

COLLECTIVE AGREEMENT

Between

Source Office Furniture & Systems LTD.
("The Employer")

And

United Food and Commercial Workers, Local 1518
("The Union" or "UFCW")

May 1, 2026 to April 28, 2029

Ratified by member vote: March 24, 2026



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ARTICLE 1 – Purposes

1.01 Purposes of Agreement

The following are the purposes of the Agreement:

- a. to establish and maintain an orderly and harmonious relationship between the Employer, the employees and the Union;
- b. to provide a fair and amicable method for final and conclusive settlement without stoppage of work for all disputes between the persons bound by this Agreement.

ARTICLE 2 – Agreement Interpretation

2.01 Employee

In this Agreement, “employee” means an employee in the bargaining unit.

2.02 Savings Clause

If any provision of this Agreement is rendered invalid by statute or by decision of a court or tribunal of competent jurisdiction, such provision shall be severed from this Agreement and the remaining provisions of this Agreement shall continue in full force and effect.

ARTICLE 3 – Scope and Recognition

3.01 Scope

This Agreement applies to all employees of the Employer included in the bargaining unit for which the Union is certified under the Labour Relations Code.

3.02 Recognition

The Employer recognizes the Union as the sole collective bargaining agent for all employees in the bargaining unit.

3.03 Copies of Agreement

The Union shall be responsible for printing this Agreement and for ensuring that each employee receives a copy.

ARTICLE 4 – Union Security and Deduction of Dues

4.01 Union Membership

Each employee must, as a condition of employment, be or become a member of the Union within 30 days following the effective date of this Agreement, or 30 days following the beginning of **their** employment, whichever is later. Each employee shall remain a member of the Union in good standing as a condition of continuing employment.

4.02 New Employee Documentation

The Employer agrees to provide each new employee at the time of hire, a Union Membership Application form and a Dues Check-Off Authorization form, both to be completed by the new employee. Once completed said forms shall be forwarded by the Employer to the Union office. The Union shall be responsible for furnishing the Employer with an adequate supply of blank forms.

4.03 Deduction of Dues

The Employer agrees to deduct from the wages of each employee, upon proper authorization from the employee affected, such initiation fees, union dues, fines and assessments as are authorized by regular and proper vote of the memberships of the Union. The Employer further agrees to automatically deduct union dues from the wages of all new employees. The employee shall, within thirty (30) days after commencement of employment, provide the Employer with a signed authorization for such deductions.

4.04 Remittance of Dues

The Employer agrees to make deductions in each calendar month for the then current month and to remit the aggregate of the amounts deducted to the Union prior to the last day of the month following the month in which the deductions are made. Such remittance shall be accompanied by information specifying the first and last names of the employee, Social Insurance Number, and the amount of each deduction.

In addition to the above, the Employer shall provide the Union, for the period of time being reported, with a complete listing of all of the following:

**New Hires
Terminations
Promotions
Demotions
Employees on extended leave of absence**

Such information shall be supplied by the Employer and in a form acceptable to the parties.

The Employer agrees to include dues deducted during the year on the employee's T4 slip.

4.05 Indemnity

The Union agrees to indemnify the Employer for any fines, dues, initiation fees or assessments improperly deducted and remitted to the Union on instructions to the Employer from the Union if such fines, dues, initiation fees or assessments are found to have been improperly deducted by a court of law or the Labour Relations Board.

ARTICLE 5 – Union Representation

5.01 Recognition of Shop Stewards

The Employer shall recognize up to two (2) Shop Stewards elected by the employees or appointed by the Union. The Union will endeavour to ensure that one Shop Steward works in the warehouse.

5.02 Qualifications

The Shop Stewards shall be employees who have completed their probationary periods.

5.03 Notification

The Union shall notify the Employer in writing of the names of the Shop Stewards; the Employer shall not be required to recognize a Shop Steward until it has been so notified.

5.04 Investigation/Processing of Grievances

A Shop Steward may, within reason, investigate and process grievances or confer with representatives of the Union during regular working hours without loss of pay. Before doing so, the Shop Steward must obtain permission from **their** manager. Such permission will not be unreasonably withheld.

5.05 No Union Activities

Neither the Union nor the employees will engage in any Union activities on Employer premises during working hours, except as provided in this Agreement.

5.06 Union Representatives

An authorized representative of the Union shall have the right to contact employees at the workplace to discuss matters respecting this Agreement or its administration. The Union shall obtain authorization from the Employer as to the appropriate time for such contact before meeting the employee(s). Such authorization shall not be unreasonably withheld. The Union representative agrees to check-in with management when they arrive and when they leave.

5.07 Bulletin Boards

The Employer shall make a bulletin board available for the posting of Union bulletins regarding meetings, appointments of committees, election of officers, seniority lists, dues, entertainment, and health and safety. The Shop Stewards shall be responsible for ensuring that the bulletin board is used in accordance with this Agreement.

5.08 Joint Labour-Management Committee

A Joint Labour-Management (JLM) Committee shall be established, consisting of two employees and two representatives of the Employer. A representative of the Union or the Employer may attend the meetings from time-to-time. Prior notice of such attendance will be provided to the other Party.

The JLM Committee shall meet every second month or as required to engage in a meaningful exchange of ideas and information on matters relating to the workplace that affect the parties or any employee bound by this Agreement. The purpose of the JLM Committee is to promote the cooperative resolution of workplace issues, to respond and adapt to changes in the economy, to foster the development of work related skills and to promote workplace productivity.

Meetings will be held during regular working hours.

ARTICLE 6 – Management Rights

6.01 Management Rights

The Union recognizes and acknowledges that the management of the business and direction of the workforce are fixed exclusively with the Employer and without restricting the generality of the foregoing, the Union acknowledges that it is the exclusive function of the Employer to:

- a. maintain order and efficiency;
- b. hire, promote, demote, classify, transfer, suspend and rehire employees, and to discipline or dismiss any employee for just and reasonable cause;
- c. determine the nature and kind of business conducted by the Employer, the methods and techniques of work, contents of jobs, the number of employees to be employed, the extension of operations or any part thereof;
- d. establish new, and abolish existing, job classifications;
- e. establish job requirements, including the determination of the experience, skills, abilities, training and qualifications required to perform the work;

and to determine and excise all functions which shall remain with the Employer except as specifically limited by the express provisions of this Agreement.

ARTICLE 7 – Employment Status

7.01 Probationary Period

Each regular employee shall serve a probationary period of three (3) months actually worked, commencing with **their** date of hire. If the Company, in its sole discretion, decides that the employee is unsuitable for continued employment, that **their** performance is unsatisfactory, or that the employee is unwilling or unable to properly carry out **their** duties, the Company may terminate the employee's employment at any time during the probationary period.

7.02 Full-Time Regular Employees

Full-time regular employees are regularly scheduled employees who work forty (40) hours per week on a continuing basis.

7.03 Part-Time Regular Employees

Part-time regular employees are regularly scheduled employees who work less than full time hours per week on a continuing basis. Such employees are covered by all provisions of this Agreement, but are not entitled to the Group Benefit Plan.

7.04 Casuals

Casuals are persons who are called into work by the Employer, on an infrequent basis, and who are not obligated to work when required.

Casuals:

- a. Are new employees who are not members of the Union, provided said non-members shall be eligible for membership in the Union and shall make application within ten (10) working days after employment and become members in thirty (30) working days; or
- b. Workers who are not employees of the Employer and will not work in excess of ten (10) working days.

ARTICLE 8 – Seniority

8.01 Definition

Seniority shall mean the length of continuous service with the Employer.

8.02 Seniority Lists

The Employer shall provide the Union with a current seniority list every six months; or when the information is required to determine seniority in order to settle a disagreement.

8.03 Probationers

Seniority shall not accrue during an employee's probationary period. Upon successful completion of the probationary period, the employee's seniority shall be backdated to **their** date of hire.

8.04 Leaving the Bargaining Unit

An employee who leaves the bargaining unit to fill another position with the Employer shall continue to accumulate seniority, and shall have the right to exercise **their** seniority to return to the bargaining unit, for a period of three (3) months. After the expiry of that period, the employee's seniority shall be lost.

8.05 Loss of Seniority

Length of continuous service or seniority can be lost and the employee deemed to be terminated if they:

- a. voluntarily leave the employ of the Employer; or
- b. are discharged and such discharge is not reversed by the grievance procedure; or
- c. are absent without leave for a period greater than four (4) working days without notification; or
- d. after being laid-off by the Employer, fails to report for work when recalled or cannot be located after a reasonable effort on the part of the Employer. The method of contact by telephone, followed by a registered or couriered letter to the employee at their last known address, will constitute a reasonable effort on the part of the Employer and within four (4) working days of receipt of such notice the employee fails to report for duty, or advise the Employer that they will return within five (5) working days, the Employer shall be entitled to assume that the said employee has left the Employer's service voluntarily; or
- e. has been laid-off for a period of:
 - i. three (3) months if less than twelve (12) months' seniority; or
 - ii. six (6) months if twelve (12) months' seniority or greater.

ARTICLE 9 – Hours of Work

9.01 No Guarantee

Nothing in this Agreement shall be construed as a guarantee of work, or of hours of work per day or per week, or of days of work per week. The provisions of this Article are intended to outline the normal or regular hours of work.

9.02 Definitions

A day shall commence at 12:01 a.m. and end twenty-four (24) hours later. A week shall commence at 12:01 a.m. Sunday and end at 12:00 midnight the following Saturday.

9.03 Time Clocks

- a. The Employer shall provide a time clock in order to enable employees to record their time for payroll purposes. Each employee's time is electronically recorded at the start and finish of work and when leaving the premises. Warehouse employees also electronically record the start and end times of their lunch breaks. Drivers and swampers must advise by text message to the manager, or their delegate, their start and end to lunch breaks.
- b. It is each employee's responsibility to ensure that every punch and scan is verified as accurate at the time of the scan.

9.04 Meal Break

An employee who works more than five (5) consecutive hours in one day shall receive an unpaid meal break of one half (1/2) hour's duration. Meal breaks will be arranged between the employee and **their** manager, and shall commence no sooner than three (3) hours, and end no later than five (5) hours, after the beginning of the employee's shift.

9.05 Breaks

The Employer will provide a ten (10) minute paid break in each half of a full-time shift.

9.06 Minimum Pay

The Employer shall pay an employee reporting to work as required by the Employer a minimum in any one day of:

- a. two (2) hours' pay; or
- b. where the employee commences work, a minimum of four (4) hours' pay unless **their** work is suspended because of weather or other reasons completely beyond the control of the Company.

9.07 Available Hours

- a. Preference in available hours of work shall be given to senior employees provided they are available and can perform the work.
- b. The Employer shall not reduce the weekly hours of work of an employee for the purpose of replacing such hours with another employee at a lower hourly rate of pay.

ARTICLE 10 – Overtime

10.01 Overtime Pay

An employee shall receive overtime pay of one and one half (1 ½) times **their** regular hourly wage for all hours worked in excess of:

- a. eight (8) in a day; and
- b. forty (40) in a week.

10.02 Double Time

An employee shall receive overtime pay of two (2) times **their** regular hourly wage for all hours worked in excess of:

- a. twelve (12) in a day.

10.03 Distribution of Overtime

- a. Where planned overtime work is available (i.e. Saturday, Sunday and Statutory Holidays) it shall be offered to qualified employees in order of seniority. In the event that insufficient numbers of employees volunteer, the Employer will allocate overtime by reverse order of seniority provided the employee is qualified.
- b. Drivers/swampers are expected to complete their assigned daily work. Therefore, when unplanned overtime is required at the end of a shift, employees so performing the work shall be required to complete their work, including the Island Run.
- c. Employees who have provided a minimum of twenty-four (24) hours' advance notice to management of an inability to work overtime on any given day, will be exempted from (b) above. Only two (2) employees will be exempted on the same day.

10.04 Authorization Required

No employee is permitted to work overtime hours without authorization by the employee's manager or delegate in advance of the overtime worked.

ARTICLE 11 – Statutory Holidays

11.01 Statutory Holidays

For the purpose of this Agreement, the following days are Statutory Holidays:

New Year's Day	Family Day	Good Friday
Victoria Day	Canada Day	B.C. Day
Labour Day	Nation Day for Truth & Reconciliation	Thanksgiving Day
Remembrance Day	Christmas Day	Boxing Day

11.02 Eligibility

Eligible employees shall receive the day off with pay on a Statutory Holiday. To be eligible for Statutory Holiday pay, an employee must have:

- a. been employed by the Employer for at least 30 consecutive calendar days; and
- b. worked or earned wages for 15 of those 30 calendar days.

11.03 Part-Time or Casual Employees

Statutory Holiday pay for eligible part-time or temporary employees shall be based upon the employee's regular hourly wage rate, multiplied by **their** average daily hours during the last thirty (30) day period prior to the Statutory Holiday.

11.04 Statutory Holiday During Vacation

If a Statutory Holiday occurs during an employee's annual vacation, an additional day's

vacation with pay shall be allowed for each such Statutory Holiday.

11.05 Work on a Statutory Holiday

Work performed on a Statutory Holiday shall be paid at one and one half (1 ½) times **their** regular hourly wage for all hours worked, in addition to regular pay or a paid day off in lieu for that day. All work performed over twelve (12) hours in that day shall be paid at two (2) times **their** regular hourly wage.

ARTICLE 12 – Annual Vacation

12.01 Vacation Entitlement

- a. Employees begin earning vacation upon the commencement of their employment.
- b. Vacation earned during one year is taken during the following calendar year.
 - i. In the first year of employment, employees will earn vacation pay for the balance of that calendar year, to be taken in the following calendar year.
 - ii. Employees who have completed twelve (12) consecutive months of employment will be entitled to two (2) weeks' paid vacation in the following calendar year(s).
 - iii. Employees who have completed five (5) consecutive years of employment shall be entitled to take three (3) weeks' paid vacation in the following calendar year(s).
 - iv. Employees who have completed eight (8) consecutive years of employment shall be entitled to four (4) weeks' paid vacation in the following year(s).
- c. The Employer must ensure an employee takes an annual vacation within twelve (12) months after completing the year of employment entitling the employee to the vacation.
- d. The Employer must allow an employee who is entitled to an annual vacation to take it in periods of one or more weeks.
- e. An annual vacation is exclusive of statutory holidays that an employee is entitled to.

12.02 Vacation Pay

The Employer shall pay annual vacation pay to each employee calculated on the employee's total wages for the year in which the employee earned the vacation, at the rate of 2% for each week of annual vacation to which the employee is entitled.

The Employer will pay full-time employees their vacation pay on their regular pay day during their vacation period.

Vacation pay for part-time and casual employees shall be calculated and paid on each pay cheque.

12.03 Scheduling

- a. Vacations shall be scheduled and taken within a calendar year. Vacations shall be scheduled by classification, and the senior employees within each classification shall be given preference in the selection of vacation periods, subject to the needs of the Employer.
- b. The Employer will post vacation schedules during the first two weeks of October in each year, for vacation in the next calendar year. Employees shall select their vacation periods for that calendar year by October 31st, and the Employer shall confirm the vacation scheduling by November 15th in each year.
- c. Should an employee not select **their** vacation by October 31st, their vacation request will be dealt with on a “first-come first-served” basis and he will not be able to use **their** seniority to bump another employee from **their** pre-selected vacation period.
- d. In the event that an employee has not scheduled vacation by June 1st, the Employer will schedule such vacation at their discretion, after discussion with the employee, to ensure vacation is taken in the calendar year.
- e. Once the approved vacation schedule has been posted, all changes require Employer approval. Employees requesting vacation of any duration, or a change to an existing scheduled vacation, will be required to submit their request in writing two (2) weeks in advance of the time-off requested.

12.04 No Carry Over

Vacations must be taken during the calendar vacation year. Vacation entitlement cannot be banked or carried over from year to year.

ARTICLE 13 – Classifications and Rates of Pay

13.01 Wage Rates

Each employee shall be paid not less than the hourly rate established by Appendix “A” for **their** job classification.

13.02 Working in a Higher Classification

Where the Employer requires an employee to work temporarily in a higher classification, the employee shall be paid the higher rate for the period so employed.

13.03 New Classifications

If the Employer creates a new or different classification, it shall establish a wage rate for that classification. The Employer and the Union will then negotiate regarding the applicable wage rate for the classification. If the Parties cannot reach agreement on a wage rate, the issue will be referred to a single arbitrator to resolve the matter.

13.04 Pay Days and Pay Slips

Employees shall be paid by direct deposit twice monthly, on the 15th (or Friday before) and the last working day of the month.

On that date, the Employer will mail either by Canada Post or electronically or hand

deliver to each active employee an itemized statement of earnings, rate of pay and deductions for the pay period covered.

13.05 Lead Hand

Lead Hands will be appointed by the Employer where it is determined to be required. One of the criteria to be considered when selecting Lead hands will be seniority. Lead Hands shall be paid a premium of one dollar and twenty five cents (\$1.25) per hour in addition to their regular hourly rate of pay, for each hour worked, as outlined in Appendix A. Such premiums will not be included in the calculation of benefits or overtime.

13.06 Forklift Trainer

A Forklift Trainer shall be provided with a premium of one dollar and fifty cents (\$1.50) per hour for each hour spent training as assigned by management.

ARTICLE 14 – Leaves of Absence

14.01 Union Business

- a. A leave of absence of up to two (2) weeks per year without pay will be granted, upon written request by the Union, to two (2) regular employees per year for the purpose of attending to Union business, provided that the Employer's work requirements allow for such leave. The Union will request such leave by giving the Employer at least one month's notice in writing. The Employer will continue to pay employees on such leave on the payroll, and the Employer shall invoice the Union and be reimbursed for all wages and benefits during such leave.
- b. Employees on leave under paragraph (a) above shall continue to accumulate seniority for the period and upon return to work shall be reinstated into the work performed prior to their leave, or to an equal job if the said work has become redundant.
- c. Where an employee is selected to work as a Union Representative, he shall be granted a leave of absence for a period of one (1) year without pay, provided that not more than one (1) employee shall be absent for said leave at any one time. The Union will request such leave by giving the Company at least one month's notice in writing.

14.02 Bereavement Leave

Bereavement leave, for all non-probationary employees, shall be granted to employees in accordance with the *Employment Standards Act*. An employee is entitled to up to five (5) days of paid leave on the death of a member of the employee's immediate family.

Employees may be granted additional leave without pay, upon request.

14.03 Leave Respecting Death of Child

- (1) If a child of an employee dies and the employee requests leave under this section, the employee is entitled to unpaid leave for a period of up to 104 weeks.
- (2) If an employee is charged with a crime that resulted in the death of the employee's child, the employee is not entitled, or, if already on leave, is no longer entitled, to leave under this section.
- (3) A leave under subsection (1) must be taken during the period that starts:

- (a) on the date the child dies, or
 - (b) on the date the child is found dead, in the case of the child disappearing before the child dies, and ends on the date that is 105 weeks after the date referred to in paragraph (a) or (b), as applicable.
- (4) A leave under subsection (1) may be taken by the employee in
- (a) one unit of time, or
 - (b) more than one unit of time, with the employer's consent.
- (5) Despite subsection (3), a leave under subsection (1) ends on the earlier of the following dates, if any apply:
- (a) the date the employee is charged with a crime that resulted in the death of the child;
 - (b) the date that is the last day of the last unit of time in respect of which the employer consents under subsection (4) (b).
- (6) If requested by the employer, the employee must, as soon as practicable, provide to the employer reasonably sufficient proof that the employee's child is dead.

14.04 Compassionate Care Leave and Family Responsibility Leave

Compassionate care and family responsibility leave shall be granted to employees in accordance with the *Employment Standards Act*, as follows.

Compassionate Care

- (1) In this section, "family member" means:
- (a) a member of an employee's immediate family, and
 - (b) any other individual who is a member of a prescribed class.
- (2) An employee who requests leave under this section is entitled to up to 27 weeks of unpaid leave to provide care or support to a family member if a medical practitioner or nurse practitioner issues a certificate stating that the family member has a serious medical condition with a significant risk of death within 26 weeks, or such other period as may be prescribed, after:
- (a) the date the certificate is issued, or
 - (b) if the leave began before the date the certificate is issued, the date the leave began.
- (3) The employee must give the employer a copy of the certificate as soon as practicable.
- (4) An employee may begin a leave under this section no earlier than the first day of the week in which the period under subsection (2) begins.

- (a) A leave under this section ends on the last day of the week in which the earlier of the following occurs: the family member dies;
 - (b) the expiration of 52 weeks or other prescribed period from the date the leave began.
- (5) A leave taken under this section must be taken in units of one or more weeks.
 - (6) If an employee takes a leave under this section and the family member to whom subsection (2) applies does not die within the period referred to in that subsection, the employee may take a further leave after obtaining a new certificate in accordance with subsection (2), and subsections (3) to (6) apply to the further leave.

14.05 Leave Respecting Disappearance of a Child

(1) In this section and section 52.4:

“child” means a person under 19 years of age;

“crime” means an offence under the Criminal Code other than an offence prescribed by the regulations made under section 209.4 (f) of the Canada Labour Code.

- (2) If a child of an employee disappears and it is probable, in the circumstances, that the child’s disappearance is a result of a crime, and the employee requests leave under this section, the employee is entitled to unpaid leave for a period of up to 52 weeks.
- (3) If an employee is charged with a crime that resulted in the disappearance of the employee’s child, the employee is not entitled, or, if already on leave, is no longer entitled, to leave under subsection (2).
- (4) A leave under subsection (2) must be taken during the period that starts on the date the child disappears and ends on the date that is 53 weeks after the date the child disappears.
- (5) A leave under subsection (2) may be taken by the employee in
 - (a) one unit of time, or
 - (b) more than one unit of time, with the employer’s consent.
- (6) Despite subsection (4), a leave under subsection (2) ends on the earliest of the following dates, if any apply:
 - (a) the date on which circumstances indicate it is no longer probable that the child’s disappearance is a result of a crime;
 - (b) the date the employee is charged with a crime that resulted in the disappearance of the child;
 - (c) the date that is 14 days after the date on which the child is found alive;
 - (d) the date on which the child is found dead;
 - (e) the date that is the last day of the last unit of time in respect of which the employer consents under subsection (5) (b).
- (7) If requested by the employer, the employee must, as soon as practicable, provide to

the employer reasonably sufficient proof that the employee's child has disappeared in circumstances in which it is probable the disappearance is a result of a crime.

14.06 Family Responsibility Leave

An employee is entitled to up to 5 days of unpaid leave during each employment year to meet responsibilities related to:

- (a) the care, health or education of a child in the employee's care, or
- (b) the care or health of any other member of the employee's immediate family.

14.07 Maternity and Parental Leave

Pregnancy and Parental Leave shall be granted to employees in accordance with the *Employment Standards Act*, as follows.

Maternity leave

- (1) A pregnant employee who requests leave under this section is entitled to up to 17 consecutive weeks of unpaid leave:
 - (a)
 - (i) no earlier than 13 weeks before the expected birth date, and
 - (ii) no later than the actual birth date and ends no later than 17 weeks after the actual birth date.
- (1.1) An employee who requests leave under this subsection after giving birth to a child is entitled to up to 17 consecutive weeks of unpaid leave, which must be taken during the period that begins on the date of the birth and ends no later than 17 weeks after that date.
- (2) An employee who requests leave under this section after the birth of a child or the termination of a pregnancy is entitled to up to 6 consecutive weeks of unpaid leave, which must be taken during the period that begins on the date of the termination of the pregnancy and ends not later than 6 weeks after that date.
- (3) An employee who requests leave under this subsection is entitled to up to 6 additional consecutive weeks of unpaid leave if, for reasons related to the birth or the termination of the pregnancy, the employee is unable to return to work when the employee's leave ends under subsection (1), (1.1) or (2).
- (4) A request for leave must:
 - (a) be given in writing to the employer,
 - (b) if the request is made during the pregnancy, be given to the employer at least 4 weeks before the day the employee proposes to begin leave, and
 - (c) if required by the employer, be accompanied by a medical practitioner's or nurse practitioner's certificate stating the expected or actual birth date or the date the pregnancy terminated or stating the reasons for requesting additional leave under subsection (3).
- (5) If an employee on leave under subsection (1) (b) (i) must or (1.1) proposes to

return to work earlier than 6 weeks after giving birth to the child, the employer may require the employee to give the employer a medical practitioner's or nurse practitioner's certificate stating the employee is able to resume work.

Parental Leave

- (1) An employee who requests parental leave under paragraph (a), (b) or (d) of this subsection is entitled to:
 - (a) for a parent who takes leave under section 50 in relation to the birth of the child or children with respect to whom the parental leave is to be taken, up to 61 consecutive weeks of unpaid leave beginning immediately after the end of the leave taken under section 50 unless the employer and employee agree otherwise,
 - (b) for a parent, other than an adopting parent, who does not take leave under section 50 in relation to the birth of the child or children with respect to whom the parental leave is to be taken, up to 62 consecutive weeks of unpaid leave beginning after the child's birth and within 78 weeks after that event, and
 - (d) for an adopting parent, up to 62 consecutive weeks of unpaid leave beginning within 78 weeks after the child is placed with the parent.
- (2) If the child has a physical, psychological or emotional condition requiring an additional period of parental care, the employee is entitled to up to an additional 5 consecutive weeks of unpaid leave, beginning immediately after the end of the leave taken under subsection (1).
- (3) A request for leave must:
 - (a) be given in writing to the employer,
 - (b) if the request is for leave under subsection (1) (a) or (b), be given to the employer at least 4 weeks before the employee proposes to begin leave, and
 - (c) If required by the employer, be accompanied by a medical practitioner's or nurse practitioner's certificate or other evidence of the employee's entitlement to leave.
- (4) An employee's combined entitlement to leave under section 50 and this section is limited to 78 weeks plus any additional leave the employee is entitled to under section 50 (3) or subsection (2) of this section.

14.08 Reservists Leave

- (1) In this section:

“Canadian Forces” has the same meaning as in section 14 of the *National Defense Act* (Canada); “Reservist” means a member of the reserve force, as defined in section 2 (1) of the *National Defense Act* (Canada).

- (2) Subject to the regulations, an employee who is a reservist and who requests leave under this section is entitled to unpaid leave, for the period described in subsection (3), if

- (a) the employee is deployed to a Canadian Forces operation outside Canada or is engaged, either inside or outside Canada, in a pre-deployment or post-deployment activity required by the Canadian Forces in connection with such an operation,
 - (b) the employee is deployed to a Canadian Forces operation inside Canada that is or will be providing assistance in dealing with an emergency or with its aftermath, or
 - (c) the prescribed circumstances apply.
- (3) An employee who is a reservist is entitled to take leave under this section for the prescribed period or, if no period is prescribed, for as long as subsection (2) (a), (b) or (c) applies to the employee.
- (4) Subject to subsection (5), a request for leave must
- (a) be in writing,
 - (b) be given to the employer,
 - (i) unless subparagraph (ii) or (iii) applies, at least 4 weeks before the employee proposes to begin leave,
 - (ii) in the case of leave under subsection (2) (a) or (b), if the employee receives notice of the deployment less than 4 weeks before it will begin, as soon as practicable after the employee receives the notice, or
 - (iii) in the case of leave under subsection (2) (c), within the prescribed period, and
 - (c) include the date the employee proposes to begin leave and the date the employee proposes to return to work.
- (5) If circumstances require leave to be taken beyond the date specified in the request under subsection (4) (c), the employee must
- (a) notify the employer of the need for the extended leave and of the date the employee now proposes to return to work, and
 - (b) provide the notice referred to in paragraph (a),
 - (i) unless subparagraph (ii) or (iii) applies, at least 4 weeks before the date the employee had proposed, in the request under subsection (4), to return to work,
 - (ii) in the case of leave under subsection (2) (a) or (b), if the employee receives notice of the extended deployment less than 4 weeks before the date referred to in subparagraph (i), as soon as practicable after the employee receives the notice, or
 - (iii) in the case of a leave under subsection (2) (c), within the prescribed period.
- (6) If an employee who is a reservist proposes to return to work earlier than specified in the request submitted under subsection (4) or the notice provided under subsection (5), if applicable, the employee must notify the employer of this proposal at least one week before the date the employee proposes to return to work.
- (7) An employer may require an employee who takes leave under this section to provide

further information respecting the leave.

- (8) If an employer requires an employee to provide further information under subsection (7), the employee must
- (a) provide the prescribed information in accordance with the regulations, or
 - (b) if no information is prescribed, provide information reasonable in the circumstances to explain why subsection (2) (a), (b) or (c) applies to the employee and provide it within a reasonable time after the employee learns of the requirement under subsection (7).

14.09 Jury Duty

Employees required to attend court as a juror shall be granted leave in accordance with the *Employment Standards Act*.

Employment is deemed continuous while an employee is on leave or jury duty for the purposes of calculating annual vacation entitlement, continuation of benefits including any increases to wages or benefits, the employee would have been entitled to had the attendance as a juror not been required.

14.10 Special Leave

An employee with two (2) or more years' seniority may be granted up to two (2) months' leave without pay for personal reasons, upon written application presented to the Employer at least one (1) month in advance. Permission for such leave shall be solely at the Employer's discretion, but shall not be unreasonably withheld.

- 14.11** It is understood that any employee taking an unpaid Leave of Absence beyond what is permitted in Article 14.10 will have their length of service frozen until they return to work for purposes of the retention bonus.

ARTICLE 15 – Layoff/Recall

15.01 Layoff Procedure

- a. Employees shall be laid off in reverse order of seniority within the affected classification as defined in Appendix A.
- b. If, an employee is laid-off from **their** position has the necessary present ability to perform the work of the least senior employee, **they** may do so. In such cases, the employee shall receive the wage rate for the classification into which **they** moved.

15.02 Recall

Employees shall remain on the recall list as follows:

- a. an employee with less than 12 months' seniority, shall be on the recall list for three (3) months;
- b. an employee with 12 months' seniority or greater, shall be on the recall list for a period of six (6) months.
- c. For the purposes of recall from layoff, the sequence in 15.01 shall be reversed. That being, the last laid-off shall be the first recalled, provided always that they can

perform the work available.

- d. The Employer will make a reasonable effort to contact the employee. The method of contact by telephone, followed by a registered or couriered letter to the employee at their last known address, will constitute a reasonable effort on the part of the Employer. If the employee fails to report for duty within four (4) working days of receipt of such notice, or advise the Employer that they will return within five (5) working days, the Employer shall be entitled to remove the employee from the recall list and considered **them** to have left the Employer's service voluntarily.

15.03 Employee's Responsibility

It is the responsibility of all laid off employees to keep the Employer advised at all times of where and how they can be contacted for recall purposes.

15.04 Rate Upon Recall

Employees recalled to work shall receive the current rate for the classification into which they are recalled.

ARTICLE 16 – Vacancies and Promotions

16.01 Vacancies

Vacancies, of greater than three (3) months, in existing or new classifications for regular employment shall be posted in a conspicuous location for five (5) consecutive working days. The posting will outline the classification, the wage rate and a brief description of the position. All applications for the posted positions must be filed in writing with the Employer by the end of the fifth (5th) working day after the initial posting, on forms supplied by the Company. If in the Company's view there are no suitable applications received by the end of the fifth (5th) working day after the initial posting, the Employer may fill the vacancy from an external source.

16.02 Criteria

Promotions or posted vacancies shall be awarded to the person whom the Employer considers to be the best qualified applicant. In evaluating qualifications, the Employer shall consider such things as the applicant's abilities, skill, past performance, and overall ability to efficiently satisfy the requirements of the job. If, in the Employer's opinion, the qualifications of two (2) or more applicants are equal, then the employee with the greatest seniority shall be awarded the job.

16.03 Trial Period

Employees filling vacancies or obtaining promotions through the procedure outlined above shall serve a trial period of three (3) months in the new position. If, during this trial period, the employee is considered by the Employer to be unsuitable for the new position, or if the employee feels that he cannot do the job, the employee shall be returned to **their** former position or one of equal rank.

ARTICLE 17 – Grievance Procedure

17.01 Definition

"Grievance" means any difference or dispute concerning the interpretation, application, operation or alleged violation of this Agreement, including a question as to whether a matter is arbitrable.

17.02 Purpose of Grievance Procedure

The parties agree that the purpose of the grievance procedure is to identify and seek to resolve grievances as quickly as possible and that there shall be no work stoppages during the term of the Collective Agreement.

17.03 Grievance Procedure

The parties further agree that they will seek, through consultation, to avoid situations that may result in grievances and to resolve as many as possible at Step 1 of the following grievance procedure:

Step 1

Within ten (10) working days of the alleged violation, the employee shall, with the aid of a Shop Steward, attempt to resolve the grievance informally through discussions with **their** immediate excluded manager. The manager shall respond orally within (3) days of the meeting with the employee and their shop steward.

Step 2

If the matter is not resolved at Step 1, the Union shall present the grievance in writing to the Warehouse Manager or delegate, clearly setting forth full particulars of the alleged violation, including the Article(s) involved and the remedy sought. The written grievance must be presented without undue delay following the response at Step 1.

The Warehouse Manager, or designate, will meet with the Union as soon as possible following receipt of the written grievance, in attempt to resolve the grievance. The Warehouse Manager, or designate, shall provide the Union with a written reply as soon as possible after the Step 2 meeting.

Step 3

If the matter is not resolved at Step 2, the Union shall present the written grievance to the General Manager or delegate, without undue delay following receipt of the Step 2 response. The General Manager and their designate shall meet with the Union Representatives or their designate and seek to resolve the grievance.

The Employer shall issue a written reply within ten (10) working days following the Step 3 meeting.

17.04 Referral to Arbitration

If the grievance remains unresolved after the conclusion of Step 3, it may be referred to arbitration. Either party shall notify the other party in writing of its desire to submit the grievance to arbitration within twenty (20) working days of the Employer's response to the Step 3 meeting.

17.05 Policy Grievance

The Union or the Employer shall have the right to initiate a policy grievance, or a grievance involving suspension or termination at Step 3.

17.06 Time Limits

The time allowance may be extended by mutual agreement between the parties.

17.07 Settlements

All settlements arrived at during the grievance procedure shall be final and binding upon

the Employer, the Union and the employee(s) concerned.

17.08 Troubleshooter

The Parties agree to using a Troubleshooter Process as follows:

- a. Either Party may refer a grievance to this process, by providing the other Party with three (3) weeks' notice of a grievance being referred.
- b. Both Parties must agree to use of the Troubleshooter process for the grievance outlined in (a) above.
- c. Irene Holden, Brian Foley or Mark Brown (or any other individual agreed by the Parties) shall be scheduled as required to hear the grievance on an expedited basis.
- d. The Parties agree to share all relevant information regarding the grievance in advance of the troubleshooting hearing.
- e. The Parties will make every effort to develop a Statement of Agreed Facts.
- f. Decisions of the Troubleshooter will be in writing and binding on the Parties with respect to the grievance before the Troubleshooter. However, the decision will not be precedent setting and shall be without prejudice and shall not be publicized.
- g. Legal counsel shall not be used by either Party when using this Troubleshooter process.
- h. The Parties shall bear equally the fees and expenses of the Troubleshooter.

17.09 Expedited Arbitration

At any time prior to arbitration the parties may agree to refer the dispute to Section 104 (Expedited Arbitration). If referred the parties agree that the decision will be final and binding.

The operation of Section 50(2)(3) of the *Labour Relations Code* of British Columbia is hereby excluded.

ARTICLE 18 – Arbitration

18.01 Arbitrator

The Board of Arbitration shall be composed of a single Arbitrator. (The parties may, by mutual consent, agree upon a three (3) person Board of Arbitration.)

18.02 Submission

Grievances submitted to the Arbitrator shall be in writing and shall clearly specify the nature of the issue.

18.03 Jurisdiction of Arbitrator

In reaching its decision, the Arbitrator shall be governed by the provisions of this Agreement. The Arbitrator shall not be vested with the power to change, modify or alter this Agreement in any of its parts, but may, however, interpret its provisions.

18.04 Binding Decision

The findings and decision of the Arbitrator shall be binding and enforceable upon the parties.

18.05 Cost of Arbitrator

The Union and the Employer shall bear equally the fees and expenses of the Arbitrator.

ARTICLE 19 – No Strikes/No Lockouts

19.01 Lawful Union Activity

No employee shall be discharged or discriminated against for any lawful union activity or for serving on a Union committee outside of business hours or for reporting to the Union the violation of any provision of this Agreement.

19.02 Prohibition

There shall be no strikes or lockouts during the term of this Agreement.

ARTICLE 20 – Health and Safety

20.01 Health and Safety

- a. The Employer shall make reasonable provisions for the health and safety of employees during their hours of employment.
- b. The Employer agrees to comply with the requirements of *Worksafe BC Occupational Health and Safety Regulations, First Aid Regulations* and *Occupational Environment Regulations*. In accordance with Part 3, Sections 3.12 and 3.13 of *Worksafe BC Regulations*, employees have the responsibility to advise management when they believe the work may be unsafe.

20.02 Joint Health and Safety Committee

A Workplace Joint health and Safety Committee shall be chosen and act in accordance with the *Workers' Compensation Act*. The worker representatives on the Committee shall be elected or chosen by the Union. Worker representation on the Committee shall be equal to or greater than Employer representation.

20.03 First Aid Premium

Employees designated by the Employer who successfully complete an Industrial First Aid course shall be given a premium of thirty dollars (\$30.00) per week. The Employer shall pay for the cost of enrollment and compensate the employee to a maximum of eight (8) hours per day at their regular hourly rate while attending the course.

20.04 Safety Inspections

The Employer agrees that when a WCB inspector arrives at the warehouse for the purposes of an inspection visit or attending to the investigation of an accident, a Union Safety Committee member shall be informed and given the opportunity to meet with the Inspector, for the duration of the warehouse tour.

20.05 Safety Footwear

The Employer agrees to provide a footwear allowance of two hundred dollars (\$200.00) each twelve (12) month period to employees who have completed their probationary period. The employee shall receive reimbursement up to this amount upon presentation

of a receipt.

20.06 First-Aid Kits for Trucks

All trucks shall be supplied with first-aid supplies and trucks shall comply with all *Worksafe BC Regulations Part 16 (Mobile Equipment)*. It is the driver's responsibility to ensure the first-aid kit is properly stocked and inform management of any requirements.

ARTICLE 21 – General

21.01 No Discrimination

The Union and the Employer agree that they shall not discriminate against employees in the administration of this Agreement on any of the grounds prohibited by the *Human Rights Code*, which include: *race, colour, ancestry, place of origin, political belief, religion, marital status, family status, physical or mental disability, sex, sexual orientation or age of that person or because that person has been convicted of a criminal or summary conviction offence that is unrelated to the employment or to the intended employment of that person.*

21.02 No Conflicting Agreements

No employee shall be asked to make any written or verbal contract which conflicts with this Agreement.

21.03 Employee's Personnel File

Subject to giving the Company advance notice, employees shall have access to their personnel file in accordance with the *Personal Information Protection Act of BC*. The employee may be accompanied to view this file by their Union Steward or Union Representative. The time spent viewing the file will be the employee's own time.

21.04 Accommodation for Religious Reasons

- a. Employees may request time off to observe religious holidays. The Employer will make every effort to provide such time off. Such requests should be at least one week in advance and only two (2) employees may be absent on the same day.
- b. Such time off shall be without pay, however, an employee may choose to use any vacation time owing.

21.05 Medical Reports

Where an employee has displayed a regular pattern of absenteeism, he shall supply the Employer, upon request, with a medical report from **their** doctor. Effective December 5, 2018, the Employer's contribution to an employee's cost of a medical report requested by the Employer shall be up to one hundred dollars (\$100.00), upon presentation of a receipt by the employee.

21.06 Staff Meetings

When the Employer schedules a staff meeting, such meetings will be considered as time worked and paid for at the employee's applicable straight time rate.

21.07 Union Decal

The Employer agrees that during the term of this Agreement it will permit the Union to supply and hang its Union decal. Such decal shall be displayed in a prominent position on the bulletin board.

21.08 Picket Lines

All employees covered by this Agreement shall have the right to refuse to cross legal picket lines. However, in the event that employees are confronted by picket lines which block their entry to the Employer and does not involve a dispute with the Employer, the employees shall telephone the Employer and the Union immediately for instructions.

21.09 Performance Appraisals

- a. Staff performance reviews are not part of the disciplinary process. Where a formal review of an employee's performance is carried out, the employee shall be provided with a copy to read and review. At the end of the performance review meeting, the employee shall sign the form indicating that the performance review meeting took place with the manager. The employee shall receive a copy of the report at the time of signing.
- b. The employee has the right, within seven (7) calendar days, to provide any written response or comments to the performance review. This response must be signed and dated by the employee and shall be appended to the review and maintained on the employee's personnel file.
- c. Performance reviews will be conducted up to two (2) times in a calendar year. All performance review meetings will be conducted during work time.

21.10 Drivers

The Employer will maintain the deliveries carried out by Sasa Boskovic and Zoran Kirov until such time as either employee leaves the Company or takes up another position in Source. In addition, and for as long as Sasa Boskovic and Zoran Kirov are driving, the Company will maintain and service the two (2) delivery truck(s).

21.11 Meal Allowance – Island Run

Effective December 5, 2018, the meal allowance for drivers shall be thirty dollars (\$30.00) per day for each employee.

ARTICLE 22 – Health and Welfare Benefits

22.01 Group Benefit Plan

The Employer shall make arrangements with an insurance carrier to provide a group benefit plan for all employees covered by this Agreement. The selection of the insurance carrier is in the sole discretion of the Employer.

22.02 Group Benefit Plan Booklet

The provisions of the group benefit plan are described in the Group Benefit Plan Booklet issued by the insurance carrier from time to time. The Employer shall provide an up-to-date copy of the Booklet to each employee covered by this Agreement.

22.03 Limitation of Liability

The obligation of the Employer under the health and welfare provisions of this Agreement is restricted to the payment of premiums, or portions of premiums, as applicable, to the insurance carrier. Neither the benefits outlined in the Booklet, nor the insurance policies governing the application of the benefits, form part of this Agreement. All benefits are subject to the conditions of eligibility and any other limitations expressed in the insurance carrier's policy. The Employer has no responsibility for the

administration of any insurance policy.

22.04 Eligibility

Employees become eligible for enrolment in the coverage outlined in this Article upon successful completion of Probation, subject to any eligibility restrictions contained in the applicable plans. Participation in the Group Benefit Plan is optional.

22.05 Premium Payments

The Employer shall pay **one-hundred** percent (**100%**) of the premium cost. Amendments to the Employer's existing health care benefits plan coverage and premiums will apply to all employees in the bargaining unit whenever such changes are introduced during the term of the collective agreement.

22.06 Benefit Coverage

The benefits provided will be as outlined in the Group Benefits Plan Booklet, as detailed in Appendix C.

22.07 Sick Pay

a. Employees who are sick or injured and unable to attend work for a reason which compensation is not payable under WorkSafe BC, will receive up to five (5) day's pay per calendar year. The five (5) sick days will accrue effective January 1st of each year. Fifty percent (50%) of any unused sick time will be paid out at the end of each calendar year, on the first payday the following January.

b. Reporting

An employee shall be required to report in, by telephone or text, to the manager, as far in advance of the start of their shift as possible. Failure to report such absence may jeopardize the employee's right to sick pay.

ARTICLE 23 – Duration

23.01 Term

The term of this Agreement shall be from **May 1, 2026** to and including **April 28, 2029**.

23.02 Notice to Bargain

Either party to this Agreement may at any time within four (4) months immediately preceding the expiry of this Agreement, by written notice require the other party to commence collective bargaining. Should either party give notice to bargain, this Agreement shall thereafter continue in full force and effect and neither party shall make any changes in the terms of the said Agreement, or increase or decrease the rate of pay of any employee for whom the collective bargaining is being conducted, or alter any other term or condition of employment until:


- a. The Union commences a lawful strike in compliance with the *Labour Relations Code* of British Columbia, or
- b. The Company commences a lawful lock-out in compliance with the *Labour Relations Code* of British Columbia.

23.03 Exclusion

The parties agree to exclude the operation of subsections (2) and (3) of Section 50 of the Labour Relations Code.

SIGNED THIS 12th DAY OF June, 2026.

For the Union
UFCW 1518



Patrick Johnson
President

For the Employer
Source Office Furniture & Systems Ltd.



Matt Stewart
President

Appendix A – Wage Rates

Position	Current	8-May-26	8-May-27	8-May-28	8-May-29	Retention Table	
		4.50%	2.00%	2.50%	2.50%	Years of Service	Addition
Service Tech	\$26.04	\$27.21	\$27.76	\$28.45	\$29.16	4	\$0.50
Delivery Driver	\$24.36	\$26.09	\$26.61	\$27.28	\$27.96	8	\$0.50
Machine Operator	\$23.97	\$25.05	\$25.55	\$26.19	\$26.84	10	\$0.50
Assembler	\$23.24	\$24.29	\$24.77	\$25.39	\$26.03	15	\$0.50
Warehouseperson/Swamper	\$23.07	\$24.11	\$24.59	\$25.21	\$25.84		

Current Drivers will receive an additional 2.5% increase in 2026 on top of the 2026 percentage increase.

Any employee overscale shall be entitled to the same wage increases on the dates as noted above, as well as, the retention increases.

RENEWED THIS 12th DAY OF June, 2026.

For the Union
UFCW 1518

For the Employer
Source Office Furniture & Systems Ltd.



Patrick Johnson
President



Matt Stewart
President

APPENDIX B – Source Office Furniture Harassment Policy

Revised March 1, 2009

Source Office Furnishings is committed to providing a workplace free from harassment based on race, creed, color, national origin, political or religious affiliation, gender, sexual orientation, marital status, family relationship, disability and other personal characteristics or circumstances that are clearly unrelated to a person's ability to do their job.

Definition of “Workplace Harassment”

The workplace includes all locations where business or social activities of the group are conducted. Workplace harassment can also include incidents that happen away from work (e.g. unwelcome phone calls or visits to a person's home if the harasser is in some way connected to the group). Source is committed to protecting its employees from harassment by customers, other employees and members of the public at large.

Harassment is considered a form of discrimination. Harassment will be considered to have taken place if a reasonable person ought to have known that such a behavior was unwelcome. Harassment may result from one incident or a series of incidents. It may be directed at a specific individual or groups but may also include any comments or conduct that create an environment that is hostile, intimidating or offensive. Harassment can include, but is not limited to, the following examples:

- Racial or ethnic slurs
- Written or verbal abuse or threats
- Unwelcome sexual remarks, invitations or requests
- Unwelcome remarks, jokes, taunts or suggestions about a person's body, age, marital status, ethnic or racial origin, religion, sexual orientation etc.
- Displays of pornographic, sexist, racist or other offensive or derogatory material (e.g. graffiti or pictures)
- Practical jokes that result in embarrassment or insult
- Leering (suggestive staring) or other offensive gestures
- Unwanted physical contact
- Vandalism of personal property
- Patronizing or condescending behavior
- Physical or sexual assault

Right to complain

Anyone has a right to complain about a situation they believe to be harassment; there will be no reprisals for doing so. However, disciplinary action may be taken against complaints filed maliciously or repeated false complaints.

Who may complain?

Generally, complaints should be filed by the victim of the alleged harassment or discrimination. However, complaints can also be made by a group of people who may have been subject to the same offensive treatment, by co-workers who witnessed the incidents or by a third party complaining on behalf of the victim.

Options available to employees

- If at all possible tell the harasser to stop.
- Keep a record- time, date, place etc. Name witnesses if there are any.
- Seek advice from co-workers.
- Bring the complaint to the attention of management.

RENEWED THIS 12th DAY OF June, 2026.

For the Union
UFCW 1518

For the Employer
Source Office Furniture & Systems Ltd.



Patrick Johnson
President



Matt Stewart
President

APPENDIX C – Source Office Furniture Group Benefits Plan

Enrollment Process

Employees who have successfully completed their probation will receive a notice of eligibility for Group benefits. Employees must select to join the Group Benefit Plan or not, in writing.

Employees who select to join the Group benefit Plan will meet with the Office Manager to complete their sign-up.

Employees will then be set-up on-line as a member of the Source Office Furniture Group Benefit Plan. Drug cards and other documentation will be sent directly to the employee's home address.

To Make a Claim

To make a claim, employees will use the drug card or submit a claim on-line or use a claim form and mail it to the insurance company. The Office Manager is available for assistance with this process.

Group Benefits

Per attachment

RENEWED THIS 12th DAY OF June, 2026

For the Union
UFCW 1518



Patrick Johnson
President

For the Employer
Source Office Furniture & Systems Ltd.



Matt Stewart
President



Your group insurance plan



SOURCE OFFICE FURNITURE & SYSTEMS INC.

Policy No. 647331

Burnaby Warehouse Employees



Your Group Insurance Plan

SOURCE OFFICE FURNITURE & SYSTEMS INC.

Policy No. 647331

Burnaby Warehouse Employees

This document is an integral part of the Insurance certificate. It is a summary of your Group Insurance Policy. Only the Group Insurance Policy may be used to settle legal matters.

Booklet published on May 5, 2025

YOU SHOULD KNOW

WHAT HAPPENS WITH THE DRUGS COVERAGE AT AGE 65?

At 65 years of age, the Participant may be covered under the provincial health plan of their province of residence for drugs and other products included in this plan's list.

Where allowed by law, they may opt out of their provincial health plan and remain covered under the Extended Health Care benefit of the group benefit plan. If so, the Participant must notify DFS of their choice, in writing, within 31 days of their 65th birthday:

- continue coverage under the group benefit plan and the required premium will be determined by DFS,

or

- choose their provincial health care plan. They might then no longer be covered under the group benefit plan for drugs and other products included in their provincial health plan's list. This election is irrevocable.

The Participant must communicate with the administrator of the plan to obtain additional information.

IMPORTANT: Dependents cannot continue their coverage under the Extended Health Care Benefit unless the Participant remains covered.

TRAVELS ABROAD

A person must be covered under a provincial health plan in Canada to be eligible under the Travel Insurance.

The Participant must contact DFS if the duration of the trip is expected to be more than 180 days. Failing to do so can lead to the person travelling not being covered.

ACCESS TO THE POLICY

Upon request to DFS, the Participant may obtain a copy of the policy and, if applicable, their application and their insurability report.

CONTACT

US HEALTH AND DENTAL INQUIRIES

There are 2 ways to reach us for any question about Eligible Expenses under the Extended Health Care Benefit or the Dental Care Benefit:

By e-mail at: Groupservice@dfs.ca

By phone at: 1-800-263-1810

For a better experience, it is important to have the policy number and the certificate number ready when an agent is available to take the call.

HEALTH ASSISTANCE

Health Assistance is a confidential telephone service that is available 24 hours a day. This phone consultation service provides the Covered Person with a quick solution when non-emergency health issues arise. Qualified nurses are standing by to answer questions and give advice.

This telephone service provides the Covered Person with information on the following topics:

- General health
- Medical and natural remedies
- Local government resources
- Vaccinations
- Childcare

Health Assistance should be considered as a medical information complement. In the event of medical emergency, the nurse will recommend that the caller hang up and dial 911.

This information service may be of use in improving the quality of life of the Participant and their Dependents.

The Covered Person may contact HEALTH ASSISTANCE at any time.

Calls from

Dial

Anywhere in
Canada

1-877-875-2632

TRAVEL ASSISTANCE SERVICE

"Travel Assistance" will take the necessary steps to provide the following services to any Covered Person who requires them:

- 1) 24-hour toll-free telephone assistance,
- 2) referral to Physicians or health-care facilities,
- 3) assistance for Hospital admission,
- 4) cash advances to the Hospital when required by the facility,
- 5) repatriation of the Covered Person to their home city, as soon as their state of health permits it,
- 6) establishing and staying in contact with DFS,
- 7) handling arrangements in the event of death,
- 8) repatriation of the Children of the Covered Person, if the Covered Person cannot be moved,
- 9) delivery of medical assistance and drugs to a Covered Person who is too far from health care facilities to be transported there,
- 10) arrangements to bring a member of the Immediate Family to the bedside of the Covered Person who must be confined to Hospital for at least 7 days, provided that such visit is ordered by the attending Physician,
- 11) assistance in replacing lost or stolen travel documents so that the Covered Person can continue their trip,
- 12) referral to lawyers if legal problems arise,
- 13) translation services for emergency calls,
- 14) transmission of urgent messages to close friends or family in case of emergency, or
- 15) information prior to departure concerning passports, visas and vaccinations required in the country of destination.

In the event of a **MEDICAL EMERGENCY**, the Covered Person must contact the travel assistance firm immediately.

Calls from	Dial	
Montreal area		(514) 875-9170
Canada and United States		1-800-465-6390 (toll-free)
Elsewhere (excluding North and South America)	overseas code +	800 29485399 (toll-free)
Collect call (Anywhere worldwide)		(514) 875-9170

GENERAL INQUIRIES

To obtain any other information, visit the "Contact us" section of DFS's website at www.desjardins.com.

HOW TO FILE A COMPLAINT

If a Participant is unhappy about something we've said or done, feels they have been wronged, or wants us to take corrective action, they can file a complaint with the Complaint handling team at DFS. The role of the team is to evaluate the merit of the decisions and practices of the company when one of its customers believes they have not received the service to which they were entitled.

There are 3 ways to reach the Complaint handling team:

<p>In writing, at the following address:</p> <p>Complaint handling team Desjardins Financial Security 100, rue des Commandeurs Levis (Quebec) G6V 7N5</p> <p>By e-mail at: complaints@desjardins.com</p> <p>By phone at: 1-877-838-8185</p>

For further information on the procedure to follow in case of complaint, or to obtain the complaint form, visit the "Contact us" section of DFS's website at www.desjardins.com.

DEFINITIONS

Wherever these terms are used in the policy, they are interpreted in agreement with the following. They apply to the entire policy unless otherwise specified.

Accident

A sudden and unexpected external event causing bodily injuries directly and independently of all other causes. An Accident does not include any form of disease, degenerative process, hernia (inguinal, femoral, umbilical or incisional) and any infection except when caused by a visible, external cut or wound accidentally sustained. A Physician must verify the bodily injuries.

Actively at Work

The performance by the Employee of all the usual and customary duties of their occupation for the scheduled number of hours. An Employee is considered Actively at Work during a paid leave or a statutory holiday.

Child

A person residing in Canada who, at the time of the event that results in a claim, has no spouse and is dependent upon the Participant or the Spouse for financial support and maintenance. A Child must be the Participant's or the Spouse's natural or adopted child. This also includes a child under the Participant's or the Spouse's parental authority or legal guardianship.

This Child must:

- 1) be under 21 years of age,
- 2) be under 26 years of age and a full-time student at an accredited educational institution, or
- 3) have reached the age of majority and be incapacitated due to a mental or physical disability on the date they were eligible as either 1) or 2) above.

The Child is considered incapacitated if they are incapable of engaging in any substantially gainful activity and are dependent upon the Participant or the Spouse for financial support and maintenance due to a mental or physical disability. In addition, they must be living with the Participant or the Spouse who exercises parental authority or have legal guardianship as if the Child were a minor.

Chronic Care Establishment
<p>An institution in Canada designated as such by law and recognized by DFS, and which:</p> <ol style="list-style-type: none"> 1) provides care and treatment to the chronically ill under the supervision of a Physician, 2) provides the services of a registered nurse on-site and on duty 24 hours per day, and 3) maintains daily records of each patient under the care of a Physician. <p>Without limitation, this term does not include an active treatment Hospital as designated by law, rest home, Convalescent or Rehabilitation Centre, home for the aged, sanatorium or a place for the care and treatment of alcoholism, drug addiction or any other dependency.</p>
<p>An institution in Canada designated as such by law and recognized by DFS, and which:</p> <ol style="list-style-type: none"> 1) provides care and treatment to patients under the supervision of a Physician or a registered nurse, 2) provides the services of a registered nurse on site and on duty 24 hours per day. and 3) maintains a daily record of each patient under the care of a Physician. <p>Without limitation, this term does not include a home for the aged, chronically ill, mentally ill, rest home or a place for the care and treatment of alcoholism, drug addiction or any other dependency.</p>
Covered Person
The Participant or their Dependent.
Day surgery
Outpatient surgery that allows an individual to return home on the same day as the surgical procedure is performed by a Physician. The procedure must require local or general anesthesia. This does not include minor surgery performed in the office of a Physician.
Deductible
The amount of eligible expenses that a Covered Person must pay before reimbursement is made.

Dentist
A person licensed to practice dentistry by the appropriate authority in the jurisdiction where the services are provided.
Dependent
A Spouse or Child who resides in Canada. However, if a Dependent resides outside Canada they will be deemed to reside in Canada provided they are covered under a provincial medical plan in Canada and prior written approval is obtained from DFS.
Earnings
The regular rate of pay paid by the Employer, including dividends. Non-regular bonuses, non-regular overtime pay and any other non-regular remuneration are excluded. For an Employee whose pay is derived in whole or in part from commissions or dividends, Earnings means the average regular rate of pay of an Employee paid by the Employer including commissions and dividends as shown on the income taxation slips of the Employee for the previous 2 calendar years. If employed less than 2 years but more than one, Earnings will be averaged over the length of time employed. If employed less than one year, Earnings will be the regular rate of pay of the Employee as reported by the Employer.
Elements (forces of nature)
Natural disasters such as an earthquake, storm, flood, landslide or any other disaster of a similar nature.
Employee
A person residing in Canada and employed by the Employer on a full-time or part-time and permanent basis.
Employer
The Policyholder or any organization designated by the Policyholder and approved by DFS.
Equivalent Drug
A brand or generic drug, deemed interchangeable under the provincial law applicable where the drug is sold.

Evidence of Insurability
Any statement of an individual's physical health or other factual information that could have a bearing on the acceptance of the risk. Only Evidence of insurability forms approved for use by DFS are acceptable.
Family Member
The Covered Person's spouse, son, daughter, father, mother, brother, sister, step-father, step-mother, step-son, step-daughter, father-in-law, mother-in-law, grandfather, grandmother, grandchild, half-brother, half-sister, brother-in-law, sister-in-law, son-in-law, daughter-in-law, uncle, aunt, nephew and niece.
Family Related Leave
Any leave of absence from work taken by a Participant in line with any provincial or federal legislation, or an agreement between the Participant and the Employer.
Hemiplegia
The total and irrecoverable paralysis of upper and lower limbs on the same side of the body.
Hospital
Any institution designated as a Hospital by law, recognized by DFS and providing 24 hours per day: 1) medical and surgical treatment for sick or injured individuals, and 2) nursing care. Without limitation, this term does not include a nursing home, home for the aged or chronically ill, a rest home, Convalescent/rehabilitation Centre or a place for the care and treatment of alcoholism, drug addiction or any other dependency.
Hospitalization
To be admitted to a Hospital as an inpatient, or any Hospital stay for Day Surgery.
Illness
Any health deterioration or bodily disorder verified by a Physician. Organ donations and related complications are also considered illnesses.

Immediate Family Member
Spouse, son, daughter, father, mother, brother, sister, step-father, step-mother, step-son, step-daughter, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law, of the Participant.
Immediate Relative
The Covered Person's spouse, son, daughter, father, mother, brother or sister.
Insurer
Desjardins Financial Security Life Assurance Company, hereafter, DFS, with its head office at 200 rue des Commandeurs, Levis (Quebec) G6V 6R2.
Irreversible
A permanent medical condition at the time of diagnosis.
Lass
<ol style="list-style-type: none"> 1) For an arm, the complete severance through or above the elbow. 2) For a finger, the complete severance of 2 entire phalanges of one finger. 3) For a foot, the complete severance through or above the ankle joint but below the knee joint. 4) For a hand, the complete severance through or above the wrist but below the elbow joint. 5) For hearing, the complete and irrecoverable loss of hearing in one ear diagnosed by a duly qualified otolaryngologist and corresponding to an auditory threshold of greater than 90 decibels. 6) For a leg, the complete severance through or above the knee joint. 7) For sight, the total and irrecoverable loss of sight of one eye diagnosed by a duly qualified ophthalmologist, corresponding to a corrected visual acuity of 20/200 or less, or to a field of vision of less than 20 degrees. 8) For speech, the total, permanent and irreversible loss of the ability to speak due to injury or disease for a continuous period of 6 months. The diagnosis must be made by a licensed Physician.

- 9) For a thumb, the complete severance of one entire phalanx of the thumb.
- 10) For a toe, the complete severance of one entire phalanx of the big toe and all phalanges of the other toes.

Loss of Use

The total and irrecoverable loss of use of a limb that continues uninterrupted for at least 12 months.

Maternity Leave

Any leave of absence from work due to pregnancy as in agreement with any labour standards type legislation in effect in the Participant's province of residence.

The period of Maternity Leave includes 2 phases:

- 1) the "health related portion" that begins on the date of delivery and continues for 6 weeks (8 weeks for a Caesarean delivery). During this phase, the Participant is deemed Totally Disabled, and
- 2) the voluntary leave phase that follows the "health related portion". It ends when the Participant ceases to receive maternity benefits under any provincial or federal legislation.

Medical Emergency

Any acute and unexpected illness or injury requiring immediate medical treatment.

Orthosis

A rigid orthopaedic appliance or apparatus used to maintain a part of the body in the correct position.

Palliative Care Establishment

An institution in Canada designated as such by law and recognized by DFS, and which:

- 1) provides care and treatment to patients under the supervision of a Physician, mainly during the terminal phase of their illness,
- 2) provides the services of a registered nurse on site and on duty 24 hours per day, and
- 3) maintains daily records of each patient under the care of a Physician.

Without limitation, this term does not include an active treatment Hospital as designated by law, extended care facility, rest home, Convalescent or Rehabilitation Centre, home for the aged or the chronically ill, sanatorium or a place for the care and treatment of alcoholism, drug addiction or any other dependency.

Paraplegia
The total and irrecoverable paralysis of both lower limbs.
Parental Leave
Any leave of absence from work taken by a Participant to take care of their newborn or adopted child, as in agreement with any provincial or federal labour standards type legislation, or other period agreed to by the Participant and the Employer.
Participant
An Employee covered under the policy.
Physician
A qualified medical practitioner who is legally licensed to practice medicine by the jurisdiction in which they operate.
Policy holder
The company or organization specified on the cover page of the policy.
Quadriplegia
The total and irrecoverable paralysis of both upper and lower limbs.
Reasonable and Customary Charges
<p>The charges generally paid for a like service or supply and limited to the lowest of:</p> <ol style="list-style-type: none"> 1) the usual charge in the area where the services or supplies are provided, or 2) the suggested fee of the applicable governing body, <p>on the date the expenses were incurred. For expenses incurred outside Canada, Reasonable and Customary Charges are those applicable in the province where the Participant resides.</p>

Specialist

A Physician practicing in Canada (or in the United States for the Critical Illness Benefit) certified as a specialist through the completion of certifying examinations in the applicable jurisdiction. The Specialist must be certified in the specific area of medicine relevant to the diagnosis for which a claim is made. In the absence or unavailability of a Specialist, the diagnosis or the necessity of a surgery may be established by a Physician practicing in Canada (or in the United States for the Critical Illness Benefit), as approved by DFS. The Specialist must not be the Covered Person, a business associate or a Family Member of the Covered Person.

Spouse

A person residing in Canada who, at the time of the event that results in a claim:

- 1) is legally married to or living in a civil union with the Participant,
- 2) is living with the Participant in a conjugal relationship for at least 12 months and has not been separated from the Participant for 90 days or more for a breakdown in the relationship, or
- 3) is living in a conjugal relationship with the Participant who is the natural parent of the Spouse's Child and has not been separated from the Participant for 90 days or more for a breakdown in the relationship.

If 2 individuals fit the definition of Spouse, DFS will recognize only one Spouse as eligible. Recognition is in the following order:

- 1) the Spouse whom the Participant last designated as such, subject to approval of any Evidence of insurability required under the policy, or
- 2) the Spouse to whom the Participant is legally married or with whom the Participant is living in a civil union.

Stable

The health condition of a Covered Person who within 30 days prior to the Trip departure date is not affected by any medical condition or is affected by a medical condition that:

- 1) does not require a change or no change is recommended in the treatment or dosage of prescribed drugs that may affect the medical condition significantly during the Trip, and
- 2) does not demonstrate any symptoms that indicate a significant deterioration of the medical condition during the Trip.

Subcontractor

The company that provides the Virtual Healthcare Service.

Survival Period
Except if otherwise indicated, the 30-day period immediately following diagnosis or surgery. At the end of 30 days, the person must be alive and not have experienced the complete and irreversible loss of brain function. Any days on life support are not included. Life support means the regular care of a Physician for nutritional, respiratory and/or cardiovascular support, when irreversible cessation of all functions of the brain has occurred.
Total Disability or Totally Disabled
<p>1) during the first 24 months of disability, a state of incapacity resulting from an Illness or Accident that entirely prevents the Participant from performing the essential duties of their own occupation,</p> <p>2) after the first 24 months of disability have elapsed, a state of incapacity, resulting from an Illness or Accident, that entirely prevents the Participant from working in any occupation that they are suited for by education, Training and Experience.</p> <p>Training and Experience means all of the knowledge and skills the Participant acquired while in school, in the performance of their current or former professional activities or during their non-working hours.</p> <p>A Participant is not considered disabled simply because an occupation that they are suited for by education, Training and Experience is not available in the area where they reside.</p> <p>A Participant who needs a government issued driver's license to perform the duties of their occupation is not considered disabled simply because their license has been revoked or not renewed.</p>
Travelling Companion
A person age 18 or older who is not a Dependent Child and who is sharing travel arrangements with the Covered Person.
Travel Service Supplier
A travel agency, a travel wholesaler, a travel package organizer, a cruise operator or an airline that has a valid license and operating certificate issued by the appropriate Canadian or foreign authorities.

Trip
Any fixed period of time that: 1) arrangements have been made with any Travel Service Supplier, or 2) reservations have been made by the Covered Person for ground travel usually included in a travel package.
Vehicle
A car, a motor home or a van with a maximum load of 1,000 kilograms.

GENERAL PROVISIONS

MODIFICATION TO GOVERNMENT PLANS

If DFS's obligations under the policy are increased due to a modification to government plans, the policy continues to apply as if government plans did not change, unless otherwise agreed in writing by the Policyholder and DFS.

APPLICABLE LAWS AND JURISDICTION

Any provision under the policy that is not compliant with applicable laws is presumed void. Even if a provision prohibited by law is included in the policy, all other provisions of the policy will still remain in force.

The policy, its interpretation, execution, application, validity and effects are subject to the applicable Canadian or provincial laws that govern, partially or totally, all of its provisions.

Any dispute resulting from its conclusion, interpretation or execution will be exclusively submitted to the competent court in the Canadian province agreed upon between the parties.

INCONTESTABILITY

If the coverage of a person is in force for a period of 2 years while that person is alive, DFS cannot contest the validity of this coverage based on any written statement given unless it refers to age or is fraudulent. However, if a disability occurs during the first 2 years of coverage, the foregoing does not apply and DFS can cancel or limit all related claims owed.

MISSTATEMENT OF AGE

If the age of any individual has been misstated, any benefits payable are based upon the actual age of the individual at the time of the event that results in a claim. Premium adjustments are made for the full time such coverage is in force.

CURRENCY

All payments under the policy, whether to or by DFS, are made in the lawful currency of Canada.

NUMBER AND GENDER

Where the context clearly requires, words in the singular include the plural. In addition, the policy is gender neutral.

ELIGIBILITY

EMPLOYEE ELIGIBILITY

An Employee is eligible for coverage on the date they meet the following requirements:

Number of hours worked per week	Waiting Period
20 hours	3 months of continuous service for the Employer

DEPENDENT ELIGIBILITY

If an Employee already has a Dependent on the date they are eligible for coverage under the policy, that Dependent is also eligible for coverage on that date.

If an Employee does not have Dependents on the date they are eligible for coverage under the policy, Dependents are eligible for coverage on the date the Employee first acquires a Dependent.

Dependents cannot be covered unless the Participant is, except for the optional benefits or if the Dependent is covered under a survivor benefit provision.

APPLICATION

The policy contains a Beneficiary provision that removes or restricts the right of the Participant to designate persons to whom or for whose amounts are to be payable for some benefits.

COVERAGE APPLICATION

Application for coverage is mandatory for any employee who meets the eligibility requirements.

1) Application within the time limit

An Employee must complete the required application form within 31 days of the date they are eligible.

2) Late application

a) All Benefits other than Dental Care Benefit

If application is not completed within the time limit specified above, the Employee may be required to submit Evidence of insurability.

b) Dental Care Benefit

If the Employee applies for coverage for themselves or their Dependents more than 31 days after the date they are eligible, DFS may limit the amount reimbursed for Eligible Expenses according to the EXCLUSIONS, RESTRICTIONS AND LIMITATIONS provision of the Dental Care Benefit.

Evidence of insurability

Evidence of insurability satisfactory to DFS is required for any amount exceeding the Maximum without Evidence of insurability for the Basic Life Benefit, if application for coverage is completed within the time limit.

Evidence of insurability satisfactory to DFS is required in any of the following instances. This applies whether the application for coverage is completed within the time limit or if it is a late application:

- 1) any amount of Optional Life Benefit
- 2) any amount of Optional Critical Illness Benefit for the Participant and the Spouse

EXEMPTION PRIVILEGE

An Employee may decline to be covered under the Extended Health Care Benefit or Dental Care Benefit if that Employee is covered as a Dependent under the policy or another similar group insurance plan. However, if that other plan terminates or the Spouse is no longer a member of an eligible class, the Employee is eligible to apply for coverage. To become covered:

- 1) the Employee must previously have opted out of coverage,
- 2) the Spouse's coverage cannot have been terminated by personal choice, and
- 3) the Employee's written application must be made within 31 days of the date the Spouse loses coverage, otherwise, the Late Application provision applies.

COVERAGE TYPES

The coverage types available under the policy are:

Coverage Types	Covered Persons
Single	Participant only
Family	Participant, Spouse and Children

The Coverage Type does not have to be the same for all benefits.

The Coverage Type can be changed due to a life event. DFS must be notified within 31 days of the event.

A life event is defined as:

- 1) marriage, new common-law spouse, separation or divorce,
- 2) birth or adoption of a child,
- 3) loss or gain of the Spouse's coverage, for a reason other than personal choice,
- 4) arrival of a Dependent in Canada,
- 5) death of a Dependent,
- 6) termination of a Dependent's eligibility because of their age, or
- 7) a Dependent Child returns to school.

BENEFICIARY

DFS will recognize the beneficiary(ies) designated by the Participant under the Employer's group insurance plan immediately prior to the Effective Date of the policy, unless DFS requires beneficiary(ies) to be designated again.

Subject to applicable laws, the Participant may designate or revoke, at any time, one or several beneficiaries. Only the benefits that include a benefit payment in the event of the Participant's death are subject to the designation of beneficiary(ies), and the same designation applies to all these benefits. The rights of a beneficiary who dies before the Participant revert to the latter. In the absence of a designated beneficiary, the amounts payable are paid according to applicable laws.

The amounts payable when a Dependent dies are paid to the Participant, if alive. If the Participant has died, the amounts are paid according to applicable laws.

DFS assumes no responsibility for the validity of any beneficiary designation or revocation.

COMMENCEMENT OF COVERAGE

COMMENCEMENT OF PARTICIPANT COVERAGE

An Employee must be Actively at Work on the date their coverage becomes effective. If they are not Actively at Work on that date, their coverage will start on the first day they are next Actively at Work.

1) If application is made within the time limit

For all benefits except optional benefits, the coverage of any Employee is effective on the date they are eligible. For optional benefits, coverage is effective on the date the insurability of the Employee is approved by DFS.

2) If late application

Coverage is effective on the date the insurability of the Employee is approved by DFS.

COMMENCEMENT OF DEPENDENT COVERAGE

Coverage for a Dependent is effective on the date the Participant is first eligible for Dependent coverage, provided application is made within the time limit. However, for late application or for benefits that require Evidence of insurability, coverage is effective on the date the Dependent's insurability is approved by DFS.

If a Participant already has Dependent coverage on the date they acquire a new Dependent, the coverage of that Dependent is effective on the date they become a Dependent, except for benefits requiring Evidence of insurability. However, the Life and Accidental Death and Dismemberment Benefits for a newborn Child are effective from birth, including a stillborn child after at least 20 weeks of gestation, subject to all other terms and conditions of the policy provisions, including those above.

If a Dependent (other than a newborn Child) is confined to a Hospital on the date their coverage would otherwise become effective, their coverage begins on the day immediately following their discharge from the Hospital.

CHANGE IN AMOUNT OF COVERAGE AND BENEFIT

Any increase or decrease in the amount of coverage or any change in Benefit is effective on the later of the following dates, provided the Participant is Actively at Work on that date:

- 1) the date the Participant is first eligible for the change provided written request is received by DFS on or before that date, or
- 2) the date the insurability of the Covered Person is approved by DFS:
 - a) if the new amount of coverage exceeds the Maximum without Evidence of insurability, or

- b) if the request for change is received more than 31 days after the date of their eligibility for the change.

If a Participant is not Actively at Work on the date their coverage should change, then the change is effective on the first day they are next Actively at Work. However, if the Policyholder and DFS agree, the change is effective as if the Participant was Actively at Work.

CONTINUATION OF COVERAGE DURING ABSENCE FROM WORK

If a Participant is not Actively at Work for any of the reasons described below, their coverage may be continued, according to the following provisions.

ILLNESS OR INJURY

All benefits that are in place immediately before the absence are continued during an absence due to Illness or injury that results in disability recognized by DFS. Premiums must continue to be paid unless the Participant is eligible for a premium waiver.

TEMPORARY LAY-OFF OR UNPAID LEAVE OF ABSENCE

The Participant is allowed to keep all benefits that are in place immediately before the absence. The benefits can be continued for any predetermined period as long as premiums continue to be paid. However, the coverage can only be continued for a maximum of 6 months. DFS must be advised of the scheduled return to work date prior to the start of the absence.

If the Participant decides not to keep their benefits, those benefits are reinstated, without Evidence of Insurability, on the date the Participant is again Actively at Work. DFS must be advised within 31 days following the return to work of the Participant otherwise, Evidence of Insurability is required.

MATERNITY, PARENTAL OR FAMILY RELATED ABSENCES AND LEAVES

For an absence or leave taken according to any applicable law, a Participant may:

- 1) as long as premiums continue to be remitted, keep all benefits, or
- 2) discontinue all benefits.

Benefits may be continued for a maximum of 12 months or longer where required by law. DFS must be advised of the scheduled return to work date no later than 31 days following the start of the absence or leave.

DFS must be advised of the Participant's choice prior to the start of the absence or leave. If benefits are discontinued, they are reinstated without Evidence of Insurability, on the date the Participant is again Actively at Work. DFS must be advised within 31 days following the return to work otherwise, Evidence of Insurability is required.

STRIKE OR LOCK-OUT

Coverage terminates on the date the strike or lock-out begins.

TERMINATION OF BENEFITS AND COVERAGE

BENEFIT TERMINATION

Each Benefit terminates on the date specified below.

BENEFIT	TERMINATION GATE
Extended Health Care Benefit	The Participant's 75 th birthday or retirement, whichever comes first.
Dental Care Benefit	The Participant's 75 th birthday or retirement, whichever comes first
Basic Life Benefit	The Participant's 75 th birthday or retirement, whichever comes first
Optional Life Benefit	The Participant's 65 th birthday or retirement, whichever comes first
Basic Accidental Death and Dismemberment Benefit	The Participant's 75 th birthday or retirement, whichever comes first
Optional Accidental Death and Dismemberment Benefit	The Participant's 65 th birthday or retirement, whichever comes first
Critical Illness Benefit	The Participant's 65 th birthday or retirement, whichever comes first

TERMINATION OF PARTICIPANT COVERAGE

Except as specifically noted elsewhere in the policy, the coverage of the Participant terminates on the earliest of:

- 1) the date they no longer qualify as an Employee,
- 2) the date they no longer belong to a class of Employees eligible for coverage,
- 3) the date their employment or contract with the Employer is terminated,
- 4) the end of the period for which the premiums are paid on their behalf,
- 5) for the Health Spending Account (HSA), the date the Extended Health Care Benefit terminates,
- 6) the date they retire,
- 7) the date they are no longer Actively at Work, or
- 8) the date the policy terminates.

TERMINATION OF DEPENDENT COVERAGE

Except as specifically noted elsewhere in the policy, the coverage for a Dependent terminates on the earliest of:

- 1) the date the Participant's coverage terminates, unless the Dependent is eligible for survivor benefits,
- 2) the date the individual no longer qualifies as a Dependent, or
- 3) the date the premiums are not paid on behalf of the Participant for Dependent coverage.

REINSTATEMENT OF COVERAGE

If an Employee's coverage terminates due to termination of employment and they are then rehired within 6 months, they are eligible for the reinstatement of their coverage on the date they resume employment. Application for reinstatement must be made within 31 days of the rehire date.

If an Employee does not qualify for reinstatement, they are considered a new Employee.

SURVIVOR BENEFIT

This provision applies to the following:

- ▶ Extended Health Care Benefit
- ▶ Dental Care Benefit

In the event of the Participant's death and subject to policy provisions, coverage continues for their Dependents, without premium payment, until the earliest of:

- 1) 24 months from the date of death,
- 2) the date Dependent coverage normally terminates had the Participant not died, or
- 3) the date the Benefit or policy terminates.

FRAUD

In case of fraud, DFS reserves the right to terminate the Participant's coverage.

CLAIMS

NOTICE AND PROOF OF CLAIM

Notice and proof of any claim must be received by DFS within the time limit specified for each Benefit:

BENEFIT	TIME LIMIT
Extended Health Care Benefit	All claims, with receipts included, must be submitted to DFS within 12 months of the date the expense is incurred.
Dental Care Benefit	All claims, with receipts included, must be submitted to DFS within 12 months of the date the expense is incurred.
Life Insurance Benefit	<ul style="list-style-type: none">• Notice of claim must be submitted to DFS within 30 days of the date of death, and• the written proof of claim must be submitted within 90 days of the date of death.
Accidental Death and Dismemberment Benefit	<ul style="list-style-type: none">• Notice of claim must be submitted to DFS within 30 days of the date of the Accident, and• the written proof of claim must be submitted within 90 days of the date of the Accident.
Critical Illness Benefit	<ul style="list-style-type: none">• For HIV infection, a written notice of claim must be submitted to DFS within 14 days of the date of Accident or injury,• For any other eligible critical illness, an initial written notice of a claim along with any medical information must be submitted to DFS within 12 months of the diagnosis.

Failure to submit notice or proof of claim within the prescribed time limit does not invalidate the claim if the notice and proof of the claim are sent as soon as reasonably possible. However, no payment is made if the notice and proof of claim are sent more than 12 months after the date the expenses are incurred or the date of the event that results in a claim.

If the policy terminates, no payment is made unless the notice and proof of claim is submitted to DFS within 120 days of the date of termination of the policy.

Every action or proceeding against DFS for the recovery of insurance money payable is barred absolutely unless commenced within the time set out in any insurance legislation applicable in the province where the Participant resides.

SUBMISSION OF CLAIMS

Claims must be submitted to DFS on the appropriate form. When necessary, DFS may also require any other information it deems useful. All amounts are paid to the Participant unless otherwise indicated in the policy.

Drugs and other Health Care Expenses

If the direct payment method is used for drug expenses, the Participant is not required to submit a claim to DFS.

For all other medical expenses, the Participant is not required to submit a claim to DFS if the professional or service provider uses the Electronic Data Interchange (EDI).
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Dental Care

The Participant is not required to submit a claim to DFS if the Dentist uses the Electronic Data Interchange (EDI).

DFS reserves the right to require radiographs, photographs and other types of diagnostics such as specialist reports, periodontal charts and study models.
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Death

Before settling any claim, DFS requires satisfactory written proof of:

- 1) death, including a medical report or death certificate, the cause and circumstances of the death,
- 2) eligibility of the deceased at the time of death,
- 3) date of birth of the deceased, and
- 4) right of the claimant to receive the proceeds.

DFS may also require any other information it deems useful.

In the case of a disappearance, DFS will pay the claim on presentation of a declaratory judgment of death.

Critical Illness

Before settling any claim, DFS requires satisfactory written proof of:

- 1) the existence of an Eligible Illness, and
- 2) the Covered Person's eligibility for benefits at the time the diagnosis was made.

DFS reserves the right to verify the diagnosis with the attending Physician(s) and to require any Participant or Dependent that submitted a claim be examined at DFS's expense.

Co-Ordination of Benefits

If an individual covered under the Extended Health Care and Dental Care benefits, is also covered under another Plan that provides similar benefits, total reimbursements made by all plans in any year are co-ordinated.

Co-ordination of benefits is calculated as specified in the guidelines of the Canadian Life and Health Insurance Association. Total amounts paid under all plans cannot exceed 100% of the individuals incurred Eligible Expenses.

Travel Insurance Expenses

If an individual covered under Travel Insurance is also covered under any other plan or insurance policy that provides similar benefits, Travel Insurance only covers Eligible Expenses in excess of the amounts payable by the other plans or insurance policies.

If the other plans or insurance policies include a similar clause or Co-ordination of Benefits provision, benefits are co-ordinated between all plans or insurance policies so that the total amounts paid do not exceed 100% of the individual's incurred Eligible Expenses.

MEDICAL EXAMINATIONS

From time to time, DFS is entitled to have a claimant examined by a health professional appointed by DFS.

SUBROGATION

When reimbursement for expenses incurred for which another party is or may be liable, DFS is subrogated to the same rights of recovery available to the Participant. DFS may bring action in the name of the Participant to enforce these rights.

When a Participant is paid disability benefits for loss of income for a cause that another party is or may be liable, DFS is subrogated to the same rights of recovery available to the Participant. The amount subject to subrogation is limited to the amount of salary loss benefits paid or payable to the Participant by DFS.

RIGHT OF RECOVERY

Payments made by DFS in excess of the maximum amount that should have been paid are recoverable by DFS, limited to that excess amount. It will be recovered from any individuals or entity to or for whom the payments were made.

WAIVER OF PREMIUM

This provision applies to the following Benefits:

- ▶ Basic Life Benefit
- ▶ Optional Life Benefit
- ▶ Basic Accidental Death and Dismemberment Benefit
- ▶ Optional Accidental Death and Dismemberment Benefit
- ▶ Optional Critical Illness Benefit

1) Beginning of the Waiver of Premium

A Participant under age 65 who becomes Totally Disabled while covered under the policy may be entitled to have their premiums waived the first day of the month coincident with or next following 6 months of continuous Total Disability. The Participant must submit proof of Total Disability satisfactory to DFS.

2) Termination of the Waiver of Premium

Premiums are no longer waived on the earliest of the following dates:

- a) the date the Participant is unable or unwilling to provide satisfactory proof of Total Disability to DFS, if such proof is not provided within 3 months of DFS's request,
- b) the date the Participant ceases to be Totally Disabled,
- c) the date the Participant is engaged in any occupation or employment for remuneration or profit. This does not include a rehabilitative program approved by DFS,
- d) the date of the Participant's 65th birthday,
- e) the date the Participant retires, or
- f) the date the coverage of the Participant terminates or the date the Benefit is cancelled or the policy terminates, except for the Life Benefit.

3) Recurrent Total Disability

A Total Disability that recurs within 6 months after the end of a previous period of Total Disability for which premiums were waived is deemed a continuation of the previous period if for the same or related causes.

4) Notice and Proof of Total Disability

For the Participant to be eligible for Waiver of Premium, DFS must receive:

- a) initial written notice of Total Disability within 30 days following 6 months of Total Disability, and
- b) written proof of Total Disability within 90 days following the date the written notice is received.

For recurrent Total Disability, DFS must receive written notice and written proof of Total Disability within 30 days of the recurrence.

Failure to submit notice or proof within the prescribed time limit does not invalidate the Waiver of Premium if the notice and proof are sent as soon as reasonably possible. However, no Waiver of Premium is granted if the notice and proof are sent more than 12 months after the date the Participant became Totally Disabled.

EXTENDED HEALTH CARE BENEFIT

SUMMARY OF BENEFITS

When DFS receives satisfactory Proof of Claim that a Covered Person incurred Eligible Expenses while covered under this Benefit, DFS will reimburse those expenses according to policy provisions.

Deductible	
Eligible Expense	Amount
All expenses	None
Percentage of Reimbursement	
Eligible Expenses	Percentage
Drugs	1) Generic drugs: 80% of the lowest priced Equivalent Drug available on the market 2) Brand name drugs: 80% of the brand name drug if no Equivalent Drug is available on the market or 80% of the lowest priced Equivalent Drug available on the market
Paramedical Services	80%
Referral Treatment	80%
All other expenses	100%

BENEFIT PAYMENT

For all Eligible Expenses, DFS will reimburse the portion of the Reasonable and Customary Charges in excess of the Deductible, subject to the Percentage of Reimbursement.

To be eligible, the expenses must be medically necessary for the treatment of the Covered Person and incurred as a result of an Illness, a pregnancy or an Accident, and cover care that:

- 1) is prescribed by a Physician or other health professional as authorized by law, before the expense is incurred,
- 2) is recognized throughout the medical field as appropriate and consistent with the diagnosis, and
- 3) cannot be omitted without endangering the person's health or the quality of medical care.

The incurred date for any Eligible Expense is the date the service is provided or the item is supplied.

Preferred Providers Network

DFS may select suppliers for the distribution of services, treatments or supplies and may restrict payment for Eligible Expenses purchased at another supplier.

ELIGIBLE EXPENSES

IN CANADA

Eligible Expenses are those listed below and incurred:

- 1) in the Participant's province of residence, and
- 2) within Canada, but outside the Participant's province of residence, if not related to a Medical Emergency.

MARK-UP AND DISPENSING FEE	
Limits for Eligible Drug Expenses	
Mark-up	Reasonable and Customary Charges
Dispensing fee	Reasonable and Customary Charges

DRUGS

- 1) Drugs with a DIN (Drug Identification Number) when dispensed by a pharmacist, and
 - a) by law require a prescription, or
 - b) do not require a prescription, but are categorized as life sustaining, including without limitation:
 - fibrinolytics
 - malarials
 - nitroglycerin
 - single entity iron salts
 - thyroid agents
 - topical enzymatic debriding agents

Compounded preparations dispensed by a pharmacist where the principal active ingredient in the compound is an eligible drug.

- 2) Insulins, lancets, syringes and test strips for diabetics.
- 3) Expenses used to cover the provincial drug insurance plan deductible and co-insurance amount for persons covered under their provincial plan.

4) Prior Authorization Drugs

Prior authorization by DFS is required for certain drugs listed on DFS's website. A prior authorization form completed by the Physician must be submitted to DFS in order to determine whether the prescribed drug meets the prior authorization criteria established by DFS. The criteria are based, in particular, on clinical practice guidelines and recommendations issued by health technology assessment agencies and they include verification that:

- a) the drug is prescribed for an approved therapeutic indication approved by Health Canada, and
- b) the drug's effectiveness is satisfactory compared to its associated cost.

Proof of the effectiveness of the approved drug, including medical results, may be requested during the course of treatment to determine if the drug is having the desired effect so that it may remain eligible for reimbursement.

DFS reserves the right to reimburse an Equivalent Drug when a less expensive equivalent or biosimilar drug is available on the market.

Patient Support Program

This program is offered by DFS. It provides support to help Covered Persons manage their health and medication. DFS may require Covered Persons to enroll in this program in order for the drug expenses to be reimbursed.

Patient Assistance Program	
This program is offered by some drug manufacturers to provide Covered Persons with information, education and financial assistance if they are prescribed certain drugs. DFS may require Covered Persons to enroll in this program in order for the drug expenses to be reimbursed.	
Other Eligible Drug Expenses	Maximum Payable Amount per Covered Person
Viscosupplementation	\$600 per calendar year
Vaccines	Reasonable and Customary Charges
Smoking cessation aids (products only)	\$600 lifetime
Fertility treatment	Drugs: \$5,000 lifetime Treatment: \$5,000 lifetime, including genetic testing

HOSPITALIZATION	
Eligible Expenses	Maximum Payable Amount per Covered Person
<u>Hospital</u> Charges for confinement in a Hospital for each day of acute care Hospitalization	The difference between the cost of a ward and a semi-private room
<u>Palliative Care Establishment</u> Charges for confinement in a Palliative Care Establishment	\$40 per day up to a lifetime maximum of 180 days

Convalescent/Rehabilitation Centre	\$40 per day up to 180 days per period of confinement
<p>Charges for confinement in a Convalescent or Rehabilitation Centre, for any period of confinement that begins within 14 days of discharge from a Hospital</p> <p>Successive periods of confinement are considered the same period of confinement if they:</p> <ul style="list-style-type: none"> • result from the same Illness or Accident, and • are separated by less than 60 consecutive days during which the Covered Person is not hospitalized. 	
Chronic Care Establishment	180 days per period of confinement
Charges for confinement in a Chronic Care Establishment	

HEAL1IH PROFESSIONALS	
Eligible Expenses	Maximum Payable Amount per Covered Person
Paramedical Services	For each type of professional, only one visit per day is eligible
<p>Services of the following professionals if they are practicing within their recognized field and are members in good standing of their professional governing body that is recognized by DFS. Medical recommendation is not required unless specified.</p> <ul style="list-style-type: none"> • acupuncturist 	
<ul style="list-style-type: none"> • chiropractor 	\$500 per calendar year, plus \$50 per calendar year for x-rays
<ul style="list-style-type: none"> • massage therapist, orthotherapist, kinesiotherapist or kinotherapist 	Combined amount of \$500 per calendar year

<ul style="list-style-type: none"> • naturopath 	\$500 per calendar year
<ul style="list-style-type: none"> • occupational therapist • physiotherapist or physiotherapy technologist 	Combined amount of \$500 per calendar year
<ul style="list-style-type: none"> • osteopath 	\$500 per calendar year, plus \$50 per calendar year for x-rays
<ul style="list-style-type: none"> • podiatrist or chiropodist 	Combined amount of \$500 per calendar year, plus \$50 per calendar year for x-rays
<ul style="list-style-type: none"> • psychologist, social worker, guidance counsellor, psychotherapist, psychoeducator, registered clinical counsellor, Canadian certified counsellor, marriage counsellor, marriage/couple/family therapist, psychoanalyst or sexologist 	Combined amount of \$500 per calendar year
<ul style="list-style-type: none"> • speech therapist 	\$500 per calendar year
<p><u>Home Nursing Care</u></p> <p>Nursing services given at home by a registered nurse or a licensed practical nurse, provided the services are within the competence of that nurse. The nurse must not be related to the Participant or to any of their Dependents by birth or marriage and must not ordinarily reside in their or their Dependent's home.</p>	\$10,000 per calendar year

GENDER AFFIRMATION	
<p>DFS will reimburse the following Eligible Expenses if:</p> <ul style="list-style-type: none"> • the Covered Person has received a diagnosis of persistent gender dysphoria, and • the expenses are incurred in Canada. 	
Eligible Expenses	Maximum Payable Amount per Covered Person
<p>Surgeries and treatments not covered under the provincial medical plan:</p> <ul style="list-style-type: none"> • Breast and chest surgeries • Genital surgeries • Thyroid chondroplasty (Adam's apple surgery) • Vocal cords surgeries • Electrolysis or laser hair removal 	<p>\$10,000 lifetime</p>

AMBULANCE
<p>Transporting the Covered Person by a licensed ground ambulance:</p> <ol style="list-style-type: none"> 1) in the event of a Medical Emergency, from the place of the Accident or Illness to the nearest Hospital where adequate treatment is available, and 2) from the Hospital to the place of residence of the Covered Person, when their health condition does not allow any other means of transportation. <p>Also eligible is transportation of the Covered Person by a licensed air ambulance to the nearest Hospital where adequate treatment is available when required due to a Medical Emergency.</p>

MEDICAL EQUIPMENT OR SUPPLIES	
MOBIUNAIDS	
Eligible Expenses	Limitations and/or Maximum Payable Amount per Covered Person
Walkers, canes or crutches	Purchase or rental, at the option of DFS Reasonable and Customary Charges
Wheelchairs	Purchase and repair, or rental, at the option of DFS, up to the cost of a non-motorized wheelchair, unless the Covered Person's health condition requires a motorized wheelchair One in any 60-month period, plus batteries for an eligible motorized wheelchair
Patient lifts	Purchase or rental, at the option of DFS, of a mechanical or hydraulic device One every 5 calendar years, up to \$2,000
Exterior access ramps	Purchase One in a lifetime, up to \$2,000

ORTHOPAEDIC SUPPLIES	
Eligible Expenses	Limitations and/or Maximum Payable Amount per Covered Person
<p>Orthopaedic shoes:</p> <ul style="list-style-type: none"> • Custom-made shoes • Open-toed shoes • In-flare or out-flare shoes • Shoes required for Denis Browne braces • Modified or adjusted prefabricated shoes • Modifications or adjustments to prefabricated shoes 	<p>Manufactured and billed by a centre recognized by DFS. In addition, the shoes and the modifications or adjustments to prefabricated shoes must be made by an orthotist who is a member in good standing of their professional governing body that is recognized by DFS.</p> <ul style="list-style-type: none"> • \$200 per calendar year
<p>Foot orthoses</p>	<p>Manufactured and billed by a centre recognized by DFS. In addition, the orthoses, must be made by an orthotist who is a member in good standing of his professional governing body that is recognized by DFS.</p> <ul style="list-style-type: none"> • One pair per calendar year, up to \$200 for adults • 2 pairs per calendar year, up to \$200 for Children under age 18
<p>Rigid or semi-rigid braces for limbs, trusses or casts</p>	<p>Purchase and repair Reasonable and Customary Charges</p>
<p>Spinal braces</p>	<p>Purchase and repair Reasonable and Customary Charges</p>
PROSTHESES	
Eligible Expenses	Limitations and/or Maximum Payable Amount per Covered Person
<p>Hearing aids</p>	<p>\$500 every 5 calendar years, including initial batteries</p>

Wigs	When required for temporary hair loss due to alopecia, chemotherapy or radiotherapy \$500 lifetime
Breast prostheses	When required due to a mastectomy, up to <ul style="list-style-type: none"> the cost of an external prosthesis, maximum of one prosthesis in any 12-month period, and 2 mastectomy brassieres per calendar year
Artificial limbs and myoelectric prosthetics	<ul style="list-style-type: none"> Purchase, up to \$10,000 per prosthesis Repair, up to \$10,000 per repair Replacement when it is required due to a physiological change up to \$10,000 per prosthesis
Artificial eyes	Purchase and repair Reasonable and Customary Charges
OTHER MEDICAL EQUIPMENT OR SUPPLIES	
Eligible Expenses	Limitations and/or Maximum Payable Amount per Covered Person
Support stockings	Purchase of support stockings at least 20 mm/Hg 4 pairs per calendar year up to a maximum of \$500
Intrauterine devices or diaphragms	Combined amount of \$80 per calendar year
TENS nerve stimulators and their supplies	Purchase or rental, at the option of DFS \$700 lifetime
Catheters	Purchase Reasonable and Customary Charges

Ostomy supplies	Purchase Reasonable and Customary Charges
Paraplegics supplies	Purchase Reasonable and Customary Charges
Tube feeding supplies	Purchase Reasonable and Customary Charges
Tracheotomy supplies	Purchase Reasonable and Customary Charges
Opaque glasses	Purchase, provided they are required during radiotherapy or psoriasis treatments Reasonable and Customary Charges
Compressive garments other than support stockings	Purchase Reasonable and Customary Charges
Medicated dressings	Purchase Reasonable and Customary Charges
Stump socks	10 per calendar year
Breast pumps	Purchase or rental, at the option of DFS Reasonable and Customary Charges
Incontinence supplies	Purchase \$1,000 per calendar year
Positive pressure airway ventilator machines (CPAP) or mandibular advancement splints	Purchase or rental, at the option of DFS One in any 60-month period
Apnea monitors	Purchase or rental, at the option of DFS Reasonable and Customary Charges

Oxygen and equipment required for its administration	Purchase or rental, at the option of DFS Reasonable and Customary Charges
Lymphoedema pumps	Purchase Reasonable and Customary Charges
Chest percussion accessories	Purchase Reasonable and Customary Charges
Enuresis sensors	Purchase or rental, at the option of DFS Reasonable and Customary Charges
Hospital beds	Purchase and repair, or rental, at the option of DFS, up to the cost of a non-electric hospital bed, unless the Covered Person's health condition requires an electric bed One in any 60-month period
Hospital bed supplies: <ul style="list-style-type: none"> • bed rails • trapeze bars • bedpans • head halters 	Purchase or rental, at the option of DFS Reasonable and Customary Charges
Traction apparatus	Purchase or rental, at the option of DFS Reasonable and Customary Charges
Standing aids	Purchase or rental, at the option of DFS Reasonable and Customary Charges

Daily living aids:	
<ul style="list-style-type: none"> • shower bars, bathtub bars • shower chairs • grab bars • standard commodes • bathtub rails • elevated toilet seats 	Purchase or rental, at the option of DFS Reasonable and Customary Charges
Glucose monitors	One monitor in any 36-month period, up to \$300
Insulin pumps	One pump in any 48-month period, up to \$5,000
Insulin pump supplies	Purchase Reasonable and Customary Charges
Other therapeutic equipment and their supplies:	Purchase or rental, at the option of DFS Each piece of equipment is limited to one in any 60-month period
<ul style="list-style-type: none"> • aerosol therapy equipment 	
<ul style="list-style-type: none"> • non-union bone stimulators Additional equipment may be included, as determined by DFS.	\$10,000 lifetime combined for any or all of the eligible equipment and their supplies

DIAGNOSTIC SERVICES	
Eligible Expenses	Limitations and/or Maximum Payable Amount per Covered Person
Imaging techniques Diagnostic laboratory tests Prenatal screening tests	For diagnostic purposes, up to \$1,000 per calendar year

DENTAL TREATMENT DUE TO AN ACCIDENT	
Eligible Expenses	Limitations and/or Maximum Payable Amount per Covered Person
<p>The services of a Dentist required to repair or replace sound teeth as a result of an accidental blow to the mouth</p> <p>A sound tooth is a natural tooth not affected by any pathology in itself or any adjacent structures. A natural tooth treated or repaired and restored to normal function is considered sound.</p>	<p>The accidental blow must occur while the Covered Person is covered under this Benefit or a comparable benefit in force immediately before the effective date of this Benefit.</p> <p>Within 12 months of the Accident:</p> <ul style="list-style-type: none"> • dental care must begin, or • a treatment plan satisfactory to DFS must be submitted. <p>No benefit is paid for services provided more than 24 months after the date of the Accident.</p> <p>Reimbursement of Eligible Expenses is governed by the current year Dental Association Fee Guide for General Practitioners where the Participant resides.</p>

DETOXIFICATION	
Eligible Expenses	Limitations and/or Maximum Payable Amount per Covered Person
<p>Room and board charges in a centre specializing in the treatment of alcoholism, drug, gambling or gaming addiction. The centre must be recognized by DFS</p>	<p>The Covered Person must require treatment under the supervision of a Physician.</p> <p>\$80 per day, up to \$2,500 lifetime</p>

VISION CARE	
Eligible Expenses	Limitations and/or Maximum Payable Amount per Covered Person
Eye exam	<p>One in any period of</p> <ul style="list-style-type: none"> • 24 months for adults, • 12 months for Children under age 18.
Eyeglasses, contact lenses and surgery	<p>Purchase and replacement</p> <p>Eyeglasses and contact lenses must be prescribed by an ophthalmologist or optometrist and dispensed by an ophthalmologist, optometrist or optician, for vision correction.</p> <p>Laser surgery for vision correction</p> <p>Combined amount of \$200 in any period of:</p> <ul style="list-style-type: none"> • 24 months for adults, • 12 months for Children under age 18.
Intraocular lenses	<p>Purchase, as a replacement for natural crystalline in case of cataracts</p> <p>\$300 in any period of 24 months</p>
Contact lenses (special condition)	<p>Contact lenses to restore the visual acuity of the best eye to at least 20/40 when eyeglasses cannot get this result, up to:</p> <p>\$300 in any period of:</p> <ul style="list-style-type: none"> • 24 months for adults, • 12 months for Children under age 18.

REFERRAL TREATMENT

Eligible Expenses are as below when incurred outside the Covered Person's province of residence due to a referral, subject to the following:

- 1) the service or treatment must not be available in Canada or in the Covered Person's province of residence,
- 2) the Covered Person must provide DFS with a letter of referral from a Physician from the province of residence they reside indicating that they are referred to another Physician,
- 3) DFS must give prior written approval, and
- 4) the provincial health and/or hospital insurance plans must pay a portion of the Eligible Expenses.

Eligible Expenses	Limitations and/or Maximum Payable Amount
Health Care Expenses	
Hospital room and board charges	In Canada: same coverage as provided for under the In Canada provision of this Benefit Outside Canada: semi-private room
Other hospital services	
Physician, surgeon or anaesthetist's fees	
Transportation Expenses	
Expenses to transport the Covered Person by a suitable means to a place of treatment competent to provide appropriate care.	
Expenses for an Immediate Family Member to be transported with the Covered Person to the place of treatment.	
Round-trip economy transportation for a qualified medical attendant when ordered by the attending Physician.	The attendant cannot be an Immediate Family Member, friend or Travelling Companion

<p>Round-trip economy air, bus or train transportation by the most direct route for one Immediate Family Member to visit the Covered Person who must be confined for at least 7 days.</p>	<ul style="list-style-type: none"> • The Covered Person must not be accompanied by an Immediate Family Member age 18 or over • The Living Expenses for the Immediate Family Member up to a maximum of \$1,500 • The visit must be considered as beneficial to the patient by the attending Physician
<p>On the death of a Covered Person, one round-trip economy air, bus or train transportation by the most direct route for one Immediate Family Member to the place of death for identification of the remains prior to repatriation.</p>	<p>The Covered Person must not be accompanied by an Immediate Family Member age 18 or over</p>
<p>On the death of a Covered Person, the cost to prepare and return the body or cremains to the place of residence by the most direct route (plane, bus or train).</p>	<p>\$5,000</p> <p>The cost of the casket or urn is not covered</p>
<p>Living Expenses</p>	
<p>The Covered Person's cost of meals and accommodation for the duration of their treatment.</p> <p>Additional child care expenses for Children not accompanying the Covered Person.</p>	<p>\$200 per day per Covered Person for a maximum of 10 days. This maximum is for all these expenses combined</p>
<p>Long-distance Telephone Charges</p>	

<p>Long-distance telephone charges to reach an Immediate Family Member if the Covered Person is hospitalized.</p>	<ul style="list-style-type: none">• \$50 per day up to an overall maximum of \$200 per Period of Hospitalization• The Covered Person must not be accompanied by an Immediate Family Member age 18 or over• These expenses are eligible if no reimbursement has been made for Transportation Expenses for one Immediate Family Member to the Hospital
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Overall Maximum Benefit	
Expenses incurred outside the province of residence, but within Canada	No maximum
Expenses incurred outside Canada	\$50,000 per calendar year per Covered Person

TRAVEL INSURANCE

If a Covered Person incurs Medical Emergency expenses during the first 180 days of a stay outside their province of residence, DFS will reimburse the Eligible Expenses subject to the following conditions:

- 1) the person must be covered under a provincial health plan in Canada,
- 2) expenses must be eligible under the Extended Health Care Benefit, and
- 3) the Covered Person's health condition must be Stable prior to the Trip departure date.

The Participant must contact DFS if the duration of the Covered Person's stay outside Canada is or may be longer than 180 days, otherwise, that person may not be covered for Travel Insurance.

Medical decisions by a Physician or other health care professional employed by, under contract to, or designated by "Travel Assistance", are based on medical factors and, as such, will be conclusive in determining the need for the services outlined below.

Eligible Expenses	Limitations and/or Maximum Payable Amount
Health Care Expenses	
Hospital room and board charges until the Covered Person is discharged from hospital	Semi-private room
Other hospital services	
Physician, surgeon or anaesthetist's fees	
All other expenses eligible under the In Canada provision of this Benefit	

<p><u>Transportation Expenses</u></p> <p>To be eligible, all the expenses listed below must be approved and arranged by "Travel Assistance"</p>	
<p>Expenses to repatriate the Covered Person, as soon as their health allows it, by a suitable means of Public Transportation to their place of residence to receive appropriate care.</p>	<p>These expenses are eligible if the means of transportation originally arranged for the return Trip cannot be used.</p>
<p>Expenses for another person also covered under this Benefit to be repatriated at the same time as the Covered Person.</p>	<p>These expenses are eligible if the means of transportation originally arranged for the return Trip cannot be used.</p>
<p>Expenses for a suitable means of Public Transportation to repatriate the children accompanying and under the care of the Covered Person during the Trip if:</p> <ul style="list-style-type: none"> • the Covered Person must be repatriated or hospitalized for more than 24 hours, and • nobody else can bring the children back to their home. 	
<p>Additional transportation to repatriate the cat or dog accompanying the Covered Person if:</p> <ul style="list-style-type: none"> • the Covered Person must be repatriated, and • nobody else can bring the animal back to the Covered Person's place of residence. 	<p>\$500 per Trip</p>
<p>The following fees for the transportation of the luggage of the Covered Person who must be repatriated:</p> <ul style="list-style-type: none"> • excess luggage if brought back by another person, or • shipment of luggage to the Covered Person's place of residence if nobody else can bring it back. 	<p>\$300 per Trip</p>

<p>Round-trip economy transportation for a qualified medical attendant when ordered by the attending Physician.</p>	<p>The attendant cannot be an Immediate Family Member, friend or Travelling Companion.</p>
<p>Round-trip economy air, bus or train transportation by the most direct route for one Immediate Family Member to visit the Covered Person who must be confined for at least 7 days.</p>	<ul style="list-style-type: none"> • The Covered Person must not be accompanied by an Immediate Family Member age 18 or over. • The Living Expenses for the Immediate Family Member is limited to \$1,500. • The visit must be considered as beneficial to the patient by the attending Physician.
<p>Cost of returning the Covered Person's personal or rented Vehicle if:</p> <ul style="list-style-type: none"> • the Covered Person suffers from a disability due to a Medical Emergency, • a Physician verifies that the disability prevents the Covered Person from operating this Vehicle, and • none of the Immediate Family Members accompanying the Covered Person are able to return it. <p>Vehicle transportation professional agency expenses or the reasonable and necessary expenses incurred by the Covered Person for gas, meals, accommodation and a one-way economy class transportation.</p>	<p>The Vehicle must be in working condition to make the return Trip without mechanical problem</p> <p>\$2,500 per trip</p>
<p>On the death of a Covered Person, one round-trip economy air, bus or train transportation by the most direct route for one Immediate Family Member to the place of death for identification of the remains prior to repatriation.</p>	<p>The Covered Person must not be accompanied by an Immediate Family Member age 18 or over.</p>

<p>On the death of a Covered Person:</p> <ul style="list-style-type: none"> the cost to prepare and return the body or cremains to the place of residence by the most direct route (plane, bus or train), or the cost to prepare the body and the cost of cremation or burial if the body is not repatriated to the place of residence. 	<p>\$5,000</p> <p>The cost of the casket or urn is not covered</p>
<p><u>Living Expenses</u></p> <p>The cost of meals and accommodation if the Covered Person's return is delayed because of an Illness or Accident verified by a Physician. The Illness or Accident must be suffered by the Covered Person themselves, an accompanying Immediate Family Member or a Travelling Companion.</p> <p>Additional child care expenses for Children not accompanying the Covered Person.</p>	<p>\$200 per day per Covered Person for a maximum 10 days per Trip, for all these expenses combined</p>
<p><u>Long-distance Telephone Charges</u></p> <p>Long-distance telephone charges to reach an Immediate Family Member if the Covered Person is hospitalized.</p>	<ul style="list-style-type: none"> \$50 per day up to an overall maximum of \$200 per Period of Hospitalization. To be eligible, the Covered Person must not be accompanied by an Immediate Family Member age 18 or over. These expenses are eligible if no reimbursement has been made for Transportation Expenses for one Immediate Family Member to the Hospital.
<p>Overall Maximum Benefit</p>	
<p>All Eligible Expenses</p>	<p>\$5,000,000 lifetime per Covered Person</p>

RESTRICTIONS, LIMITATIONS AND EXCLUSIONS

DFS reserves the right to apply certain restrictions, limitations and exclusions namely to services, products or drugs that:

- 1) are used to treat specific conditions other than those for which they are approved by Health Canada,
- 2) are taken in a higher dose, greater quantity or at a frequency that exceeds DFS's criteria of good clinical practice, or
- 3) do not meet DFS's prior authorization criteria as of the date the expense is incurred.

Additional Restrictions Applicable to Drugs
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Maintenance drugs are limited to a 100-day supply. All other drugs and products are limited to a 34-day supply.

Limitations

Eligible Expenses are subject to the limitations and maximums specified in this benefit.
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Alternate Benefit Clause

For each Eligible Expense for which several products are available on the market, reimbursement is limited to the lowest cost alternative product that represents reasonable treatment.

Additional Limitations Applicable to Drugs

For biologic drugs, DFS reserves the right to reimburse a less expensive biosimilar drug if available on the market.
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Limitations and Exclusions Applicable to the Preferred Providers Network

Benefits may be limited or no reimbursement made for drugs or supplies available at a supplier in the Preferred Providers Network, but purchased elsewhere.

General Exclusions

No reimbursement is made for:

- 1) services or treatments that a government health plan prohibits from being paid in whole or in part, except to the extent that it permits reimbursement of the excess amount,
- 2) services, treatments or supplies that a person received without charge or that may be reimbursed under any provincial or federal law, whether or not the person is covered under those laws,
- 3) Eligible Expenses which result directly or indirectly from the following:
 - a) cosmetic treatment other than what is provided for under this Benefit,
 - b) committing or attempting to commit a criminal offence, including operating a vehicle while impaired as set out under the Criminal Code of Canada,
 - c) any cause that payment is provided for under any Workers' Compensation Act or similar legislation or under any other government plan,
 - d) war, whether declared or not, or service in the armed forces of any country, or participation in a riot, insurrection or civil commotion,
- 4) services, treatments or supplies which are experimental,
- 5) services, treatments or supplies provided to the Covered Person by an Immediate Relative,
- 6) hospital stay if the stay is primarily for the participation in a therapeutic program, a therapy or a cure,
- 7) confinement in a Convalescent or Rehabilitation Centre if the stay is primarily for custodial care,
- 8) home nursing care services rendered solely for custodial care, supervision, companionship or psychotherapy,
- 9) surgeries and treatments for the reversal of a Gender Affirmation surgery,
- 10) robotic walking aid apparatus,
- 11) extra-depth shoes and off-the-shelf shoes that are regular stock,
- 12) charges for any surgically implanted item, except for the expenses listed in the Gender Affirmation provision,

- 13) supports such as "Obus form" or similar devices,
- 14) physical exercise class or program of any kind,
- 15) therapeutic bath of any kind,
- 16) fasting therapy and related charges,
- 17) appliances, supplies and equipment conceived or customized for participation in sporting activities,
- 18) diagnostic services received in a hospital and expenses incurred for genetic testing, unless genetic testing is required for fertility treatment,
- 19) dental services that are not due to an Accident or that are necessary because of food or an object placed purposely or accidentally in the mouth,
- 20) dental services and supplies for full mouth reconstructions, vertical dimension correction or any other temporomandibular joint dysfunction,
- 21) expenses incurred for the treatment of sexual dysfunction,
- 22) travel for health reasons or for medical examinations required for insurance, consultation or assessment purposes, or
- 23) services, treatments or supplies not included in the list of Eligible Expenses.

Additional Exclusions Applicable to Drugs

No reimbursement is made for:

- 1) drugs or products that are on DFS's list of excluded drugs or products. This list is available on DFS's website. In part, the list is based on the drug or product's effectiveness and cost, clinical practice guidelines and recommendations issued by health technology assessment agencies,
- 2) drugs or products that are or should be administered in a hospital or hospital setting, as determined by DFS. This includes drugs or products that require special supervision during treatment due to the severity of the patient's condition, the complexity of the treatment or for safety reasons. In part, DFS uses information from Health Canada approved product monographs and recommendations issued by health technology assessment agencies to make its determination,
- 3) contraceptives other than hormonal contraceptives,

- 4) sclerotherapy,
- 5) the following, whether prescribed or not:
 - a) shampoos and other scalp care products, including hair growth products,
 - b) aesthetic products, sunscreens, soap and any other hygiene products,
 - c) natural products and homeopathic products,
 - d) disinfectants and non-medicated dressings,
 - e) any infant milk formulas,
 - f) dietary supplements,
 - g) vitamins and minerals.

Additional Exclusion Applicable to the Patient Support Program

A Covered Person who refuses to enroll in the program might not be eligible for reimbursement of the drug expenses.

Additional Exclusion Applicable to the Patient Assistance Program

A Covered Person who refuses to enroll in the program might not be eligible for reimbursement of the drug expenses.

Additional Exclusions Applicable to Travel Insurance

"Travel Assistance" must be contacted immediately when a Medical Emergency outside the Participant's province of residence requires services. Failure to contact "Travel Assistance" may result in limited reimbursement of any costs incurred or denial of the claim. DFS is not responsible for the availability or quality of the medical services even after repatriation.

No reimbursement is made:

- 1) if the purpose of the Trip is to receive medical or paramedical treatment or Hospital services,

- 2) for elective, non-emergency treatment or surgery that could have been provided in the province of residence of the Covered Person without endangering their life or health, even if the service is provided due to a Medical Emergency,
- 3) if the Covered Person did not agree to:
 - a) the treatment prescribed by the Physician or "Travel Assistance",
 - b) change hospital or clinic,
 - c) be examined for diagnostic purposes,
 - d) repatriation as recommended by "Travel Assistance";
- 4) for any Medical Emergency incurred in a country, region or area that the Canadian government issues an "avoid all travel" warning for prior to the Trip departure date.

If a Covered Person is in a country, region or area for which a travel warning is issued during his Trip, the above does not apply. However, arrangements must be made to leave the country, region or area as soon as possible but no later than 14 days following the warning issuance,
- 5) if the Covered Person refuses to disclose to DFS necessary information regarding other insurance plans under which they also have travel coverage or if they refuses the use of the information by DFS,
- 6) if the expenses incurred are related to a health condition that is not Stable prior to the Trip departure date,
- 7) if a Physician advised the Covered Person not to travel,
- 8) for expenses resulting from a pregnancy, miscarriage, delivery or related complications, if these expenses are incurred after the first 32 weeks of pregnancy,
- 9) for an Accident that occurs while travelling and resulting from the Covered Person participating in a sports activity in return for payment (including cash prizes) or a high-risk sport or activity, including without limitation:
 - a) hang gliding and paragliding,
 - b) kitesurfing, if the Covered Person does not hold at least a level 3 IKO certification,
 - c) skydiving and free falling,
 - d) bungee jumping,

- e) outdoor climbing when not top-roping,
- f) mountain climbing on a trail rated class 4 or 5 on the Yosemite Decimal System,
- g) freestyle skiing during training, competition practice or a competition,
- h) off-track skiing outside of the marked and supervised trails of a ski station,
- i) amateur scuba diving if the Covered Person does not hold at least a basic scuba diving licence from a certified school,
- j) combat sports,
- k) motorized race and motorized training activities.

ADDITIONAL SERVICES

VIRTUAL HEALTHCARE SERVICE

Virtual Healthcare Service consists of exclusively virtual access to a nurse practitioner or Physician via a secure mobile application and web platform. This service allows certain remote health services and the exchange of related information between the Subcontractor and the Covered Person through telecommunications and technology. It is a tool for improving health, productivity and attendance at work. The goal is to provide Participants and their covered Dependents with fast and confidential access to professional resources to help them deal with various types of problems.

The service is rendered by nurse practitioners or Physicians who comply with the guidelines of their respective professional bodies, including those specific and applicable to virtual healthcare.

Virtual Healthcare Service is available under the Extended Health Care Benefit of the policy, to Participants and eligible Dependents who are covered under this Benefit.

If a Participant or one of their covered Dependents use the Virtual Healthcare Service offered by the Subcontractor and described below, the Covered Person has no out-of-pocket expenses, subject to any limitation relating thereto. Supporting documents are required for the use of this service, in particular for identification of the Covered Person and for the renewal of a prescription.

Services offered

The services offered, if medically appropriate, include:

- 1) triage, according to the symptoms of the Covered Person,
- 2) diagnosis of common medical problems,
- 3) medical and health advice,
- 4) writing prescriptions, prescription renewals, requests for laboratory tests and requests for imaging examinations,
- 5) referral to specialists or health professionals,
- 6) the production of a medical note to prescribe an absence from work of up to 3 days, if the condition of the Covered Person so requires.

Common medical problems may include, but are not limited to:

- 1) common illnesses such as colds, flu, infections, digestive disorders, minor injuries, skin problems and allergies,
- 2) post-examination follow-ups such as X-ray results and laboratory analysis results,
- 3) the management of chronic diseases such as diabetes, high blood pressure and heart conditions,
- 4) certain mental health problems,
- 5) issues related to anemia, smoking cessation, weight loss and travel medicine.

Limitations

Virtual Healthcare Service is subject to the regulatory limitations and conditions associated with virtual healthcare applicable in the province of residence of the Covered Person.

Some medical problems are not supported by Virtual Healthcare Service, such as those resulting from work-related accidents, motor vehicle accidents or disability management.

DENTAL CARE BENEFIT

SUMMARY OF BENEFITS

When DFS receives satisfactory Proof of Claim that a Covered Person incurred Eligible Expenses while covered under this Benefit, DFS will reimburse those expenses according to policy provisions.

Deductible	
Eligible Expenses	Amount
All Eligible Expenses	None
Percentage of Reimbursement	
Eligible Expenses	Percentage
Preventive Services	80%
Basic Services	80%
Major Restorative Services	50%
Maximum Benefit	
Eligible Expenses	Amount
Preventive, Basic and Major Restorative Services	Combined maximum of \$1,500 per calendar year per Covered Person

BENEFIT PAYMENT

For all Eligible Expenses DFS will reimburse the portion of the charges in excess of the Deductible subject to the Percentage of Reimbursement and the applicable Fee Guide.

To be eligible, the services must be necessary and recommended by a Dentist and performed by:

- 1) a Dentist,
- 2) a dental hygienist when the services are within the scope of their license, or
- 3) a licensed dentist.

The incurred date of any Eligible Expense is the date the service is provided or the appliance is obtained. For the following, the date the expense is incurred is deemed:

- 1) the date of insertion of the appliance for a bridge, crown, denture or any other appliance, and
- 2) the date of the final treatment for root canal therapy.

PREDETERMINATION OF BENEFIT

When the total cost of any proposed dental treatment for a Covered Person is expected to exceed \$500, the Participant should submit a detailed treatment plan to DFS before treatment starts. The treatment plan should outline the type of treatment to be provided, the anticipated treatment dates and the cost of the treatment.

No reimbursement is made for charges incurred after the date the Participant's coverage terminates, even if a predetermination was filed and benefits were determined by DFS prior to the termination date.

FEE GUIDE

Reimbursement of Eligible Expenses incurred in Canada is governed by the Provincial Dental Association Fee Guide for General Practitioners, dental hygienists or denturists of the province where the services are provided, and recognized by DFS, for the calendar year during which the services are provided.

Reimbursement of Eligible Expenses incurred outside Canada is governed by the Provincial Dental Association Fee Guide for General Practitioners of the province where the Participant resides and recognized by DFS, for the calendar year during which the services are provided.

In the absence of a fee guide recognized by DFS or if the fee guide is not recognized by DFS for the year expenses are incurred, Eligible Expenses are limited to the Reasonable and Customary Charges. Additional expenses related to Eligible Expenses for which no amount is set in the fee guide are limited to the Reasonable and Customary Charges. The Eligible Expenses for lab fees are limited to 60% of the amount for the corresponding procedure in the applicable Fee Guide.

ELIGIBLE EXPENSES**IN CANADA**

PREVENTIVE SERVICES	
Eligible Expenses	Limitations and/or Maximum per Covered Person
Examinations	
• Complete oral examination	One in any 24-month period
• Preventive or recall oral examination	One in any 6-month period
• Emergency oral examination	
• Specific oral examination	2 per calendar year
Radiographs (X-rays)	
• Complete series of radiographs or a panoramic radiograph	One in any 24-month period
• Intraoral radiographs (except bitewing films)	
• Bitewing films	One series of films in any 6-month period
• Extraoral radiographs	
• Cephalometric radiographs	
• Photography	
Lab Tests and Examinations	
• Microbiological testing	
• Biopsy	
• Pulp vitality test	
• Diagnostic cast	

Consultations	
<ul style="list-style-type: none"> • Consultation with a patient 	
Preventive Services	
• Oral hygiene instruction	Once in a lifetime
• Polishing	Once in any 6-month period
• Fluoride treatment	Once in any 6-month period
• Finishing restorations, including disking and recontouring of natural teeth to improve function	
• Pit and fissure sealants	
• Interproximal disking	
• Space maintainer	
• Control of oral habits appliance	
• Scaling and root planing	12 units per calendar year

BASIC SERVICES	
Eligible Expenses	Limitations and/or Maximum per Covered Person
Restorations	
• Amalgam restoration (metal fillings)	
• Composite restoration (white fillings)	
• Retentive pin for amalgam and composite restoration	
• Prefabricated restoration	

<ul style="list-style-type: none"> • Caries / trauma / pain control procedures {as a separate procedure from a restoration) 	
Endodontics	
<ul style="list-style-type: none"> • Endodontic emergency and treatment of the pulp chamber 	
<ul style="list-style-type: none"> • Root canal therapy 	
<ul style="list-style-type: none"> • Periapical services 	
<ul style="list-style-type: none"> • Miscellaneous endodontic services other than bleaching 	
Periodontics	
<ul style="list-style-type: none"> • Periodontal surgery 	
<ul style="list-style-type: none"> • Post-operative visit 	4 visits per calendar year
<ul style="list-style-type: none"> • Gingival curettage 	One whole mouth in any 60-month period
<ul style="list-style-type: none"> • Periodontal bruxism appliance 	One maxillary (upper arch) and one mandibular {lower arch) appliance in any 24-month period
<ul style="list-style-type: none"> • Adjustment to a periodontal bruxism appliance 	Once per calendar year
<ul style="list-style-type: none"> • Occlusal equilibration 	8 units in any 12-month period or One major and 3 minor equilibrations in any 12-month period
Maintenance of Removable Dentures	
<ul style="list-style-type: none"> • Repair or addition 	
<ul style="list-style-type: none"> • Relining 	
<ul style="list-style-type: none"> • Rebasing 	

<ul style="list-style-type: none"> • Adjustment when performed at least 3 months after the initial insertion 	Once in any 6-month period
Oral Surgery	
<ul style="list-style-type: none"> • Extraction 	
<ul style="list-style-type: none"> • Removal of residual roots 	
<ul style="list-style-type: none"> • Surgical exposure of teeth without orthodontic attachment 	
<ul style="list-style-type: none"> • Alveolectomy, alveoplasty, stomatoplasty, tuberoplasty and osteoplasty 	
<ul style="list-style-type: none"> • Alveolar ridge reconstruction 	
<ul style="list-style-type: none"> • Extension of mucous folds 	
<ul style="list-style-type: none"> • Excision in the oral cavity 	
<ul style="list-style-type: none"> • Incision in the oral cavity 	
<ul style="list-style-type: none"> • Frenectomy 	
<ul style="list-style-type: none"> • Treatment of salivary glands 	
<ul style="list-style-type: none"> • Antral surgery (sinuses) 	
<ul style="list-style-type: none"> • Control of hemorrhage 	
<ul style="list-style-type: none"> • Post-surgical care 	
General Services	
<ul style="list-style-type: none"> • General anaesthesia, conscious or deep sedation 	When administered in conjunction with a dental Eligible Expense
<ul style="list-style-type: none"> • Provision of facilities, equipment and support services for general anaesthesia or deep sedation 	When administered in conjunction with a dental Eligible Expense

MAJOR RESTORATIVE SERVICES	
Initial	
Expenses incurred for an initial appliance are eligible if the appliance is necessary because at least one natural tooth is extracted while the Covered Person is covered under this Benefit or a comparable coverage under the Policyholder's group benefit plan in effect immediately prior to the effective date of this Benefit.	
Replacement of a Prosthodontic Appliance	
Replacement of an existing appliance by a permanent appliance is eligible if:	
<ol style="list-style-type: none"> 1) it is necessary because at least one natural tooth is extracted while the Covered Person is covered under this Benefit or a comparable coverage under the Policyholder's group benefit plan in effect immediately prior to the effective date of this Benefit, 2) the existing appliance is at least 60 months old, or 3) the existing appliance is temporary and is less than 12 months old. Reimbursement for the permanent appliance is reduced by the amount DFS previously reimbursed for the temporary appliance. After that period the temporary appliance is considered permanent. 	
Replacement - Other Restorations	
Replacement of an existing restoration is eligible if:	
<ol style="list-style-type: none"> 1) the existing restoration is at least 60 months old, or 2) the existing restoration is temporary and is less than 12 months old. Reimbursement for the permanent restoration is reduced by the amount DFS previously reimbursed for the temporary restoration. After that period the temporary restoration is considered permanent. 	
Eligible Expenses	Limitations and/or Maximum per Covered Person
Removable Dentures	
• Complete denture	
• Partial denture	
• Remake	

• Remount with occlusal equilibration	
• Therapeutic tissue conditioning	
Fixed Prosthodontics	
• Bridgework (retainer and pontic)	
• Repair	
• Removal	
• Recementation	
Other Restorations	
• Veneer, gold foil, inlay, onlay and crown	
• Repair	
• Retentive pin, post and core	
• Recementation	
• Removal	

OUTSIDE CANADA

For dental treatment rendered outside Canada to be eligible, the services must be:

- 1) for emergency treatment only, and
- 2) included in the list of Eligible Expenses in Canada.

RESTRICTIONS, LIMITATIONS AND EXCLUSIONS

Restrictions
<p>Late Application</p> <p>If the Participant's application for the Dental Care Benefit is late, for either themselves or their Dependents, reimbursement is limited to \$250 per Covered Person for the first 12 months of coverage.</p>

Limitations

Eligible Expenses are subject to the limitations and maximums specified in this benefit.

Any amount that exceeds the maximum indicated in the appropriate Fee Guide cannot be reimbursed.

Alternate Benefit Clause

When 2 or more courses of eligible dental treatment are available that adequately correct a dental condition, reimbursement is based on the cost of the least expensive eligible treatment that provides the Covered Person with adequate care.

For a crown or denture on implant, benefits are limited to the amount that would have been payable for a tooth supported crown or a non-implant related denture.

The concept of a suitable course of treatment can vary among dental professionals. This limitation is not meant to affect the treatment plan as agreed to by the professional and the Covered Person.

General Exclusions

No reimbursement is made for:

- 1) services or treatments that a government health plan prohibits from being paid in whole or in part, except to the extent that it permits reimbursement of the excess amount,
- 2) services, treatments or supplies that a person received without charge or that may be reimbursed under any provincial or federal law, whether or not the Covered Person is covered under those laws,
- 3) any dental treatment not approved by the Canadian Dental Association or that is considered experimental,
- 4) charges made by a Dentist for missed appointments, claim forms or telephone advice,
- 5) Eligible Expenses that result directly or indirectly from:
 - a) committing or attempting to commit a criminal offence, as set out under the Criminal Code of Canada,
 - b) a cause that is the responsibility of a Workers' Compensation Act or similar legislation or any other government plan,
 - c) war, whether declared or not, or service in the armed forces of any country, or participation in a riot, insurrection or civil commotion,

- 6) any dental treatment for cosmetic purposes, when the form and function of the teeth are satisfactory and no pathological condition exists,
- 7) complete orthodontic examination and specific orthodontic examination,
- 8) audio-visual oral hygiene instruction,
- 9) nutritional counselling,
- 10) any dental services or supplies, including X-rays, provided for:
 - a) full mouth reconstruction,
 - b) vertical dimension correction, or
 - c) the correction of temporomandibular joint dysfunctions,
- 11) bleaching,
- 12) expenses incurred for implantology, except for crowns or dentures on implants,
- 13) patient motivation (psychological evaluation),
- 14) expenses incurred to replace lost, mislaid or stolen dentures and appliances,
- 15) anaesthesia administered by acupuncture, by hypnosis or electronically,
- 16) mouth guards and appliances conceived or customized for participation in sporting activities,
- 17) semi-precision or precision attachments,
- 18) myofunctional therapy, and
- 19) services, treatments or supplies not included in the list of Eligible Expenses.

LIFE BENEFIT

PRIMARY OF RIGHTS

When DFS receives satisfactory proof of claim that a person died while covered under this Benefit, DFS will pay the amount applicable to that person according to policy provisions.

BASIC LIFE BENEFIT

Participant
Amount of Insurance
\$25,000
Reduction
The Amount of Insurance is reduced by 50% on the Participant's 65 th birthday.

Dependents	
Amount of Insurance	
Spouse	Each Child
\$5,000	\$2,500
Reduction	
None	

OPTIONAL LIFE BENEFIT

Participant
Amount of Insurance
Any multiple of \$10,000 Minimum \$20,000 Maximum \$500,000

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Dependents	
Amount of Insurance	
Spouse	Each Child
Any multiple of \$10,000 Minimum \$20,000 Maximum \$500,000	Any multiple of \$1,000 Maximum \$25,000

SUICIDE EXCLUSION

No amount of Optional Life Benefit is paid if a person dies by suicide or dies due to a suicide attempt, while sane or insane, within 2 years of the effective date of:

- 1) the person's coverage under this Benefit,
- 2) the reinstatement of their coverage, or
- 3) any subsequent increase to the amount of coverage.

Coverage or any increase in coverage is void. DFS's liability is limited to refunding the premiums paid.

The 2 year period mentioned above must be uninterrupted. It includes any period that the person is covered under a comparable benefit under the Employer's prior group insurance policy in effect immediately prior to the Effective Date of the policy.

LIVING BENEFIT

A Totally Disabled Participant whose life expectancy is less than 24 months may apply for payment of a portion of their amount of Basic Life Benefit subject to the following conditions:

- 1) approval is obtained from DFS,
- 2) the Participant must attend any examination by a Physician designated by DFS when required,
- 3) the Participant must qualify for approval for the Waiver of Premium Benefit under the Basic Life Benefit of the policy, and
- 4) any designated irrevocable Beneficiary must sign a consent to such payment on a form provided by DFS.

The Living Benefit is 50% of the amount of Basic Life Benefit applicable to the Participant. The amount cannot be less than \$5,000 or more than

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\$100,000.

On the death of the Participant, the Value of the Living Benefit is deducted from the amount of Life Benefit otherwise payable had the Living Benefit not been paid.

The Value of the Living Benefit is:

- 1) the total amount of the Living Benefit paid,
- 2) the reasonable costs to verify the medical condition of the Participant, plus
- 3) interest calculated on the Living Benefit from the payment date until the date of death.

The interest rate is set according to the annual average rate of return on one-year guaranteed investment certificates issued by Canadian trust companies. The rate is that established immediately after the payment of the Living Benefit, as published in the monthly or weekly issue of the Bank of Canada Statistical Summary.

LIVING BENEFIT EXCLUSION

The Living Benefit is not payable if there is any material misrepresentation or non-disclosure in the application. If the application or coverage is discovered to be void after the Living Benefit is paid, the Value of the Living Benefit will be repaid to DFS by the recipient of the Living Benefit.

CONVERSION PRIVILEGE

If the Life Benefit of a Participant aged 65 or younger terminates, the Participant is entitled to convert their and their Dependents' amount of insurance to an individual policy (subject to any minimum amount) without Evidence of Insurability, up to the lesser of:

- 1) the amount of insurance that is lost because of termination,
- 2) the maximum amount required by legislation in the Participant's province of residence, or
- 3) the difference between the amount of Life Benefit in force on the date of termination of coverage and the amount of insurance that the Participant is eligible for under another group life insurance at the time they exercise their conversion right.

A written application for conversion must be submitted to DFS within 31 days of the date of termination of their coverage under this Benefit.

The amount of Life Benefit that a Participant is eligible to convert is reduced by the amount of any in force individual Life Benefit that they previously converted under the terms of this provision. Any amount converted under any other group insurance policy issued by DFS is also reduced from the amount the Participant is eligible to convert.

The individual policy takes effect after 31 days immediately following the date of termination of their coverage under this Benefit.

If a Participant dies within 31 days of termination of their coverage under

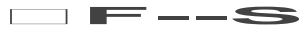
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this Benefit, the amount they are able to convert is eligible to be paid.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT



When DFS receives satisfactory Proof of Claim that:

- 1) a Covered Person suffered one of the losses specified below within 365 days of an Accident,
- 2) the loss is the direct result of the Accident, independent of any other cause, and
- 3) the Accident and the loss occurred while the Person is covered under this Benefit,

DFS will pay the amount as specified in the Schedule of Losses and all other policy provisions.

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Participant
Amount of Insurance
Equal to the Basic Life Benefit
Reduction
The Amount of Insurance is reduced by 50% on the Participant's 65 th birthday.

OPTIONAL ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Participant
Amount of Insurance
Any multiple of \$10,000 Minimum \$20,000 Maximum \$500,000

Dependents	
Amount of Insurance	
Spouse	Each Child
Any multiple of \$10,000 Minimum \$20,000 Maximum \$500,000	Any multiple of \$5,000 Maximum \$20,000

SCHEDULE OF LOSSES

The amount payable is based on the percentage of the amount of insurance specified in the Summary of Benefits.

<u>Loss of</u>	Percentage
Life	100%
Sight of Both Eyes	100%
Both Hands or Both Feet	100%
Both Arms or Both Legs	100%
One Hand and Sight of One Eye	100%
One Foot and Sight of One Eye	100%
Hearing in Both Ears and Speech	100%
One Hand and One Foot	100%
One Arm or One Leg	75%
One Hand or One Foot	67%
Sight of One Eye	67%
Hearing in Both Ears or Speech	67%
Thumb and Index Finger of the Same Hand	33%
At least Four Fingers of the Same Hand	33%

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<u>Loss of</u>	Percentage
All Toes of One Foot	25%
Hearing in One Ear	25%

Loss of Use of	Percentage
Both Arms or Both Hands	100%
Both Legs or Both Feet	100%
One Hand and One Foot	100%
One Arm or One Leg	75%
One Hand or One Foot	67%
Thumb and Index Finger of the Same Hand	33%
Hemiplegia, Paraplegia, Quadriplegia	200%

DISAPPEARANCE

If a Covered Person disappears due to an Accident involving the sinking or disappearance of a conveyance in which they are riding and their body is not found within 365 days of the Accident, it is presumed that the Covered Person died due to the Accident unless there is evidence to the contrary.

EXPOSURE TO THE ELEMENTS (FORCES OF NATURE)

Loss due to unavoidable exposure to the Elements is considered an Accident.

REHABILITATION

(Applicable to the basic benefit only)

If a Participant requires training because of an eligible loss, DFS reimburses the reasonable and necessary training expenses actually incurred, up to a maximum of \$10,000, provided that:

- 1) the Participant requires the training in order to qualify for employment in an occupation they would otherwise not engage in except for the loss, and
- 2) expenses are incurred within 2 years of the date of the Accident.

FAMILY TRANSPORTATION AND HOTEL ACCOMMODATION
(Applicable to the basic benefit only)

If a Covered Person is confined in a Hospital due to an eligible loss under this Benefit, DFS reimburses the reasonable expenses incurred by members of their Immediate Family for hotel accommodation and transportation by the most direct route to the Hospital, up to a lifetime maximum of \$1,500 for all expenses combined, provided that:

- 1) they are confined as an inpatient,
- 2) the Hospital is located more than 150 kilometres from their normal place of residence, and
- 3) they are under the regular care of a Physician.

REPATRIATION
(Applicable to the basic benefit only)

If a Covered Person dies due to an Accident, DFS reimburses the reasonable and customary expenses incurred for preparation of the body for burial or cremation and transportation of the body from the place of the Accident to the Covered Person's place of residence in Canada, up to a maximum of \$10,000, provided that:

- 1) the Accident occurs 100 kilometres or more from their normal place of residence, and
- 2) the loss of life benefit is eligible to be paid under this Benefit.

HOME OR VEHICLE CONVERSION
(Applicable to the basic benefit only)

DFS reimburses the initial costs of converting the following if the Covered Person suffers an eligible loss requiring the use of a wheelchair, proof of payment is required:

- 1) the Covered Person's home so that it is wheelchair-accessible, and
- 2) one Vehicle belonging to the Covered Person so that they can access this vehicle and/or drive it.

Reimbursement is limited to one conversion for each expense and an overall maximum of \$10,000.

Reimbursement is only made if:

- 1) the modifications made to the home are done by one or more people approved by a licensed organization that offers support and assistance to wheelchair users, and
- 2) the modifications made to the vehicle are done by one or more people authorized by the provincial motor vehicle office in the Covered Person's

province of residence.

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EDUCATION COSTS
(Applicable to the basic benefit only)

If a Participant dies due to an Accident DFS reimburses an Education Costs benefit for each Child who was covered under the policy on the date of the Accident and the date the Participant dies, if:

- 1) on the date of the Accident the Child is:
 - a) enrolled as a full-time student in an institution of higher learning above the secondary school level, or
 - b) in a secondary school, but then enrolls as a full-time student in an institution of higher learning within 365 days of the death of the Participant, and
- 2) the loss of life benefit is eligible to be paid under this Benefit.

The Education Costs Benefit includes all reasonable and necessary expenses incurred for tuition and related costs, up to

- 1) 2% of the amount that the Participant is covered for under this Benefit on the date of their death, and
- 2) an overall maximum of \$5,000 per year for a maximum of 4 years.

The Child must continue their education on a full-time basis in an institution of higher learning without any interruption longer than the normal school vacation.

SPOUSAL RETRAINING
(Applicable to the basic benefit only)

If the Spouse is covered under the policy on the date the Participant dies due to an Accident, DFS reimburses the reasonable and necessary expenses actually incurred by the Spouse to take part in a formal occupational training program. Reimbursement is limited to a maximum of \$10,000 provided that:

- 1) the Spouse requires training in order to gain the skills necessary to perform the duties of a specific occupation they otherwise do not have sufficient qualifications for,
- 2) the expenses are incurred within 2 years of the date of the Accident, and
- 3) the loss of life benefit is eligible to be paid under this Benefit.

LIMITATIONS AND EXCLUSIONS

Limitations

For multiple losses to the same limb from a single Accident, the maximum amount payable is the loss in the schedule with the highest percentage. Payment for all losses caused by a single Accident cannot exceed:

- 1) 200% of the Amount of Insurance for Hemiplegia, Paraplegia and Quadriplegia, or
- 2) 100% of the Amount of Insurance for other losses.

Exclusions

No benefit is paid for a loss resulting in whole or in part, directly or indirectly from any of the following:

- 1) suicide or intentionally self-inflicted injury, while sane or insane,
- 2) an illness that does not result from an Accident, but that appears at the time of the Accident,
- 3) dental or medical treatment, a surgical procedure or the administration of anaesthesia,
- 4) war, whether declared or not, service in the armed forces of any country or participation in a riot, insurrection or civil commotion,
- 5) travel or flight aboard any aircraft as a pilot or crew member, and not solely as a passenger in an aircraft that:
 - a) is certified airworthy or has a flight permit issued under the appropriate authorities in Canada or under the laws of the country where the aircraft is registered, and all the conditions under which the certificate or permit is issued have been complied with, and
 - b) is used for the sole purpose of transportation and not for aviation training or practice, or for experimental or test purposes,
- 6) committing or attempting to commit a criminal offence, including operation while impaired, as set out under the Criminal Code of Canada.

Under the REHABILITATION, EDUCATION COSTS and SPOUSAL RETRAINING provisions, costs for room and board, ordinary travelling, living and clothing expenses are not eligible.

CRITICAL ILLNESS BENEFIT

SUMMARY OF BENEFITS

When DFS receives satisfactory Proof of Claim for a Critical Illness, DFS will pay the Amount of Insurance then in force according to policy provisions:

- 1) a Specialist diagnosed a Covered Person as having one of the Eligible Illnesses, and
- 2) when the diagnosis of an Eligible Illness is first made, the individual is covered for this Benefit.

In addition, to be eligible, a surgery listed in the Eligible Illnesses provision must be:

- 1) performed in compliance with the written advice of a Specialist, and
- 2) performed by a Physician in Canada.

OPTIONAL CRITICAL ILLNESS BENEFIT

Participant	
Type of Plan	Amount of Insurance
Enhanced	Any multiple of \$10,000 Maximum \$100,000

Dependents		
Amount of insurance		
Type of Plan	Spouse	Each Child
Enhanced	Any multiple of \$10,000 Maximum \$100,000	Any multiple of \$5,000 Minimum: \$10,000 Maximum: \$25,000 No Evidence of insurability is required if application is completed within the time limit

BENEFIT PAYMENT

If, while covered under this benefit, a Covered Person is diagnosed with:

- 1) an eligible illness, DSF pays the Amount of Insurance specified in the Summary of Benefits. The Amount of Insurance is paid for each eligible illness,
- 2) a specific illness eligible to a partial payment, DFS pays a portion of the Amount of Insurance specified in the Summary of Benefits, according to the SPECIFIC ILLNESSES ELIGIBLE TO A PARTIAL PAYMENT provision.

However, for the Participant and the Spouse, certain limitations and exclusions apply for successive illnesses, according to the LIMITATIONS AND EXCLUSIONS provision, whereas a Dependent Child's coverage terminates when an amount is paid for that Child.

ELIGIBLE ILLNESSES

IMPORTANT: A Dependent Child's coverage terminates when an amount is paid for that Child.

CRITICAL ILLNESSES - ENHANCED PLAN

The following Critical Illnesses apply to all Covered Persons.

<p>Aortic Surgery</p> <p>Surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta refers to the thoracic and abdominal aorta, but not its branches.</p> <p>Survival Period: To qualify, the Covered Person must be alive for at least 30 days after the surgery and satisfy the Survival Period definition.</p> <p>Exclusions: No benefit is payable under this condition for the following:</p> <ul style="list-style-type: none"> 1) angioplasty, 2) intra-arterial procedures, 3) percutaneous trans-catheter procedures, or 4) if the Covered Person has already received payment under this Benefit for an Aortic Surgery, a Coronary Artery Bypass Surgery, a Dilated Cardiomyopathy, a Heart Attack (Acute Myocardial Infarction), a Heart Valve Replacement or Repair, Loss of Independent Existence, Progressive Systemic Sclerosis or a Stroke (Cerebrovascular Accident).

Aplastic Anemia

Definite diagnosis of a chronic, persistent bone marrow failure, confirmed by biopsy. This must result in anemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following:

- 1) marrow stimulating agents,
- 2) immunosuppressive agents, or
- 3) bone marrow transplantation.

Exclusion: No benefit is payable under this condition if the Covered Person has already received payment under this Benefit for an Aplastic Anemia, a Cancer (Life-threatening), Loss Of Independent Existence, a Major Organ Failure On Waiting List or a Major Organ Transplant.

Bacterial Meningitis

Definite diagnosis of meningitis confirmed by cerebrospinal fluid that shows growth of pathogenic bacteria in culture. This must result in a documented neurological deficit lasting for at least 90 days from the date of diagnosis.

Exclusions: No benefit is payable under this condition for the following:

- 1) viral meningitis, or
- 2) if the Covered Person has already received payment under this Benefit for a Bacterial Meningitis or Loss Of Independent Existence.

Benign Brain Tumour

Definite diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgical or radiation treatment or cause Irreversible, objective neurological deficits.

Exclusions: No benefit is payable under this condition for the following:

- 1) pituitary adenomas less than 10 mm, or
- 2) if the Covered Person has already received payment under this Benefit for a Benign Brain Tumour or Loss Of Independent Existence.

Exclusion Period: No benefit is payable under this condition if, within the first 90 days following the later of the date of Commencement of Coverage or the effective date of last reinstatement of coverage under this Benefit, the Covered Person:

- 1) had signs, symptoms or investigations that lead to a diagnosis of Benign Brain Tumour without regard to the date of the diagnosis, or
- 2) had a diagnosis of Benign Brain Tumour.

Blindness

Definite diagnosis of the total and Irreversible loss of vision in both eyes, evidenced by:

- 1) corrected visual acuity being 20/200 or less in both eyes, or
- 2) the field of vision being less than 20 degrees in both eyes.

Exclusion: No benefit is payable under this condition if the Covered Person has already received payment under this Benefit for a Bacterial Meningitis, a Benign Brain Tumour, Blindness, Coma, Loss Of Independent Existence, a Motor Neuron Disease, Multiple Sclerosis, Muscular Dystrophy, an Occupational HIV Infection or Progressive Systemic Sclerosis.

Cancer (Life-Threatening)

Definite diagnosis of a malignant tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Types of cancer include carcinoma, melanoma, leukemia, lymphoma and sarcoma.

Exclusions: No benefit is payable under this condition for the following:

- 1) lesions described as benign, non-invasive, pre-malignant, of low and or uncertain malignant potential, borderline, carcinoma in situ, or tumours classified as Tis or Ta,
- 2) malignant melanoma of skin that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis,
- 3) any non-melanoma skin cancer, without lymph node or distant metastasis,
- 4) prostate cancer classified as T1a or T1b, without lymph node or distant metastasis,
- 5) papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest dimension and classified as T1, without lymph node or distant metastasis,
- 6) chronic lymphocytic leukemia classified as Rai stage O without enlargement of lymph nodes, spleen or liver and with normal red blood cell and platelet counts,
- 7) gastrointestinal stromal tumours classified as AJCC stage 1,
- 8) grade 1 neuroendocrine tumours (carcinoid) confined to the affected organ, treated with surgery alone and requiring no additional treatment other than medication to counteract the effects from hormonal oversecretion by the tumour,
- 9) thymomas (stage 1) confined to the thymus, without evidence of invasion into the capsule or spread beyond the thymus, or
- 10) if the Covered Person has already received payment under this Benefit for a Cancer(Life Threatening) unless all the criteria under the LIMITATIONS AND EXCLUSIONS provision of this Benefit are met, an Aplastic Anemia, a Fulminant Viral Hepatitis, Loss Of Independent Existence, a Major Organ Failure On Waiting List, a Major Organ Transplant, an Occupational HIV Infection or a Progressive Systemic Sclerosis.

Exclusion Period: No benefit is payable under this condition if, within the 90 days immediately following the later of the Commencement of Coverage or of last reinstatement of coverage under this Benefit, the Covered Person:

- 1) had signs, symptoms or investigations that lead to a diagnosis of a life-threatening cancer, or
- 2) has received a diagnosis of a life-threatening cancer.

Coma

Definite diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours. The Glasgow Coma Score must be 4 or less during this period.

Exclusions: No benefit is payable under this condition for the following:

- 1) a medically induced coma,
- 2) a coma which results directly from alcohol or drug use,
- 3) a diagnosis of brain death, or
- 4) if the Covered Person has already received payment under this Benefit for a Bacterial Meningitis, a Benign Brain Tumour, Coma, a Coronary Artery Bypass Surgery, a Dilated Cardiomyopathy, a Heart Attack (Acute Myocardial Infarction), a Heart Valve Replacement Or Repair, a Liver Failure Of Advanced Stage, Loss Of Independent Existence, a Major Organ Failure On Waiting List, a Major Organ Transplant, a Motor Neuron Disease, Multiple Sclerosis, Muscular Dystrophy, an Occupational HIV Infection, a Paralysis, the Parkinson's Disease And Specified Atypical Parkinsonian Disorders, Progressive Systemic Sclerosis or a Stroke (Cerebrovascular Accident).

Coronary Artery Bypass Surgery

Heart Surgery to correct a narrowing or blockage of one or more coronary arteries with bypass grafts.

Survival Period: To qualify, the Covered Person must be alive for at least 30 days after the surgery and satisfy the Survival Period definition.

Exclusions: No benefit is payable under this condition for the following:

- 1) angioplasty,
- 2) intra-arterial procedures,
- 3) percutaneous trans catheter procedures,
- 4) non-surgical procedures, or
- 5) if the Covered Person has already received payment under this Benefit for an Aortic Surgery, a Coronary Artery Bypass Surgery, a Dilated Cardiomyopathy, a Heart Attack (Acute Myocardial Infarction), a Heart Valve Replacement Or Repair, Loss Of Independent Existence, Progressive Systemic Sclerosis or a Stroke (Cerebrovascular Accident).

Deafness

Definite diagnosis of the total and Irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz.

Exclusion: No benefit is payable under this condition if the Covered Person has already received payment under this Benefit for a Bacterial Meningitis, a Benign Brain Tumour, Coma, Deafness, Loss Of Independent Existence, a Motor Neuron Disease, Multiple Sclerosis, Muscular Dystrophy or an Occupational HIV Infection.

Dementia, Including Alzheimer's Disease

Definite diagnosis of dementia, which must be characterized by a progressive deterioration of memory and at least one of the following areas of cognitive function:

- 1) aphasia (disorder of speech),
- 2) apraxia (difficulty performing familiar tasks),
- 3) agnosia (difficulty recognizing objects), or
- 4) disturbance in executive functioning (inability to think abstractly and to plan, initiate, sequence, monitor and stop complex behavior), which is affecting daily life.

The Covered Person must exhibit:

- 1) dementia of at least moderate severity, which must be evidenced by a Mini Mental State Exam (MMSE) of 20/30 or less, or equivalent score on another generally medically accepted test or tests of cognitive function, and
- 2) evidence of progressive worsening in cognitive and daily functioning either by serial cognitive tests or by history over at least a 6-month period.

Exclusions: No benefit is payable under this condition for the following:

- 1) affective or schizophrenic disorders, or delirium, or
- 2) if the Covered Person has already received payment under this Benefit for Dementia (including Alzheimer's Disease), a Dilated Cardiomyopathy, a Heart Attack (Acute Myocardial Infarction), a Heart Valve Replacement Or Repair, Loss Of Independent Existence or a Stroke (Cerebrovascular Accident).

Dilated Cardiomyopathy

Definite diagnosis of impaired ventricular function resulting in significant physical impairment of at least Class III of the New York Heart Association (NYHA) Classification of Cardiac Impairment. The Diagnosis must be confirmed by a new echocardiography demonstrating abnormal cardiac function and a persistent low ejection fraction (less than 40%) for at least 3 months.

NYHA Class III cardiomyopathy impairment means that the patient is comfortable at rest and is symptomatic during less than ordinary daily activities despite the use of medication and dietary adjustment. There must be evidence of abnormal ventricular function on physical examination and in laboratory studies.

Survival Period: To qualify, the Covered Person must be alive for at least 30 days after the diagnosis and satisfy the Survival Period definition.

- 1) ischemic and toxic causes (including alcohol and prescription or non prescription drug use), or
- 2) if the Covered Person has already received payment under this Benefit for a Dilated Cardiomyopathy, Loss Of Independent Existence or Muscular Dystrophy.

Exclusions: No benefit is payable under this condition for the following:

- 1) ischemic and toxic causes (including alcohol and prescription or non prescription drug use), or
- 2) if the Covered Person has already received payment under this Benefit for a Dilated Cardiomyopathy, Loss Of Independent Existence or Muscular Dystrophy.

Fulminant Viral Hepatitis

Definite diagnosis of a sub-massive to massive necrosis of the liver caused by any virus leading to sudden liver failure. All of the following conditions must be met:

- 1) a rapidly decreasing liver size as confirmed by abdominal ultrasound,
- 2) necrosis involving entire lobules leaving only a collapsed reticular framework (available histology to be included),
- 3) rapidly deteriorating liver function tests, and
- 4) deepening jaundice.

Exclusions: No benefit is payable under this condition for the following:

- 1) chronic hepatitis,
- 2) liver failure caused by alcohol, toxins or drugs, or
- 3) if the Covered Person has already received payment under this Benefit for a Fulminant Viral Hepatitis or Loss Of Independent Existence.

Heart Attack (Acute Myocardial Infarction)

Definite diagnosis of the death of heart muscle due to blood flow obstruction that resulted in the rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction. At least one of the following must be present:

- 1) heart attack symptoms,
- 2) new electrocardiogram (ECG) changes consistent with a heart attack, or
- 3) development of new Q waves during or immediately following an intra-arterial cardiac procedure including without limitation coronary angiography and coronary angioplasty.

Survival Period: To qualify, the Covered Person must be alive for at least 30 days after the diagnosis and satisfy the Survival Period definition.

Exclusions: No benefit is payable under this condition for the following:

- 1) elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including without limitation, coronary angiography and coronary angioplasty, in the absence of new Q waves,
- 2) ECG changes suggesting a prior myocardial infarction that does not meet the Heart Attack (Acute Myocardial Infarction) definition as described above, or
- 3) if the Covered Person has already received payment under this Benefit for an Aortic Surgery, a Coronary Artery Bypass Surgery, a Dilated Cardiomyopathy, a Heart Attack (Acute Myocardial Infarction), a Heart Valve Replacement Or Repair, a Kidney Failure, a Liver Failure Of Advanced Stage, Loss of Independent Existence, a Major Organ Failure On Waiting List, a Major Organ Transplant, Progressive Systemic Sclerosis or a Stroke (Cerebrovascular Accident).

Heart Valve Replacement or Repair

Surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities.

Survival Period: To qualify, the Covered Person must be alive for at least 30 days after the surgery and satisfy the Survival Period definition.

Exclusions: No benefit is payable under this condition for the following:

- 1) angioplasty,
- 2) intra-arterial procedures,
- 3) percutaneous trans catheter procedures,
- 4) non-surgical procedures, or
- 5) if the Covered Person has already received payment under this Benefit for an Aortic Surgery, a Coronary Artery Bypass Surgery, a Dilated Cardiomyopathy, a Heart Attack (Acute Myocardial Infarction), a Heart Valve Replacement Or Repair, Loss Of Independent Existence or a Stroke (Cerebrovascular Accident).

Kidney Failure

Definite diagnosis of chronic Irreversible failure of both kidneys to function resulting in regular hemodialysis, peritoneal dialysis or for which renal transplantation is initiated.

Exclusion: No benefit is payable under this condition if the Covered Person has already received payment under this Benefit for a Coronary Artery Bypass Surgery, a Dilated Cardiomyopathy, a Heart Attack (Acute Myocardial Infarction), a Kidney Failure, a Liver Failure Of Advanced Stage, Loss Of Independent Existence, a Major Organ Failure On Waiting List, a Major Organ Transplant, an Occupational HIV Infection, a Primary Pulmonary Hypertension (Idiopathic Pulmonary Arterial Hypertension And Familial Pulmonary Arterial Hypertension), a Progressive Systemic Sclerosis or a Stroke (Cerebrovascular Accident).

Liver Failure Of Advanced Stage

Definite diagnosis of liver failure due to cirrhosis and resulting in all of the following:

- 1) permanent jaundice,
- 2) ascites, and
- 3) encephalopathy.

Exclusions: No benefit is payable under this condition for the following:

- 1) liver disease secondary to alcohol or drug use, or
- 2) if the Covered Person has already received payment under this Benefit for a Cancer (Life Threatening), a Coronary Artery Bypass Surgery, a Dilated Cardiomyopathy, a Fulminant Viral Hepatitis, a Heart Attack (Acute Myocardial Infarction), a Kidney Failure, a Liver Failure Of Advanced Stage, Loss Of Independent Existence, a Major Organ Failure On Waiting List, a Major Organ Transplant, an Occupational HIV Infection, a Progressive Systemic Sclerosis or a Stroke (Cerebrovascular Accident).

Loss Of Independent Existence

Definite diagnosis of the total inability, due to disease or injury, to perform independently at least 3 of 6 activities of daily living listed below, with or without the aid of assistive devices. The inability must last for a continuous period of at least 90 days with no reasonable chance of recovery.

Activities of daily living are:

- 1) bathing - washing oneself in a bathtub, shower or by sponge bath,
- 2) dressing - putting on and removing necessary clothing, braces, artificial limbs or other surgical appliances,
- 3) toileting - getting on and off the toilet and maintaining personal hygiene,
- 4) bladder and bowel continence - managing bowel and bladder function with or without protective undergarments or surgical appliances so that hygiene is maintained,
- 5) transferring - moving in and out of a bed, chair or wheelchair,
- 6) feeding - consuming food or drink that already have been prepared and made available.

IMPORTANT: A person's coverage under this Benefit terminates when an amount for Loss Of Independent Existence is paid for that person.

<p>Loss Of Limbs</p> <p>Definite diagnosis of the complete severance of 2 or more limbs at or above the wrist or ankle joint as the result of an Accident or medically required amputation.</p> <p>Exclusion: No benefit is payable under this condition if the Covered Person has already received payment under this Benefit for Loss Of Independent Existence or Loss Of Limbs.</p>
<p>loss Of Speech</p> <p>Definite diagnosis of the total and Irreversible loss of the ability to speak as the result of physical injury or disease, for a period of at least 180 days.</p> <p>Exclusions: No benefit is payable under this condition for:</p> <ol style="list-style-type: none"> 1) all psychiatric related causes, or 2) if the Covered Person has already received payment under this Benefit for a Bacterial Meningitis, a Benign Brain Tumour, Coma, Loss Of Independent Existence, Loss Of Speech, a Motor Neuron Disease, Multiple Sclerosis, Muscular Dystrophy, an Occupational HIV Infection, a Paralysis, or Parkinson's Disease And Specified Atypical Parkinsonian Disorders.
<p>Major Organ Failure On Waiting list</p> <p>Definite diagnosis of the Irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, for which transplantation is medically necessary. The Covered Person must become enrolled as the recipient in a recognized transplant centre in Canada or in the United States that performs the required form of transplant surgery.</p> <p>Survival Period: To qualify, the Covered Person must be alive for at least 30 days after the date of the enrollment in the transplant centre, in the case of a Definite diagnosis of the Irreversible failure of the heart. Any days on life support are not included. Life support means the regular care of a Physician for nutritional, respiratory and/or cardiovascular support, when Irreversible cessation of all functions of the brain has occurred.</p> <p>Exclusion: No benefit is payable under this condition if the Covered Person has already received payment under this Benefit for a Coronary Artery Bypass Surgery, a Dilated Cardiomyopathy, a Fulminant Viral Hepatitis, a Heart Attack (Acute Myocardial Infarction), a Heart Valve Replacement Or Repair, a Kidney Failure, a Liver Failure Of Advanced Stage, Loss Of Independent Existence, a Major Organ Failure On Waiting List, a Major Organ Transplant, a Primary Pulmonary Hypertension (Idiopathic Pulmonary Arterial Hypertension And Familial Pulmonary Arterial Hypertension), a Progressive Systemic Sclerosis or a Stroke (Cerebrovascular Accident).</p>

Major Organ Transplant

Medically necessary transplantation due to a Definite diagnosis of the Irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow. To qualify under Major Organ Transplant, the Covered Person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these organs or tissues.

Survival Period: In the case of a heart transplant, the Covered Person must be alive for at least 30 days after the surgery and satisfy the Survival Period definition.

Exclusion: No benefit is payable under this condition if the Covered Person has already received payment under this Benefit for a Coronary Artery Bypass Surgery, a Dilated Cardiomyopathy, a Fulminant Viral Hepatitis, a Heart Attack (Acute Myocardial Infarction), a Heart Valve Replacement Or Repair, a Kidney Failure, a Liver Failure Of Advanced Stage, Loss Of Independent Existence, a Major Organ Failure On Waiting List, a Major Organ Transplant, a Primary Pulmonary Hypertension (Idiopathic Pulmonary Arterial Hypertension And Familial Pulmonary Arterial Hypertension), a Progressive Systemic Sclerosis or a Stroke (Cerebrovascular Accident).

Motor Neuron Disease

Definite diagnosis of one of the following conditions:

- 1) amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease),
- 2) primary lateral sclerosis,
- 3) progressive spinal muscular atrophy,
- 4) progressive bulbar palsy, or
- 5) pseudo bulbar palsy.

Exclusion: No benefit is payable under this condition if the Covered Person has already received payment under this Benefit for Loss Of Independent Existence or a Motor Neuron Disease.

Multiple Sclerosis

Definite diagnosis of at least one of the following:

- 1) 2 or more separate clinical attacks confirmed by magnetic resonance imaging (MRI) of the nervous system that show multiple lesions of demyelination,
- 2) well-defined neurological abnormalities lasting more than 6 months confirmed by MRI imaging of the nervous system that show multiple lesions of demyelination, or
- 3) a single attack, confirmed by repeated MRI imaging of the nervous system that show multiple lesions of demyelination that developed at intervals at least one month apart.

Exclusion: No benefit is payable under this condition if the Covered Person has already received payment under this Benefit for Loss Of Independent Existence, Multiple Sclerosis or Progressive Systemic Sclerosis.

Muscular Dystrophy

Definite diagnosis of hereditary muscle disorders with slow and progressive deterioration leading to increasing weakness and disability. The diagnosis must be supported by DNA analysis, electromyography and muscle biopsy.

Exclusion: No benefit is payable under this condition if the Covered Person has already received payment under this Benefit for Loss Of Independent Existence or Muscular Dystrophy.

Occupational HIV Infection

Definite diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Covered Person's normal occupation that exposed the person to HIV contaminated body fluids. All of the following conditions must be met:

- 1) the accidental injury must be reported to DFS within 14 days of the accident,
- 2) an HIV serum test must be taken within 14 days of the accidental injury and the result must be negative,
- 3) an HIV serum test must be taken between 90 days and 180 days after the accidental injury and the result must be positive,
- 4) all HIV tests must be performed by a duly licensed laboratory in Canada or in the United States, and
- 5) the accidental injury must be reported, investigated and documented in accordance with current Canadian or United States workplace guidelines.

The accidental injury leading to the infection must have occurred after the later of the date of Commencement of Coverage, or the effective date of last reinstatement of coverage.

Exclusions: No benefit is payable under this condition for the following:

- 1) the Covered Person refused any available licensed vaccine offering protection against HIV,
- 2) a licensed cure for HIV infection has become available prior to the accidental injury,
- 3) HIV infection has occurred due to non-accidental injury including without limitation, sexual transmission and intravenous (IV) drug use,
- 4) if the Covered Person has already received payment under this Benefit for Loss Of Independent Existence or an Occupational HIV Infection.

Paralysis

Definite diagnosis of the total loss of muscle function of 2 or more limbs due to injury or disease to the *neNe* supply to those limbs. The paralysis must last for at least 90 days following the causative event.

Exclusion: No benefit is payable under this condition if the Covered Person has already received payment under this Benefit for a Bacterial Meningitis, a Benign Brain Tumour, Coma, Loss Of Independent Existence, a Motor Neuron Disease, Multiple Sclerosis, Muscular Dystrophy, an Occupational HIV Infection, a Paralysis, Parkinson's Disease And Specified Atypical Parkinsonian Disorders, a Progressive Systemic Sclerosis or Severe Burns.

Parkinson's Disease and Specified Atypical Parkinsonian Disorders

1) Parkinson's Disease

Definite diagnosis of primary Parkinson's Disease, a permanent neurologic condition which must be characterized by bradykinesia (slowness of movement) and at least one of:

- a) muscular rigidity, or
- b) rest tremor.

The Covered Person must exhibit objective signs of progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's Disease.

2) Specified Atypical Parkinsonian Disorders

Definite diagnosis of progressive supranuclear palsy, corticobasal degeneration or multiple system atrophy.

Exclusions: No benefit is payable under this condition for the following:

- 1) any other types of parkinsonism, or
- 2) if the Covered Person has already received payment under this Benefit for Loss Of Independent Existence or Parkinson's Disease And Specified Atypical Parkinsonian Disorders.

Primary Pulmonary Hypertension (Idiopathic Pulmonary Arterial Hypertension And Familial Pulmonary Arterial Hypertension)

Definite diagnosis of primary pulmonary hypertension with a substantial right ventricular enlargement confirmed by investigations (including cardiac catheterization) and resulting in permanent, Irreversible physical impairment to the degree of at least Class IV of the New York Heart Association (NYHA) Classification of Cardiac Impairment.

The NYHA Classification of Cardiac Impairment states the following about Class IV: *"Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest."*

Survival Period: To qualify, the Covered Person must be alive for at least 30 days after the diagnosis and satisfy the Survival Period definition.

Exclusions: No benefit is payable under this condition for:

- 1) all other types of pulmonary arterial hypertension, or
- 2) if the Covered Person has already received payment under this Benefit for Loss Of Independent Existence or a Primary Pulmonary Hypertension (Idiopathic Pulmonary Arterial Hypertension And Familial Pulmonary Arterial Hypertension).

Progressive Systemic Sclerosis

Definite diagnosis of progressive systemic scleroderma with systemic involvement of the heart, lungs or kidneys. The diagnosis must be unequivocally supported by biopsy and serological evidence.

Exclusions: No benefit is payable under this condition for the following:

- 1) localized scleroderma (linear scleroderma or morphea),
- 2) eosinophilic fasciitis,
- 3) CREST syndrome, or
- 4) if the Covered Person has already received payment under this Benefit for Loss Of Independent Existence or a Progressive Systemic Sclerosis.

Severe Burns

Definite diagnosis of third-degree burns over at least 20% of the body surface.

Exclusion: No benefit is payable under this condition if the Covered Person has already received payment under this Benefit for Loss Of Independent Existence or Severe Burns.

Stroke (Cerebrovascular Accident)

Definite diagnosis of an acute cerebrovascular event caused by intracranial thrombosis, hemorrhage or embolism from an extra-cranial source, with:

- 1) acute onset of new neurological symptoms, and
- 2) new objective neurological deficits on clinical examination persisting for more than 30 days following the date of diagnosis.

These new symptoms and deficits must be corroborated by diagnostic imaging testing.

Survival Period: To qualify, the Covered Person must be alive for at least 30 days after the diagnosis and satisfy the Survival Period definition.

Exclusions: No benefit is payable under this condition for the following:

- 1) transient ischoomic attacks,
- 2) intracerebral vascular events due to trauma,
- 3) lacunar infarctions that do not meet the definition of Stroke as described above.or
- 4) if the Covered Person has already received payment under this Benefit for an Aortic Surgery, a Benign Brain Tumour, a Coronary Artery Bypass Surgery, a Dilated Cardiomyopathy, a Heart Attack (Acute Myocardial Infarction), a Heart Valve Replacement And Repair, a Kidney Failure, a Liver Failure Of Advanced Stage, Loss Of Independent Existence, a Major Organ Failure On Waiting List, a Major Organ Transplant, an Occupational HIV Infection, a Primary Pulmonary Hypertension (Idiopathic Pulmonary Arterial Hypertension And Familial Pulmonary Arterial Hypertension), a Progressive Systemic Sclerosis or a Stroke (Cerebrovascular Accident).

The following Eligible Illnesses apply to Dependent Children only.

Cerebral Palsy
Definite diagnosis of a chronic disorder appearing in the first few years of life due to damage to the motor areas of the brain.
Congenital Heart Disease
Definite diagnosis of any serious cardiac malformation present at birth for which corrective surgery has been performed. Survival Period: To qualify, the Covered Person must be alive for at least 30 days after the surgery and satisfy the Survival Period definition.
Cystic Fibrosis
Definite diagnosis of a genetic disease affecting the sweat and mucous glands particularly in the lungs and digestive system, characterized by excess production of thick mucous leading to chronic progressive respiratory disease and nutritional problems.
Down Syndrome
Definite diagnosis of a congenital condition caused by an extra copy of chromosome 21.
Serious Cerebral Lesion
Definite diagnosis of any lesion characterized by an invasive development problem or serious intellectual deficiency that prevents a Dependent Child from performing the basic activities of daily living. The Child must also require daily professional specialized services for treatment, rehabilitation, re-education or schooling.
Serious Mental Deficiency
Definite diagnosis of a deficiency that when evaluated through standard testing, demonstrates an IQ under 70.
Spina Bifida Cystica
Definite diagnosis of a congenital defect, caused by failure of the spine to close properly allowing the spinal cord and its protective covering (meninges) to protrude through the skin. Exclusion: No benefit is payable under this condition for Spina Bifida Occulta.

**SPECIFIC ILLNESSES ELIGIBLE TO A PARTIAL PAYMENT
(Applicable to the Participant and Spouse only)**

Only one of the following Specific Illnesses is eligible during a Covered Person's lifetime.

<p>Coronary Angioplasty</p> <p>An interventional procedure to unblock or widen a coronary artery that supplies blood to the heart to allow an uninterrupted flow of blood.</p> <p>Survival Period: To qualify, the Covered Person must be alive for at least 30 days after the surgery and satisfy the Survival Period definition.</p> <p>Exclusion: No benefit is payable under this condition if the Covered Person has already received payment under this Benefit for an Aortic Surgery, a Coronary Artery Bypass Surgery, a Dilated Cardiomyopathy, a Heart Attack (Acute Myocardial Infarction), a Heart Valve Replacement Or Repair, Loss Of Independent Existence, a Progressive Systemic Sclerosis or a Stroke (Cerebrovascular Accident).</p>
<p>Ductal Carcinoma In Situ Of The Breast</p> <p>Non-invasive breast cancer originating in the ducts of the breast. The diagnosis must be confirmed by biopsy.</p> <p>Exclusions: No benefit is payable under this condition for the following:</p> <ol style="list-style-type: none">1) if, within the first 90 days following the later of the date of commencement of coverage or the effective date of last reinstatement of coverage under this Benefit, the Covered Person has any of the following:<ol style="list-style-type: none">a) signs or symptoms or investigations that lead to a diagnosis of cancer regardless of when the diagnosis is made, orb) a diagnosis of cancer, or2) if the Covered Person has already received payment under this Benefit for an Aplastic Anemia, a Cancer (Life Threatening), a Fulminant Viral Hepatitis, Loss Of Independent Existence, a Major Organ Failure On Waiting List, a Major Organ Transplant, an Occupational HIV Infection or a Progressive Systemic Sclerosis.

Stage A (T1a or T1b) Prostate Cancer

A clinically unapparent malignant tumour localized in the prostate that is neither palpable nor visible by imaging. The diagnosis must be confirmed by pathological examination of prostate tissue.

Exclusions: No benefit is payable under this condition for the following:

- 1) if, within the first 90 days following the later of the date of commencement of coverage or the effective date of last reinstatement of coverage under this Benefit, the Covered Person has any of the following:
 - a) signs or symptoms or investigations that lead to a diagnosis of cancer regardless of when the diagnosis is made, or
 - b) a diagnosis of cancer, or
- 2) if the Covered Person has already received payment under this Benefit for an Aplastic Anemia, a Cancer (Life Threatening), a Fulminant Viral Hepatitis, Loss Of Independent Existence, a Major Organ Failure On Waiting List, a Major Organ Transplant, an Occupational HIV Infection or a Progressive Systemic Sclerosis.

Stage 1a Malignant Melanoma

Diagnosis of a melanoma less than or equal to 1.0 mm in thickness that does not have ulceration or Clark level IV or V invasion. The diagnosis must be confirmed by biopsy.

Exclusions: No benefit is payable under this condition for the following:

- 1) if, within the first 90 days following the later of the date of commencement of coverage or the effective date of last reinstatement of coverage under this Benefit, the Covered Person has any of the following:
 - a) signs or symptoms or investigations that lead to a diagnosis of cancer regardless of when the diagnosis is made, or
 - b) a diagnosis of cancer, or
- 2) if the Covered Person has already received payment under this Benefit for an Aplastic Anemia, a Cancer (Life Threatening), a Fulminant Viral Hepatitis, Loss Of Independent Existence, a Major Organ Failure On Waiting List, a Major Organ Transplant, an Occupational HIV Infection or a Progressive Systemic Sclerosis.

If the Covered Person is diagnosed with one of the Specific Illnesses, DFS pays an amount equal to 10% of the Amount of Insurance specified in the Summary of Benefits to a maximum of \$25,000, subject to the limitations specified under the LIMITATIONS AND EXCLUSIONS provision.

LIMITATIONS AND EXCLUSIONS

Any benefit payment is subject to the exclusions listed under each of the eligible Illnesses.

IMPORTANT: A Dependent Child's coverage terminates when an amount is paid for that Child.

Successive Cancers (Life-Threatening)
<p>DFS pays the Amount of Insurance specified in the Summary of Benefits if a Covered Person receives the diagnosis of a Cancer (Life-Threatening) subsequent to a prior Cancer (Life-Threatening) diagnosis if:</p> <ol style="list-style-type: none">1) more than 60 months have passed since the last benefit payment for Cancer (Life-Threatening), and2) no treatment directly or indirectly related to that cancer has been received within that 60-month period (treatment does not mean preventative medications and follow up visits to the Physician). <p>The subsequent diagnosis of Cancer (Life-Threatening) must be made while coverage is in force.</p>
Successive Critical Illnesses
<p>Subject to the exclusions listed under each illness of the ELIGIBLE ILLNESSES provision, if a Covered Person is diagnosed with a Critical Illness after a benefit payment was made for another Critical Illness, DFS pays the Amount of Insurance specified in the Summary of Benefits provided the Critical Illness is diagnosed at least 90 days after the settlement of the prior claim. No amount is paid if the Critical Illness is diagnosed less than 90 days after the settlement of the prior claim.</p>
Critical Illness following a Specific Illness Eligible To A Partial Payment
<p>If a Covered Person is diagnosed with a Critical Illness after a benefit payment was made for an eligible Specific Illness Eligible To A Partial Payment, DFS pays:</p> <ol style="list-style-type: none">1) the Amount of Insurance specified in the Summary of Benefits provided the diagnosis is made at least 90 days after the settlement of the prior claim, or2) the Amount of Insurance specified in the Summary of Benefits less the amount paid for the Specific Illness Eligible To A Partial Payment, if the Critical Illness is diagnosed less than 90 days after the settlement of the prior claim.

Specific Illnesses Eligible To A Partial Payment following a Critical Illness
Subject to the exclusions listed under each illness of the ELIGIBLE ILLNESSES provision, if a Covered Person is diagnosed with a Specific Illness Eligible To A Partial Payment after a benefit payment was made for a Critical Illness, DFS pays the partial amount provided for Specific Illnesses under this Benefit. This amount is paid in addition to the Amount of Insurance for a Critical Illness.
Geographic Limitation
If an Eligible Illness is diagnosed outside of Canada, the Covered Person may submit a claim for consideration upon their return to Canada. The diagnosis must be confirmed by an appropriate Specialist licensed to practice in Canada.
Pre-existing condition
<p>No amount is paid for any Specific or Critical Illness that results directly or indirectly from a condition or symptoms for which:</p> <ol style="list-style-type: none"> 1) medical expenses are incurred, treatment is received, drugs or medicine are prescribed and/or taken or a Physician or healthcare practitioner is consulted, or 2) an ordinarily prudent person would seek diagnosis, care or treatment, <p>within the 24-month period preceding the date of the Covered Person's Commencement of Coverage or effective date of last reinstatement of coverage.</p> <p>This restriction applies only to amounts equal to or below the Non-Evidence Maximum of Insurability specified in the Summary of Benefits. However, if the Covered Person is continuously covered for more than 24 months or has submitted Evidence of Insurability satisfactory to DFS for an amount in excess of the amount specified in the Summary of Benefits as the Non-Evidence Maximum of Insurability, this restriction does not apply.</p> <p>If the Covered Person was covered under a comparable benefit under the Policyholder's prior group insurance policy for any period of time immediately prior to the Effective Date of this Benefit, that period of time will be taken into account for this restriction.</p>

All other exclusions

No benefits are payable for any Specific or Critical Illness resulting directly or indirectly from any of the following:

- 1) intentionally self-inflicted injury, voluntary exposure to an illness or attempted suicide while sane or insane,
- 2) war, whether declared or not, or active service in the armed forces of any country or participation in a riot, insurrection or civil commotion,
- 3) committing or attempting to commit a criminal offence, including operating a vehicle while impaired as set out under the Criminal Code of Canada,
- 4) alcohol abuse, or
- 5) the use of any medication, narcotic, intoxicant or any other harmful substance, except when taken as prescribed or recommended by a Physician.

**CONVERSION PRIVILEGE
(Applicable to the Participant and Spouse only)**

If the coverage of a Participant who is 65 or younger terminates, the Participant is entitled to convert their and their Spouse's Amount of Insurance to an individual policy without Evidence of Insurability. Eligible Illnesses are limited to those provided under the individual policy and are subject to the conditions indicated therein. The minimum amount that can be converted is \$5,000 and the maximum amount is limited to the lesser of:

- 1) the Amount of Insurance in effect on the date of termination, or
- 2) a total aggregate amount of \$200,000.

The Participant must submit written application for conversion to DFS within 31 days of the termination of their coverage under this Benefit. The individual policy takes effect after 31 days immediately following the date of termination of their coverage under this Benefit.

If the Participant or their Spouse receives the diagnosis of an Eligible Illness within 31 days of termination of coverage under this Benefit, the amount they are eligible to convert is payable.

Once a person is paid the whole Amount of Insurance for a Critical Illness they are no longer entitled to convert their coverage.

HEALTH SPENDING ACCOUNT (HSA)

This benefit is not insured by DFS. It is administered by DFS on behalf of the Policyholder.

ELIGIBILITY

An Employee must be covered under the HSA for their Dependents to be eligible.

SUMMARY OF BENEFITS

When DFS receives satisfactory Proof of Claim that a Covered Person incurred Eligible Expenses while covered under this benefit, DFS will reimburse those expenses according to the HSA agreement provisions.

Allocated Credit Amount
\$250 per HSA Plan Year
HSA Plan Year
From May pt to April 30 of each year

ELIGIBLE EXPENSES

All health related expenses that qualify for the Medical Expense Tax Credit under the Canadian Income Tax Act may be covered under the HSA according to the following for each type of expenses.

Type of expenses	Limitation
Drugs	Expenses covered
Vision Care	Expenses covered
Dental Care	Expenses covered
Other Expenses	Expenses covered

The HSA can be used to claim health related expenses incurred by the Participant and their Dependents.

For most expenses, prescription by a Physician or other health professional as authorized by law is required and particular conditions or limits may apply.

The incurred date for any Eligible Expense is the date the service is provided or the item is supplied.

CREDIT UTILIZATION - CLAIMS CARRYOVER

The Participant's allocated credits are used to reimburse Eligible Expenses incurred during the HSA Plan Year. Any unused credits at the end of the HSA Plan Year are forfeited. However, any portion of Eligible Expenses not reimbursed at the end of an HSA Plan Year can be carried over to the following HSA Plan Year.

CREDITS AVAILABLE UPON REINSTATEMENT OF COVERAGE

If a Participant is hired again during the same HSA Plan Year as the one of employment termination, unused credits are reactivated.

CREDIT MANAGEMENT DURING AN ABSENCE FROM WORK

If a Participant is absent from work:

- 1) credits are maintained while their coverage is continued,
- 2) credits are suspended for the period while their coverage is not continued. Credits remaining unused before the absence from work are reactivated if the Participant returns to work during the same HSA Plan Year. If the Participant returns to work on a subsequent HSA Plan Year, credits are managed according to the applicable CREDIT UTILIZATION provision.

CREDIT MANAGEMENT AT THE PARTICIPANT'S RETIREMENT

Any credits that remain unused at the Participant's retirement can be used for Eligible Expenses incurred before the date of retirement.

CREDIT MANAGEMENT AT THE PARTICIPANT'S DEATH

Any credits that remain unused at the Participant's death can be used for Eligible Expenses incurred prior to the Participant's death only and must be submitted by their Dependents or legal representatives.

SUBMISSION OF CLAIMS

Claims must be submitted to DFS on the appropriate form. When necessary, DFS may also require any other information it deems useful.

DFS manages claims to ensure co-ordination of benefits with any government, group or private insurance plan takes place.

Claims should be submitted in the following order:

- 1) the Participant should submit Eligible Expenses to the group benefit plan under which they are covered as an employee. The same should apply to the Spouse and any other Dependent who is covered as an employee under their own group benefit plan. Claims for dependent children are submitted first to the plan of the parent who has coverage for dependent children. If both parents have dependent coverage, claims are submitted to the plan of the parent whose birth date is the earliest in a calendar year,
- 2) any amount remaining unpaid after 1) should be submitted to the Spouse's plan for co ordination of benefits,
- 3) any amount remaining unpaid after 1) and 2) should be submitted under the HSA.

At any time, benefits payable from all sources cannot exceed 100% of expenses incurred.

All claims for expenses incurred during the HSA Plan Year must be received by DFS 90 days after the end of the HSA Plan Year at the latest , except in the situations described below. All claims will be declined after this date.

SITUATIONS	TIME LIMIT
Retirement	90 days from the date of retirement
Participant's death	90 days from the date of death

SUBMISSION OF CLAIMS IN CASE OF TERMINATION OF COVERAGE

Claims must be submitted to DFS within 90 days of the Participant's termination of coverage or on January 31st of the calendar year following the Participant's termination of coverage, whichever occurs first.

SUBMISSION OF CLAIMS IN CASE OF TERMINATION OF THE HSA AGREEMENT

No amounts are paid as soon as the HSA agreement is terminated, no matter the date the expenses are incurred.

Assuris protection

Desjardins Insurance is a member of Assuris, a not for profit corporation, funded by the life insurance industry. It protects Canadian policyholders against loss of benefits due to the financial failure of a member company.

Details about the extent of Assuris' protection are available at www.assuris.ca or in their brochure, which you can get by writing to info@assuris.ca or calling 1-866-878-1225.

Our commitment to you

We will always be here to answer your questions. You can rely on our knowledgeable team to deliver outstanding service and process your claims efficiently. We are here to help you stay healthy and to give you advice and financial support when you need them most

desjardinslifeinsurance.com/planmember

Desjardins Insurance

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