceeds 85% of your net income at the date of disability.

- Canada Pension Plan dependent benefits;
- Disability benefits through employment or from a group insurance or association plan; and
- Payments from Government plans except those being received prior to effective date of insurance.

Cost of living increases in Canada Pension Plan benefits that take effect after you qualify for benefits are not included as "other income" when your long term disability benefit is calculated.

Termination of Coverage

Long term disability insurance coverage terminates on your attainment of age 65, termination of employment, or the date you cease to be in an eligible classification, whichever is earlier. If you are granted a leave of absence or are on seasonal lay-off, you may continue long term disability insurance for one (1) month from your last day worked.

General Limitations and Exclusions

- No benefits will be payable for disability periods that begin before your insurance starts or after it ends.
- Benefits will not be paid for any period in which you do not participate and co-operate in a reasonable and customary treatment program. If your disability involves a psychiatric disorder, the treatment program must be supervised by a Psychiatrist. If substance abuse contributes to your disability, the treatment program must include participation in a recognized substance withdrawal program. Substance abuse includes alcoholism or drug addiction.
- No benefits will be paid if you fail to participate or co-operate in a recommended or approved rehabilitation program.
- No benefits will be paid during any period for which Employment Insurance maternity benefits are paid.
- No benefits will be paid if disability arises from attempted suicide or intentionally self-inflicted injury while sane or insane.
- No benefits will be paid if the disability arises from active service in the armed forces of any country or in any civilian non-combatant unit that serves with the forces in combat.
- Disabilities arising from war, insurrection, or voluntary participation in a riot are not covered. Benefits will not be paid for any period of confinement in a prison, nor will they be paid for any 12 month period in which the disabled employee does not reside in Canada for at least six of the twelve months.
- Pre-Existing Conditions: If you become totally disabled within the first 12 months of receiving Long Term Disability coverage, no benefits will be payable if the disability is directly or indirectly the result of an illness or injury for which medical care was sought during the 6 month period immediately prior to the effective date of coverage Medical care is considered to be obtained when you consult a doctor, use medication on the advice of a doctor, or receive other medical services or supplies. This limitation expires on the date one year after your effective date of coverage.

Conversion Privilege

Should your insurance terminate on or before the attainment of age 65, you may be eligible to convert the terminated amount to an individual disability income policy without medical evidence subject to the following conditions:

- your insurance terminates at the end of a rehabilitation program that requires you to change employers;
- you start employment with another employer during the rehabilitation program or within six months after its end;
- you apply for conversion in writing within 31 days after your insurance terminates, if you are then employed. If you are not employed, your application must be made within 31 days after employment starts; and
- your application must be acceptable in accordance with the insurer's underwriting rules for individual disability insurance other than medical evidence and length of employment rules.

The individual policy then being offered to conversion applicants will conform to the conditions, terms and amounts of individual insurance plans regularly used by the Insurer at the date of conversion.. Coverage will be effective on the date the insurer approves the application provided the first premium has been paid.

Termination of Benefits

Long Term Disability benefits will cease on the earliest of

1. the date on which you cease to be Totally Disabled,
2. the date on which you engage in any gainful occupation other than an approved gainful occupation for the purpose of rehabilitation,
3. the date set by the Insurer on which you are required to provide satisfactory proof of Total Disability or to undergo a medical examination requested by the Insurer, but neglected or refused to do so,
4. The date on which you reach age 65
5. the date on which you refuse to take up rehabilitation employment considered appropriate by the Insurer
6. the date on which the Participant retires, except in the case of medical retirement, or
7. the date this benefit terminates

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Optional Group Life Insurance

In order to be insured under this benefit, you must also be insured under the basic group life insurance program.

Amount of Insurance
Your basic group life insurance covers you for two times your current salary. However, additional group life insurance is available over and above what you are covered for under the basic plan. You may apply to purchase, on behalf of your self and/or your spouse, additional group life insurance from $10,000 up to $300,000 in units of $10,000, but not to exceed $300,000 per insured person. For new employees, up to $100,000 is available without medical evidence of insurability if applied for within 31 days of your employment date.

Payment of Benefits
You and/your spouse are covered 24 hours a day and benefits are paid as the result of death from any cause whatsoever.

Beneficiary Designation
You may appoint any beneficiary(ies) to receive the benefits you have selected. You are automatically the beneficiary of any coverage selected for your spouse.

Waiver of Premium
While insured under the plan, should you become disabled from engaging in your own occupation, your optional group life insurance may be continued in force following four (4) months of continuous disability for the duration of such disability without further premium payment up to your attainment of age 65, recovery or death. Application must be made in accordance with the group insurance policy.

Termination of Coverage
You and/or your spouse's coverage terminates on the earlier of your termination of employment or you/your spouse's attainment of age 75. Coverage may be continued during early retirement but not beyond your 65th birthday.

Conversion Privilege
If insurance terminates on or prior to age 65, you and/or your spouse may be entitled to convert the amount of optional group life insurance within 31 days of this date, without submission of evidence of health. The premium rate will be determined from your and/or your spouse's age and class of risk at the time of conversion. For further information please contact your Administrator.

Applying for Coverage

Employee
For new employees, the first $100,000 of optional group life insurance coverage is available without medical evidence if applied for within 31 days of becoming eligible. If the employee selects an amount of insurance over $100,000 an evidence of insurability form must be completed.

Spouse
Employees may select coverage for their spouse up to $100,000 upon the spouse signing a declaration of good health form. For amounts in excess of $100,000 an evidence of insurability form must be completed. If the spouse is not in good health evidence of insurability must be completed for all amounts of insurance. The completed forms must be forwarded to your Administrator for forwarding to the insurance company.

Effective Date of Insurance
For new employees only, the first $100,000 of optional life insurance becomes effective on the date the application is received by your employer but, in no event prior to the commencement of active, regular employment. Optional Group Life Insurance coverage in excess of $100,000 and all amounts for the spouse of an employee will not become effective until the application has been approved by the insurance company. If additional medical information is required, you will be notified accordingly.

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Optional Accidental Death and Dismemberment Insurance

Amount of Insurance
In order to be insured under this benefit, you must also be insured under the basic group life insurance program.

This plan provides additional accidental death and dismemberment insurance for you, your spouse and dependent children, if desired, on an employee-pay-all basis. You are covered 24 hours a day, 365 days a year, on or off the job, while traveling or at home.

You may select coverage for yourself or yourself and your family by choosing one of the following plans:

- **Employee Only Plan**
  You may purchase, in units of $10,000, any amount of coverage between $10,000 and $300,000.

- **Family Plan**
  You may elect to insure your family under the following plan:

  Your spouse is insured for 40% of the benefit which you have selected and each dependent child is insured for 5% of the selected amount.

  Where there are no dependent children, the spouse is automatically insured for 50% of the benefit selected. Where there is no spouse, each dependent child will be covered for 10% of your benefit. (Refer to the Benefit Summary for definition of eligible dependents.)

Payment of Benefits
Benefits are payable for injuries or death sustained in an accident occurring while the policy is in force, which results in a loss within 365 days of the accident. Benefits are payable as a percentage of the principal sum in accordance with the schedule applicable to the basic accidental death and dismemberment insurance plan.

Beneficiary Designation
Your loss of life benefit will be paid to the beneficiary(ies) you have named on your Group Enrollment Card. All other benefits for you, your spouse and dependent children will be paid to you.

Waiver of Premium
While insured under the plan, should you become disabled from engaging in any occupation for which you are, or may become qualified, by education, training or experience, your optional accidental death and dismemberment insurance may be continued in force following four months of continuous disability for the duration of such disability without further premium payment up to your attainment of age 65, recovery or death. Application must be made in accordance with the group insurance policy.

Termination of Coverage
Your optional accidental death and dismemberment insurance coverage terminates on the earlier of termination of employment or on your attainment of age 75. Coverage may be continued during early retirement but not beyond your 65th birthday.

Conversion Privilege
If your insurance reduces and/or terminates on or prior to age 65, you may be entitled to convert up to $100,000 of optional accidental death and dismemberment insurance to an individual policy of the type then being offered by the insurer to conversion applicants. Application for conversion must be made within 31 days of the termination or reduction date and no medical evidence of insurability would be required. The premium rate would be based on your age and class of risk at that time. For further information, please contact your Administrator.

Additional Benefits
The following benefits are covered in addition to the benefits provided under the basic accidental death and dismemberment policy.

Common Disaster Benefit
In the event that you and your insured spouse both suffer loss of life due to injury sustained in the same accident, the principal sum applicable to your insured spouse will be increased to equal the principal sum applicable to you. Both deaths must occur within 90 days of the date of the accident.

Extended Family Benefit
If an insured employee suffers loss of life for which benefits are payable under the schedule of benefits in this policy, the insurance which is in force for the insured spouse and dependents will be continued for a period of six months without payment of premium.

Escalation Benefit
An increase in the Employee's Principal sum of 3% per year with maximum of 15% will be applied on each and every anniversary date of the policy, up to a maximum of five years, provided the policy remains in effect. The amount of such increase shall not form part of the employee's principal sum for the purpose of calculating subsequent increases under this provision.

Exclusions
The exclusions applicable to the basic accidental death and dismemberment insurance plan also apply to the optional plan.

Applying for Coverage
You may elect coverage for yourself, or yourself and your family by indicating on your Group Enrollment Card the plan selected and the amount of coverage you want. Your coverage becomes effective on the date the application is received by your employer but in no event prior to the commencement of active, regular employment.

Open Enrollment Period
If an Employee chooses not to take advantage of this benefit provision within 31 days of the date of eligibility, an opportunity to enroll or increase present coverage in this plan is provided once every two years during an open enrollment period. The date of the open enrollment period is selected by the policyholder and agreed upon by the company.

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Critical Illness

Critical Illness is available to all active employees (under age 65) and their eligible dependents on an optional and employee-pay-all basis. In order to be insurance under this benefit, you must also be insured under the basic group insurance program. Evidence of Insurability is required for coverage.

Amount of Insurance
You may apply to purchase optional Critical Illness insurance, a benefit which pays a lump sum cash payment to cover you and/or your family in the event a Critical Condition strikes and you are saddled with a long recovery period and unexpected expenses. The benefit payable is:

Insured Person Cash	Payment
Employee	$25,000
Spouse	$10,000
Dependent	$ 5,000

Payment of Benefits
Critical Illness is a living benefit, which means the covered person must survive the onset of the critical condition for a period of 30 days before the benefit will be paid. At the end of this 30-day period, the covered person must still meet the definition of the critical condition.

Definition of Critical Condition
An illness or disease whereby you are unable to perform 3 of the 5 Activities of Daily Living.

Activities of Daily Living
The five Activities of Daily Living that a person would normally perform without assistance are:

Eating: manipulating prepared food or liquid into the mouth.

Dressing: putting on and removing necessary articles of clothing that are normally worn, including leg braces.

Bathing: the ability to cleanse the entire body using soap and water; including turning on faucets and shower mechanisms, getting into and out of the bath itself and drying oneself off.

Ambulation: the ability to move independently from place to place with or without the use of equipment.

Toileting: the ability to use a toilet, bedside commode or urinal.

Covered Critical Conditions

The following critical conditions are covered under Critical Illness. All conditions with the exception of burns, must be the result of illness or disease. Conditions resulting from an accident (except in the case of burns) will not be eligible for coverage.

Alzheimer's disease: Unequivocal diagnosis by a specialist. Loss of cognitive function must be to a degree that warrants supervision on a daily basis.

Blindness: Permanent and uncorrectable loss of sight from both eyes as determined through vision acuity testing and according to set degrees of severity.

Burns: Third-degree burns covering at least 20 per cent of the body.

Coma: State of unconsciousness with no reaction to external stimuli and the requirement of life support systems.

Deafness: Permanent and uncorrectable functional deafness as determined by a specialist.

Heart transplant: Medically-necessary heart transplant from a donor to the insured person.

Kidney failure or transplant: End-Stage renal disease requiring permanent, regular dialysis or kidney transplantation.

Life-threatening cancer: A malignant tumor characterized by uncontrollable growth and spread of malignant cells (including Leukemia) which is likely to result in death within 24 months.

Liver failure or transplant: End-stage liver failure with permanent jaundice, encephalopathy and ascites, or liver transplantation.

Loss of speech: Complete, permanent and uncorrectable loss of speech.

Lung Failure or transplant: End-stage lung disease requiring permanent oxygen therapy. The condition must meet set degrees of severity according to a respiratory specialist, or require lung transplantation.

Motor neuron disease: Unequivocal diagnosis by a specialist. The condition must be to the degree of severity that the insured person is unable to perform 3 of the 5 Activities of Daily Living without assistance.

Multiple Sclerosis: Unequivocal diagnosis by a specialist. The condition must be to the degree of severity that the insured person is unable to perform 3 of the 5 Activities of Daily Living without assistance.

Paralysis: Total and permanent loss of use of two or more limbs.

Parkinson's disease: Unequivocal diagnosis by a specialist. The condition must be to the degree of severity that the insured person is unable to perform 3 of the 5 Activities of Daily Living without assistance.

Senile dementia: Unequivocal diagnosis by a specialist. The degree of severity must require daily supervision for the insured person.

Severe heart attack: The death of heart muscle to a degree of severity of at least Class 4 of the Canadian Cardiovascular Society's classification of cardiac impairment.

Severe stroke: Significant, permanent neurological impairment as determined by a specialist. The condition must be to the degree of severity that the insured person is unable to perform 3 of the 5 Activities of Daily Living without assistance.

Applying for Coverage
You may apply at any time and provide Evidence of Insurability to the insurance company. Coverage is not effective until approved.

One Year Waiver of Premium
While insured under this plan, should you become totally disabled from engaging in any occupation as a result of accident or sickness, prior to attaining age 65 and you remain so disabled for at least four consecutive months, your Critical Illness Insurance may be continued in force for One Year from the date last worked. Application must be made in accordance with the group insurance policy.

Termination of Coverage
Critical Illness insurance terminates on your attainment of age 65 or termination from active employment, whichever is earlier.

General Limitations and Exclusions
Critical Conditions benefits are not payable for any condition due to or resulting, directly or indirectly, from any of the following:

- An accident, except for severe burns.
- Self-inflicted injury or sickness, while sane or insane. Insurrection, war (declared of not), or the hostile action of the armed forces of any country, or participation in any riot or civil commotion.
- Driving a vehicle when the blood of the insured person contained in excess of 80 milligrams of alcohol per 100 millilitres of blood. (Vehicle means any form of transportation which is drawn, propelled or driven by any means and includes but is not restricted to an automobile, truck, motorcycle, moped, bicycle, snowmobile or boat).
- Committing or attempting to commit a criminal offense, or provoking an assault.

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How to Submit your Claims

Basic Group Life, Dependent Life, Optional Life, Basic and Optional Accidental Death and Dismemberment Insurance

Life, dismemberment or loss of use claims:
Your Plan Administrator will co-ordinate claim forms and advise procedures.

Waiver of Premium:

- Notice of Disability/Sickness should be provided to your Plan Administrator no later than 2 months from your last day worked.
- Once the Plan Administrator and Desjardins Financial Security have been notified, all forms for application of benefit will be sent to you for completion. Please return these forms to Desjardins Financial Security in the time frame allowed.

Optional Long Term Disability Insurance

- If you are participating in the long term disability insurance plan and it appears that you will be off work for a period of more than 119 days, you should obtain the appropriate claim forms **(Early Notice Form and Proof of Claim)** within 2 months from last day worked from your Plan Administrator. Upon completion, all forms must be returned to Desjardins Financial Security.

Notice and Proof of Claims

1. **Notice of Claim**
   To permit prompt assessment of Waiver of Premium and Long Term Disability Benefits and early participation in rehabilitation programs, written notice of claim must be received by the insurance company **(Early Notice Form)** within ten (10) months from the last day worked.

   It is recommended that the Notice of Claim (Early Notice Form) be completed within two (2) months from the last day worked and forward to the insurance company.

2. **Proof of Claim:**
   Long Term Disability benefits under this Policy will only be payable for periods for which the insurance company has received satisfactory proof that the Employee is entitled to benefits.

   The claimant must provide information required to prove the Employee's entitlement to benefits and must also authorize the insurance company to obtain information from other sources for this purpose. Proof of claim must be submitted within six (6) months of receipt of the notice of claim; thereafter, whenever the company requests information or authorization, it must be submitted within six (6) months.

   Written proof of disability will not be accepted if received by the insurance company more than ten months after the date of disability, or more than six months after termination of the policy. Please note that even if benefits are payable from Workers' Compensation, which may totally offset the long term disability benefit, a notice of disability should be submitted for long term disability benefits within the specified time period.

Optional Critical Illness
Your Plan Administrator will co-ordinate claim forms and advise on procedures

Supplementary Health Insurance

Hospital Insurance:

- Present your identification card upon admission to hospital.
- The hospital will forward your claim directly to the Insurance Company Benefit Payments Office for payment of eligible expenses.

Prescription Drugs:

- Present your identification card to the pharmacist when purchasing eligible drugs.
- You pay the pharmacist's professional fee and any applicable surcharge while the cost of the eligible ingredient is payable under this program.
- For any prescription drug requiring Special Authorization, please refer to the section titled ***"Special Authorization"*** in this booklet.

Vision Care:

- Obtain a Claims Submission form from one of the following:
  - Desjardins Financial Security
    - Website (**http://www.desjardinslifeinsurance.com/en/Pages/home.aspx**)
    - Call centre (1-866-838-7553)
  - Government of Newfoundland and Labrador website (**http://www.intranet.gov.nl.ca/docs/default.asp**)
  - Your designated contact for group insurance benefits
- Obtain a completed Vision Care Claim form from the provider of service (i.e. Optometrist and Optician).
- Complete the Claims Submission form, attach a paid-in-full receipt and the completed Vision Care Claim form, and forward to the Insurance Company Benefits Payments Office.

Extended Health:

- Obtain a Claims Submission form from one of the following:
  - Desjardins Financial Security

- Website (**http://www.desjardinslifeinsurance.com/en/Pages/home.aspx**)
- Call centre (1-866-838-7553)
- Government of Newfoundland and Labrador website (**http://www.intranet.gov.nl.ca/docs/default.asp**)
- Your designated contact for group insurance benefits

- Attach a paid-in-full receipt which shows:
  - Patient's name,
  - Date and nature of treatment, and
  - Complete itemization of charges.
- Forward the above items to the Insurance Company Benefits Payments Office.

The address of the Desjardins Financial Benefits Payment Office is:

430 Topsail Road (Village Shopping Centre)
P. O. Box 97
St. John's, NL
A1E 4N1
Telephone: 1-877-838-7763
Fax: (709) 747-8476

44 Maple Valley Road
Corner Brook Plaza, Corner Brook, NL
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