NISHNAWBE-ASKI LEGAL SERVICES CORP.

NISHNAWBE-ASKI LEGAL SERVICES CORP.

DAVID SUTHERLAND

59086 68934

Employee Benefits for First Nations

CINUP

Certificate Of Insurance

HOMEWOOD HEALTH
DESJARDINS FINANCIAL SECURITY

CERTIFICATE DETAILS

Issue Date **12Nov2024**

DAVID SUTHERLAND
15 RIVERSIDE ROAD
BOX 87
FORT ALBANY ON P0L 1H0

Company **NISHNAWBE-ASKI LEGAL SERVICES CORP.**
Division# **59086 NISHNAWBE-ASKI LEGAL SERVICES CORP.**
Certificate# **0063468934** *Birth Date* **07Mar1951**
Class **S - Status**
Beneficiary **ON FILE**

Benefits:			***Effective Date***
Employee Assistance	Confidential support service		01Jul2021
Extended Health	100% All Benefits	SINGLE	01Jul2021
Dental	100% Basic / 80% Major / 50% Ortho	SINGLE	01Jul2021

2024-11 CU

BOOKLET-API

This certifies that the individual named is insured on the listed Effective Date(s). This certificate replaces and cancels any Group Certificate previously issued to the certificate holder in connection with the group benefit plan. It is valid only while the individual is insured under the terms of the group policy or policies. Benefits are administered by Johnston Group Inc. If you have any questions about your benefits, please contact CINUP:

CINUP Customer Care
1051 King Edward Street
Winnipeg MB R3H 0R4
1 800 665 1234
Email: contactus@cinup.ca

You can also contact us through our website, where you can find general plan information:
www.cinup.ca

Manage your benefits online at www.my-benefits.ca

CINUP

DAVID SUTHERLAND
15 RIVERSIDE ROAD
BOX 87
FORT ALBANY ON P0L 1H0

Benefits Card

Division & Certificate Numbers

Use the Division & Certificate Numbers to identify yourself when calling our Customer Service line and on all correspondence and claim forms.

Prescription Drug Purchases

Use this card for your prescription drug purchases at any pharmacy displaying the ASSURE logo. Please refer to your Benefit Booklet for details.

Dental Claims

Use this card at the dental office. Our CDAnet carrier number can be found on the bottom of the card.

Travel Health

For 24-hour emergency Medical Travel Assistance while outside your province of residence, call the number shown. In the event of an emergency hospital admission, the Medical Travel Assistance service MUST be notified within 48 hours.

CU 59086 68934

BOOKLET-API

CINUP

Division **59086**
Certificate **0063468934**

CDANet: Carrier # 627223
Customer Support 1-800-665-1234
Administered by Johnston Group Inc.

22 641028 0063468934 01
SUTHERLAND, DAVID
NISHNAWBE-ASKI LEGAL SERV

Voyage Assistance
Canada/USA: 1 800 465 6390
Worldwide Toll Free: 800 294 85399
Worldwide Call Collect: 514 875 9170

assure

CINUP

1.800.665.1234

This card is issued to you as part of your firm's group insurance benefit plan. Only you and your covered dependents may use the card to access the benefits provided in your plan. By using the card, you accept the conditions and limits of the coverage including any future modification or cancellation of the card. Because unauthorized use of this card is fraud, please report a lost or stolen card immediately to JG Benefits Inc. at **1.800.665.1234**.

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WELCOME TO CINUP

We are very pleased to welcome you to the Member benefits program referred to as CINUP. CINUP is a Member benefits program specifically designed to meet the needs of Status and Non-Status Members.

The group insurance benefits detailed in this Member booklet have been designed in accordance with First Nations and Inuit Health Branch (F.N.I.H.B.)/First Nations Health Authority (F.N.H.A.) which permits employers to offer their employees the most comprehensive portfolio of benefits based on their financial budget.

Your Member benefits plan described in this booklet has been arranged by NISHNAWBE-ASKI LEGAL SERVICES CORP.. The Member Benefits personnel at CINUP are very keen to make sure that both the employer and all eligible employees and their dependents receive the excellent level of service they both expect and deserve. If the team can be of any assistance, please contact their staff.

This group insurance program is administered by **JG Benefits Inc.** located in Winnipeg, Manitoba. In the event that any questions arise in the future about the benefit coverage, please do not hesitate to contact your employer's Plan Administrator or contact the CINUP Customer Care Centre at:

Telephone: (800) 665-1234
Fax: (833) 702-4687
Email: contactus@cinup.ca

Claim Submission: Claim forms are available from your employer or online at *www.cinup.ca.* Upon completion, claims should be sent to the CINUP Customer Care Centre at:

CINUP

1051 King Edward Street

Winnipeg, MB R3H 0R4

Fax: (800) 457-8410

Important: To avoid delays, always include your Full Name and Certificate #, your Employer Name and Group Policy # on any claim forms or correspondence submitted.

Changing your Records: To ensure your coverage is kept up-to-date, it is vital that you advise your Plan Administrator of any changes, such as change of name, change in marital status, change of beneficiary, or application for benefits previously waived. Changes reported more than 31 days after they occur may require evidence of insurability.

Disclaimer: This Booklet outlines the benefits that are available under CINUP. In the event of a discrepancy between this document and the Group Master Policy, the latter will govern.

REGISTER FOR *MY-BENEFITS*

Access your coverage online with my-benefits

Register now by going to www.my-benefits.ca. Click on Sign me up and then the I am a Plan Member (Employee) button. Verify your identity, choose your own user ID, and your registration is complete. **It's that simple**.

You now have immediate, secure access to your group insurance plan. Submit most of your Health and Dental claims electronically, quickly, and easily... with claim payments deposited directly into your account within 48 hours of being processed.

Once you are registered, you can download the free *my-benefits* app to your mobile device. No need to carry cards in your wallet as your coverage information and prescription drug card are stored on your mobile device.

Look for *my-benefits* at the iPhone App Store and Google Play.

my-benefits health

By registering, you also gain access to our health and wellness site, where you will find up-to-date news, articles, tools, and information on medical conditions and treatments. Locate doctors, clinics, hospitals, support groups, and private or public services in your area.

Use our **Health Risk Assessment** tool to learn about your health risks and what habits and behaviors you may be able to adjust to improve your overall health.

BENEFIT SUMMARY

Firm # 59086 NISHNAWBE-ASKI LEGAL SERVICES CORP.

Certificate # 68934 DAVID SUTHERLAND

CLASS S Status

This *Benefit Schedule* outlines the principal features of the benefits available under your benefit program. More detailed information regarding each benefit can be found in the *Benefit Descriptions* section. In the event of a discrepancy between this document and any contracts of insurance or services, the latter will govern.

Benefits are underwritten or provided by:

Benefit	Insurance Company	Group Policy #
EMPLOYEE ASSISTANCE PROGRAM	HOMEWOOD HEALTH	1574
EXTENDED HEALTH CARE	DESJARDINS FINANCIAL SECURITY	641028
DENTAL (Plan II-10)	DESJARDINS FINANCIAL SECURITY	641028

Your CINUP advisor is:

WP PENSIONS + BENEFITS

497 ELIZABETH STREET

BURLINGTON, ON

L7R2M4

Phone: 905-632-7557

BENEFIT SCHEDULE

EMPLOYEE ASSISTANCE PLAN (EAP) - 01Jul2021

Benefit:	Voluntary, confidential support (counselling, coaching, resources) designed as short term, solution-focused assistance for employees and their family members. Your EAP is a proactive option for professionally helping you manage your health and happiness for a broad range of personal or family issues. There is no limit to the number of assessed problems covered under the plan
Termination:	Coverage terminates at the earlier of retirement or termination of employment.

EXTENDED HEALTH CARE - 01Jul2021

Emergency Travel Coverage (Voyage Assistance)

To access these services under your Health coverage, contact the travel assistance firm at:

- Inside Canada or the US: **1.800.465.6390** (toll-free)
- Elsewhere (excluding North and South America) overseas code**: +800.29.48.53.99** (toll-free)
- Anywhere worldwide: **514.875.9170** (call collect)

(Refer to Benefit Description Section for full details)

Deductible Amount:	Nil
Percentage Of Reimbursement	
Drugs:	• Generic drugs: 100% of the lowest priced equivalent drug available on the market. • Brand name drugs: o 100% of the brand name drug if no equivalent drug is available on the market or if the prescription states "NO SUBSTITUTION". o 100% of the lowest priced equivalent drug available on the market, provided the prescription does not state "NO SUBSTITUTION".
Hospitalization Expenses:	100%
Travel Insurance	Regular Members only: 100%
Paramedical and Other Expenses:	100%
Vision Care:	Eye exams: 100% Eyeglasses, Contact Lenses and Eye surgery: 100%
Limits For Eligible Expenses	
Drugs:	Unlimited

Short-Term Hospitalization Expenses:	The cost of a semi-private room for each day of Hospitalization with no limit as to the number of days.
Hostel Care:	Reasonable and Customary Charges of the per diem rate.
Long-term Hospitalization Expenses:	Convalescent / Rehabilitation Centre: Payable amount of $60 per day and a combined maximum of 180 days per hospitalization period.
Travel Insurance	Regular Members only: Lifetime maximum payable amount of $5,000,000 per Insured Person. Chief and Council and/or Elected officials working less than 24 hours per week and/or who are paid an honorarium are not eligible for the Travel Insurance benefit.
Nursing Care:	Payable amount of $5,000 per Insured Person each Calendar Year.

Paramedical Services:	For the following paramedical practitioners, eligible expenses will be covered up to a maximum of $500 per Insured Person each Calendar Year.
	• *Acupuncturist*
	• *Audiologist*
	• *Chiropractor*
	  o (including 1 x-ray per calendar year (not included in the maximum))
	• *Massage therapist or reflexologist***
	• *Naturopath*
	• *Osteopath*
	  o (including 1 x-ray per calendar year (not included in the maximum))
	• *Podiatrist, chiropodist or foot care nurse***
	  o (including 1 x-ray per calendar year (not included in the maximum))
	  o Alberta and Ontario only - Podiatry coverage is payable from first dollar
	• *Speech therapist*
	• *Dietitian*
	For *Occupational Therapist, Athletic Therapist or Physiotherapist***, eligible expenses will be covered up to a maximum of $1,000 per Insured Person each Calendar Year.
	*For services of a licensed Clinical Psychologist, Social Worker, Registered Clinical Counsellor, Canadian Certified Counsellor, Psychotherapist or any other certified mental health practitioner** covered under the plan and belonging to an accredited association or organization that answers to a disciplinary committee (subject to the approval of the Insurance Company)* eligible expenses will be covered up to a maximum of $1,000 per Insured Person each Calendar Year.
	For *Cardiac Rehabilitation*, eligible expenses will be covered up to a lifetime maximum of $300 per Insured Person.
	***The amount specified applies to all disciplines in that grouping.*

Vision Care:	*Eye exams:* One examination per Insured Person once in any 24 month period for adults and any 12 month period for dependent children subject to a reasonable and customary maximum. *Eyeglasses, lenses:* Covered per Insured Person once in any 24 month period for adults and dependent children subject to a maximum of $300. *Laser eye surgery:* Maximum combined with above Eyeglasses, lenses benefit.
Pocketpills:	Pocketpills makes medication more accessible and affordable for you and your dependents. Fill prescriptions online, consult a pharmacist from the comfort of home, and get all your medications delivered directly to your door. Go to pocketpills.com/cinup for more information.
Teladoc Medical Expert:	Teladoc Medical Expert is a service that helps you make medical decisions with confidence. Whether you're dealing with a chronic condition, questioning surgery or facing a life-threatening illness, Teladoc Medical Expert can guide you in the right direction with the following services: • Expert Medical Opinion • Find a Doctor • Care Finder • Personal Health Navigator
Teladoc Mental Health Navigator:	Mental Health Navigator is a confidential virtual service that provides you with an expert's review of your current mental health condition to either confirm or modify your diagnosis or treatment plan to make sure you are receiving the care and support that is right for you.
Teladoc myStrength:	myStrength is a flexible and comprehensive digital mental health program with proven tools to help manage stress, depression, sleep quality and more. Access is available anytime, in one app.
Teladoc Mental Health Care:	With Mental Health Care members can connect with psychologists, psychiatrists and licensed therapists via phone or video session eliminating the need to travel or wait at the provider's office.
Teladoc:	The Teladoc Telemedicine service allows you to consult with a physician about non-urgent medical matters by video conference, by phone, or by app from wherever you are in Canada or the United States, 24 hours a day, 365 days a year. During your visit, you can receive a diagnosis, treatment recommendations, and even be prescribed medication when necessary.
EHN Program:	EHN Canada is the country's largest network of treatment services for mental health, workplace trauma, and addiction with over 100 years of collective experience. A nationwide team of doctors, nurses, psychotherapists, social workers, occupational therapists, and support counsellors provide treatment using evidence-based best practice in mental health and addiction.
Termination:	Coverage terminates at the earlier of retirement or termination of employment.

DENTAL CARE - 01Jul2021

(Refer to Benefit Description Section for full details)

Fee Guide:	Benefits are based on the current Dental fee guide in your province of residence
Deductible Amount:	Nil
Percentage of Reimbursement	
Preventive Services:	100%
Basic Services, Endodontics and Periodontics:	100%
Status / Status Blend Members:	Claims for preventive, basic, endodontic and periodontic services will initially be reimbursed at 15%. The claim must then be submitted to NIHB. Any remaining unpaid balance may then be re-submitted. Reimbursement from all parties cannot exceed the reimbursement percentage of the incurred expense.
Major Restorative Services:	80%
Orthodontics:	50% Eligible Expenses for children up to age 18 only.
Maximum Benefit	
Preventive Services, Basic Services, Endodontics, Periodontics and Major Restorative Services:	Combined maximum of $1,500 per Insured Person each Calendar Year.
Orthodontics:	Lifetime Maximum of $1,500 per Insured Person.
Limitations:	Fees for composite restorations performed on either anterior or posterior teeth are eligible.

Services Covered	
Basic Services Covered	• Recall Exams - Once every 6 months • Complete Exams - Once every 3 calendar years • Tests, lab exams, treatment planning • Fluoride treatments - Once every 6 months • Polishing - Once every 6 months • Scaling/Root Planing - Reasonable and Customary • X-rays - Complete series of periapical films, panoramic radiographs or cephalometric films, limited to one series in any 24 months • Consultations • Pit and Fissure sealants limited to one application per tooth every 36 months (dependents under age 18 only) • Bitewings - Reasonable and Customary • Space maintainers for children • Fillings (nonbonded, composite, acrylic & silicate) • Extractions - Uncomplicated and complex • Oral surgery • General anaesthesia (if performed in conjunction with an eligible expense) • Relining and rebasing of dentures • Repairs to dentures / fixed bridgework • Adjustment to dentures (3 months after insertion) • Oral Hygiene Instruction is covered once per lifetime
Endodontic and Periodontal services covered	• Treatment of disease of the pulp chamber and canals of the teeth (root canals, pulpectomy) • Treatment of the gums and bones supporting teeth (periodontic surgery & appliances) • Root Canal Therapy - limited to one treatment per tooth per lifetime
Major Services Covered	• Crowns • Replacement of crowns (existing crown must be 5 years old) • Fixed bridgework • Replacement of bridgework (existing bridge must be 5 years old) • Dentures • Replacement of dentures (existing denture must be 5 years old) • Denture adjustments
Orthodontic Services Covered	• Services for diagnostic purposes • Preventive orthodontic treatment • Comprehensive orthodontic treatment
Termination	
Termination	Coverage terminates at the earlier of retirement or termination of employment.

GENERAL GUIDELINES

Participation: Mandatory

Eligibility Requirements:

Minimum Number of Working Hours: Permanent and annual renewable (rolling) contract Employees working a minimum of 20 hours per week. Individuals working for the Employer on a contract basis will be considered as Employees provided the employment contract is for a minimum of 24 months and all other eligibility requirements are met.

Eligibility Period:

All benefits commence immediately.

Waiver of Premium: Premiums are waived in the event of Total Disability for Basic Member Life Insurance, Dependent Life Insurance, and Member Long Term Disability Benefit. Where there is Member Long Term Disability Benefit coverage premiums are waived at the end of the Elimination Period of the Member Long Term Disability Benefit. Where there is no Member Long Term Disability Benefit coverage, premiums are waived after 6 months of Total Disability.

This booklet gives a brief outline of the Group Insurance Program provided by your Employer under CINUP. This booklet does not create or confer any rights to benefits; it is for descriptive purposes only. The exact terms of the plan are described in the more detailed provisions of the group policies. In the event of a discrepancy between the booklet and the group policies, the terms of the policies will be applicable. Your Group Insurance Benefits Card, in addition to your Group Insurance Member Booklet is subject to eligibility requirements and all other terms, conditions and limitations of the master policies.

Your Employer has appointed a Plan Administrator who looks after your insurance. The administrator arranges for enrolment in the plan, changes to insurance, termination from the plan and beneficiary designations.

GENERAL PROVISIONS

MEMBER ELIGIBILITY

All permanent employees in the active service of the Employer are eligible once they have completed the waiting period as stated in the *Benefits Schedule - General Guidelines*. A permanent Employee is one who works a minimum of 20 hours per week.

Part-time employees in Saskatchewan working less than 20 hours per week may be eligible for limited benefits. Please contact the CINUP Customer Care Centre to verify whether your organization would be eligible for these benefits.

An Employee not actively at work on the day the insurance would normally commence will not be eligible until they return to permanent work.

Employees of an organization or other business formally associated or affiliated with the Employer as a subsidiary or otherwise are eligible for insurance, provided that such organization is listed in the group policies.

DEPENDENT ELIGIBILITY

Eligible dependents include a legal spouse or common-law spouse*, as well as any children under Age 21, or 26 if in full-time attendance in school**. *Adopted by custom* children, siblings children, grandchild, etc., may be eligible if acceptable supporting documentation is submitted. Please contact CINUP, or your Plan Administrator for further information.

** Common law spouse must cohabitate with the Member for a minimum of 12 months.*

*** Must submit "Confirmation of School Attendance" for over age dependent children.*

The dependent child Age restriction does not apply to a developmentally or physically disabled dependent child, regardless of Age, provided that the Member provides satisfactory proof of the dependent child's disability within 31 days of the limiting ages above, and as required thereafter.

LATE APPLICANT

You have 31 days from the date you become eligible to apply for insurance benefits.

Submitting an application more than 31 days after becoming eligible for coverage may result in retroactive charges going back to the date you should have been enrolled. Late submission also may result in you becoming a *Late Applicant. Late Applicants* may be required to provide proof of insurability, which could result in delayed coverage, costs to you for the completion of medical forms, tests, etc., or possibly denial of all coverage entirely.

WAIVING EXTENDED HEALTH CARE (EHC) AND DENTAL CARE COVERAGE

If you have similar coverage through a spouse's or partner's group insurance plan through their employer, Extended Health and/or Dental Care coverage under CINUP may be waived. You may also hold *duplicate* coverage under both plans. [See Coordination of Benefits]

If you are single and do not have coverage through a spouse's plan, you do not have the option to waive coverage under CINUP.

MEMBERS INSURED UNDER THEIR SPOUSE'S PLAN

If coverage under your spouse's EHC and/or Dental plan terminates, either because the particular plan terminates or because your spouse becomes ineligible for either or both plans, you are eligible for immediate coverage under your employer's EHC and/or Dental Care Benefits. Any application received after this 31 day period will be considered a *Late Applicant*.

CHANGES IN DEPENDENT STATUS

A Member can change coverage from single to family, or family to single, after a birth, adoption, marriage, separation, divorce or death. If the Member wishes to change from single to family coverage, and does not report the change during the 90 days following the date of the change, the dependents may be considered Late Applicants.

If a Member holds dependent coverage, any subsequent dependents will be provided coverage as soon as CINUP is informed of the new dependent and eligibility has been confirmed. The Member may be asked to provide information to confirm eligibility, such as guardianship papers, or a cohabitation date in the case of a common-law relationship.

TERMINATION OF INSURANCE

Employee Termination

Insurance coverage will cease on the earliest of:

- the date the policy terminates;
- the date you reach the Age Limit for each benefit as specified in the *Benefit Schedule*;
- the date you are no longer in an eligible class;
- the date your class is no longer eligible;
- the last day for which you made any required Employee contribution;
- the date your employment terminates.

Coverage may continue if:

- you are disabled;
- you are on a government regulated leave, i.e., maternity/parental/compassionate care, but no longer than is provincially or federally required;
- your employment is terminated due to loss of eligibility, but no longer than is provincially or federally required.

Dependent Termination

You will cease to be insured for dependent coverage on the earliest of:

- the date your insurance is terminated;
- the date the policy is terminated;
- the date you are no longer in a class eligible for dependent coverage;
- the date you no longer have dependents;
- the last day for which you made any required dependent contribution.

A dependent's insurance will terminate on the earlier of:

- the date you no longer are insured for dependent insurance, or
- the day your dependent loses status as a dependent.

On termination of insurance, you may qualify for Extension of Coverage or Conversion Privilege, as described in certain benefits of the policies.

Should you become temporarily laid off, take a leave of absence or be absent due to disability, please consult your plan administrator as to the status of your coverage under this plan.

ACCESS TO INFORMATION

Where legislated, you have the right to obtain copies of the following documents:

- your enrolment form or application for insurance, and
- any written statement or other record not otherwise part of the application, provided to the insurer as evidence of insurability.

All requests for copies of documents should be directed to the CINUP Customer Care Centre.

COORDINATION OF BENEFITS

Coordination of benefits is available if both spouses in a family are regularly employed and Extended Health Care (EHC) and/or Dental Care plans are provided by both places of employment.

Under the *Coordination of Benefits* provision, you are entitled to claim benefits from both plans, as long as the total benefits received do not exceed the actual expenses incurred.

If the services are provided to you, Desjardins Financial Security / Johnston Group Inc. would be the *primary* carrier and would pay benefits first. The other carrier would then be responsible for considering any unpaid eligible expenses.

If the services are provided to your spouse, the other insurer would be the *primary* carrier and would pay benefits first. Your spouse should submit the claim form to their insurer. After receiving payment, any unpaid eligible expenses can be submitted to Johnston Group Inc. with completed claim forms along with the statement of benefits paid from the other insurer.

If the services are provided to a dependent child, the plan of the covered person with the earlier month and day of birth would be the *primary* carrier. The claim would then be processed according to the procedures listed above.

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

- the plan of the parent with custody of the child;
- the plan of the spouse of the parent with custody of the child;
- the plan of the parent without custody of the child;
- the plan of the spouse of the parent without custody of the child.

DEFINITIONS

Wherever used in the policy:

Accident	means any event due to sudden and unforeseeable external causes that inflicts bodily injuries that are certified by a Physician, directly and independently of any other cause. It does not mean any form of disease, or degenerative process, an inguinal, femoral, umbilical or incisional hernia, or any infection other than an infection of a visible, external cut or wound accidentally sustained.
Actively At Work	means, on any day, the performance by the Employee of all the usual and customary duties of their job with the Employer for the scheduled number of hours for that day.
Age	means the age of the Insured Person on their last birthday when stated or calculated, or on the day when an event referred to under the policy occurs.
Child/Children	means a person who is aged from birth (live birth) up to 21 years of Age or under Age 26 if in full-time attendance at a recognized college or university and is the Member's natural offspring or a child adopted by law. If dependent upon and living with the Member and is aged from birth (live birth) up to 21 years of Age or under Age 26 if in full-time attendance at a recognized college or university, the following other Children will also be eligible: 1. A step-child or foster child; 2. A child adopted by custom; and 3. Any other child who meets the foregoing criteria. The Age limit will not apply where the Child is developmentally or physically disabled and proof of the disability is provided within 31 days of the limiting Age. The requirement that the Child be living with the Member will be waived if the Child must reside in another location to attend school that is not available in their community.
Continuing Medical Care	means the treatment a Member receives. It must be accepted by the medical profession as an effective, appropriate and essential treatment in the diagnosis or care of the specific illness or injury. It must be reasonable, considered as standard practice and provided or prescribed by a Physician or, when the Insurer deems necessary, by a specialist in the appropriate field. Such care is not limited to examination and tests, and must be provided at the frequency required for the specific illness or injury.
Dependent	means a Spouse or Child who is domiciled in Canada. However, if a Dependent is domiciled outside Canada, such Dependent may be deemed to be domiciled in Canada provided such individual is covered under a provincial medical plan and prior written approval is obtained from the Insurer.

Earnings	means the regular rate of pay of an Employee paid by the Employer, including dividends, but excluding bonuses, overtime pay and any non regular form of remuneration. For the Member Weekly Indemnity Insurance benefit that is registered for premium reduction under the Employment Insurance Act, if applicable, bonuses, overtime pay or any other form of pay included in regular compensation and declared to the Insurer is part of Earnings.
Employee	means a person who is domiciled in Canada, except as below, and who is: • employed by the Employer on a permanent or contract basis for not less than the number of hours specified in the *Benefit Schedule*; • retired, having been immediately prior to retirement a person specified in 1) above and who also meets the eligibility requirements as specified in the *Benefit Schedule* (where applicable). • If an Employee is domiciled outside Canada, such Employee may be deemed to be domiciled in Canada provided prior written approval is obtained from the Insurer.
Employer	means any companies listed on the application of the Policyholder for the policy - a type of First Nation legal business, company or entity, which has at least 25% ownership in such legal business, company or entity: • band council; • municipality; • partnership; • proprietorship; • corporation; • educational authority; • a company that employs a minimum of 25% First Nation persons as part of the total number of Employees.
Family-Related Leave	means any leave of absence from work taken by a Member in accordance with such provincial or federal legislation, or an agreement between the Member and the Employer.
Hospital	means any hospital that is designated as such by law and is intended for the care and treatment of sick and injured individuals, and which has organized facilities for diagnosis and major surgeries as well as 24 hour nursing service. The term does not include a nursing home, home for the aged or chronically ill, rest home, Convalescent Hospital, or a place for the care and treatment of alcoholism or drug abuse.
Illness	means any health deterioration or bodily disorder certified by a Physician. For the purposes of the policy, organ donations and related complications are also considered illnesses.
Immediate Family	means a person who is the Spouse, child(s), parent(s), sibling(s), children-in-law, parent-in-law, or sibling-in-law of the Member.
Insurance Act	means the Insurance Act in force in the jurisdiction where a Subscriber resides.
Insured Person	means the Member or one of their insured Dependents, as the case may be.

Insurer	means Desjardins Financial Security.
Maternity Leave	means any leave of absence from work due to pregnancy in accordance with any labour standards legislation that is applicable in the Insured Person's province of residence. Maternity Leave consists of a voluntary portion and a *health related portion*. The *health related portion* of the Maternity Leave commences on the date of the delivery and lasts for at least 6 weeks (8 weeks for a Caesarean delivery). The person is considered to be on Maternity Leave during the entire period for which they are receiving maternity benefits under any provincial or federal legislation. If they're absent from work due to a Total Disability that commenced before or during pregnancy, the Member is considered to be on Maternity Leave in accordance with any provincial or federal legislation.
Parental Leave	means any leave of absence from work taken by a Member to take care of their newborn or adopted child, in accordance with such provincial or federal labour standards legislation, or an agreement between the Member and the Employer.
Member	means an Employee who is insured under the policy.
Physician	means a legally qualified medical practitioner lawfully entitled to practice medicine in the place where the member provides the medical services.
Policyholder	means the company or group indicated on the application and specified on the cover page of the policy.
Spouse	means a person who is domiciled in Canada and who is: • the legal Spouse of the Member by virtue of a religious or civil marriage ceremony; or • the common-law Spouse of the Member with whom the Member has been living in a conjugal relationship continuously for a period of at least 12 months. At any one time, only one person may be insured as a Spouse of the Member.
Usual, Customary, and Reasonable	means the following: • Usual is the usual charge for a given service or supply by an individual providing services or supplies hereunder in their personal practice. • Customary is that range of usual charges by individuals providing services or supplies hereunder of similar training and experience for the same service within a specific limited geographic or socio-economic area. • Reasonable is a charge which meets the above two criteria, or, in the opinion of the provider's professional association, is justifiable in the special circumstances of the particular case in question.

ELIGIBILITY

EMPLOYEE ELIGIBILITY

An Employee is eligible for insurance:

- on the EFFECTIVE DATE, if the member meets the Eligibility Requirements specified in the *Benefit Schedule*; or
- after the EFFECTIVE DATE, on the date on which the member meets the Eligibility Requirements specified in the *Benefit Schedule*.

Except where prohibited, a Member, whose insurance under the policy terminated due to termination of employment and who is re-hired by the Employer within 12 months immediately following the termination of their insurance, will be eligible for the reinstatement of their insurance on the date the Member resumes employment, provided application for reinstatement is made within 31 days of eligibility.

DEPENDENT ELIGIBILITY

A Member with a Dependent on the date they become eligible for insurance under the policy will be eligible for Dependent insurance on such date.

A Member without Dependents who is insured under the policy will be eligible for Dependent insurance on the date the member acquires a Dependent.

Where Spouses are both Employees and insured under the policy, each Spouse will be considered a Dependent of the other and both Spouses may cover their eligible Children.

INSURANCE APPLICATION

An eligible Member must complete an application or an application for exemption for themselves and for their Dependents, if any, within 31 days of the date on which the member becomes eligible.

EVIDENCE OF INSURABILITY

Evidence of insurability means any declaration relating to an individual's physical health or to other factual information that could have a bearing on the acceptance of the risk. Only declarations that are provided on the forms approved by the Insurer will be accepted.

COMMENCEMENT OF INSURANCE AND WAIVER OF PREMIUM

COMMENCEMENT OF MEMBER INSURANCE

The insurance of any Member will become effective on the latest of the following dates, provided that Member is Actively At Work on such date:

- the Effective Date of the policy,
- the date on which the Member first becomes eligible, provided their written application, completed using the form required by the Insurer, is received by the Insurer within 180 days of their date of eligibility,
- the date on which the insurability of the Member is approved by the Insurer, if the application of the Member for insurance is received by the Insurer more than 180 days after the date of their eligibility, the date on which their written application, completed using the form required by the Insurer, is signed by the member.

If a Member is not Actively At Work on the date their insurance would have otherwise commenced, such insurance will commence on the first day the Member is subsequently Actively At Work.

If the Member is not Actively At Work on the date their insurance would have otherwise commenced, due solely to a paid leave or a statutory holiday, then the Member will be considered Actively At Work on such date.

If a Member requests an amount of insurance that exceeds the maximum amount the Insurer will provide without evidence of insurability, as specified in the *Benefit Schedule*, this excess amount will become effective on the latest of the dates specified in the preceding provision or on the date on which the insurability of the Member is approved, if later.

COMMENCEMENT OF DEPENDENT INSURANCE

The insurance for the Dependent of a Member will become effective on the latest of the following dates:

- the date the insurance of a Member first becomes effective under the policy,
- the date a Member insured under the policy first becomes eligible for Dependent insurance, provided written application is made within 90 days of the date of such eligibility,
- the date the insurability of the Dependent is approved by the Insurer, if evidence of insurability is requested of a Member because their application for insurance is received more than 180 days after the date the Member became eligible, the date on which their written application, completed using the form required by the Insurer, is signed by the Member.
- the date the insurability of the Dependent is approved by the Insurer, if the application of the Member for Dependent insurance is made more than 90 days after the Member first became eligible for such insurance, the date on which the written application completed using the form required by the Insurer, is signed by the Member.

The insurance for any individual becoming an eligible Dependent of a Member insured with Dependent insurance will become effective on the date on which such individual becomes a Dependent as defined in this policy.

WAIVER OF PREMIUM

For the Benefits listed in the WAIVER OF PREMIUM provision in the *Benefit Schedule*, as of the Beginning of Waiver of Premium mentioned in the WAIVER OF PREMIUM provision in the *Benefit Schedule*, premiums will be waived for a Member who becomes Totally Disabled while insured under the policy but prior to attaining Age 65 for retirees and age 70 for all other Members, if the Member submits Proof of Claim satisfactory to the Insurer. Premiums will continue to be waived for as long as the Total Disability persists. For the purpose of this provision, premiums will cease to be waived on the earliest of the following dates:

- the date on which the Member is unable or unwilling to provide satisfactory proof of Total Disability to the Insurer, if such proof is not provided within 3 months of the request;
- the date on which the Member ceases to be Totally Disabled;
- for the Life Insurance Benefit, the date on which the Member converts their insurance under the CONVERSION PRIVILEGE provision;
- the date on which the Member attains Age 65 for retirees or the earlier of attaining Age 70 or retirement for all other Members; or
- in respect of each of the Benefits listed in the WAIVER OF PREMIUM provision in the *Benefit Schedule*, the date on which each Benefit or the policy terminates except for the Basic Member Life Insurance Benefit, the Dependent Life Insurance Benefit, the Member Optional Life Insurance Benefit, the Spouse Optional Life Insurance Benefit and the Member Long Term Disability Benefit.

Under the policy, any provision for an increase in coverage is suspended during a Total Disability.

A recurrence of Total Disability within 6 months after the termination of a previous period of Total Disability for which premiums have been waived under the policy shall be deemed a continuation of the previous period if due to the same or related causes.

In the case of the Life Insurance Benefit, if a Totally Disabled Member dies more than 31 days after their insurance terminates, prior to attaining Age 65, and written notice and proof of Total Disability has not been received by the Insurer, the amount of Life Insurance applicable to such Member in accordance with the *Benefit Schedule* that was in effect at the time their insurance terminated will be payable provided that

- the Member became Totally Disabled while insured under this Benefit,
- the Total Disability of the Member was uninterrupted from the onset of their Total Disability to the date of their death,
- the Member dies within 12 months from the onset of their Total Disability,
- the Member did not convert any or all of their insurance under the CONVERSION PRIVILEGE provision at the time their insurance terminated, and
- satisfactory proof of the Total Disability and death of the Member is received by the Insurer within 90 days of their death.

To be eligible for WAIVER OF PREMIUM, the Insurer must receive written notice of Total Disability within 12 months of the date the Member becomes Totally Disabled, and proof satisfactory to the Insurer of Total Disability within 90 days following the date the Insurer received written notice.

In the event of recurrent Total Disability, the Insurer must receive written notice and proof of claim within 12 months of the date of such recurrence.

TERMINATION OF INSURANCE

TERMINATION OF MEMBER INSURANCE

Except as specifically provided to the contrary elsewhere in the policy, the insurance of the Member will terminate on the earliest of the following dates:

- the date the Member no longer qualifies as an Employee, as defined in the policy;
- the date the Member ceases to belong to a class of Members eligible for insurance;
- the date the Member reaches the applicable Age Limit specified in the *Benefit Schedule*;
- the end of the period for which required premiums were paid on behalf of the Member;
- the date the Member ceases to be Actively At Work, except where there is retiree coverage; or
- the date of termination of the policy.

TERMINATION OF DEPENDENT INSURANCE

Except as specifically provided to the contrary elsewhere in the policy, the Dependent insurance of a Member will terminate on the earliest of the following dates:

- the date the insurance of the Member terminates,
- the date the Member no longer has any Dependents,
- the end of the period for which required premiums for Dependent insurance were paid on behalf of the Member, or
- the date Dependent insurance under the policy is terminated.
- The insurance of any Dependent of a Member will terminate on the date the Dependent no longer qualifies as a Dependent, as defined in the policy.

CONTINUATION OF INSURANCE

If a Member ceases to be Actively At Work, the insurance may be continued as specified in the policy.

CLAIMS

NOTICE AND PROOF OF CLAIM

Notice and proof of any claim must be received by the Insurer within the time limit, if any, specified for each Benefit. However, if the policy terminates, no payment will be made unless the notice and proof of a claim is submitted to the Insurer within 120 days of the date of termination of the policy.

Failure to submit notice or proof of claim within the prescribed time limit does not invalidate the claim, provided that the notice and proof of the claim are sent as soon as reasonably possible. However, no payment will be made if the notice and proof of claim are sent more than 12 months after the expenses were incurred.

No action or proceedings may be brought against the Insurer for the recovery of any claim within 60 days or after 3 years following the expiration of the time in which proof of claim is required.

BENEFICIARY

Subject to legal provisions, a Member may designate or revoke, at any time, one or several beneficiaries of the insurance on written notice to the Head Office of the Insurer. The rights of a beneficiary who dies before the Member revert to the latter.

The Insurer assumes no responsibility with respect to the validity of any beneficiary designation or revocation.

The death benefit payable when a Dependent dies is paid to the Member, if alive. If the Member is deceased, the death benefit is paid as follows:

- in the event of the Spouse's death to the Spouse's legal heirs;
- in the event of the death of the Member's Dependent Child, to the Spouse, if alive, or if the Spouse is deceased, to the legal heirs of the Dependent Child.

CLAIMS

Claims under the policy must be submitted to the Insurer on the appropriate form.

Any living benefits will be paid to the Member unless otherwise indicated in the policy.

Within 90 days of a death, the beneficiary or the Member must submit to the Insurer proof of death, including a death certificate, proof of the Age, and Earnings of the Member or the insured Dependent, as well as any other information deemed useful by the Insurer.

If the designated beneficiary is the estate or personal representative of the deceased, or is a minor, or dies before the Member, or is not competent to give valid release, the Insurer reserves the right to pay, at its option and at its discretion, a part of the proceeds of the Member Life Insurance Benefit in an amount not exceeding $5,000 to any person the Insurer deems equitably entitled to such amount to cover the Member's burial expenses. Such payment will fully discharge the Insurer, and the other insurers, provided this payment is made in good faith.

MEDICAL EXAMINATIONS

From time to time, the Insurer will be entitled to have a claimant examined by a Physician or Physicians of its choice.

EMPLOYEE ASSISTANCE PLAN (EAP) PATHFINDER PRO

Homewood Health offers team-based telephonic account support with quick and easy access to all of our online resources, including digital collateral. Your Employee Assistance Program (EAP) is a professional, confidential, and proactive service to support you with a wide range of personal, family, and work-related concerns. Your EAP is here for you whenever you need it, 24 hours a day, seven days a week, 365 days of the year

INDIGENOUS SUPPORT

Homewood Health is one of the largest EAP providers to Indigenous peoples in Canada.

- Elder and Knowledge Keeper Access
- Counsellor matching with experts in Indigenous & First Nations Culture, Residential School System and/or Racism
- Network of over 500 registered licensed counsellors specialized in Indigenous Culture
- Clinical experts experienced working with Indigenous, Inuit, Metis, First Nations

Connecting with an Elder for Indigenous support.

- Call 1-800-663-1142 and request Elder/Knowledge Keeper Support
- Provide us with your 'identified' Elder information
- If you do not have an Elder/Knowledge Keeper, we will connect you with a professional counsellor specialized in Indigenous Culture

WE GUARANTEE YOUR CONFIDENTIALITY

We are Homewood Health, a trusted company with years of experience delivering the best possible support for clients like you. Everyone is guaranteed confidentiality within the limits of the law. You won't be identified to anybody - including your employer.

People frequently use an EAP for personal challenges such as relationship concerns, family or parenting issues, anxiety, depression, addictions, grief, coping with the health issues, or work-related challenges.

We will match you with a counsellor who suits your needs and provide you with short-term solutions.

If you are identified as requiring additional, longer-term treatment or specialized support, our counsellors will refer you to community-based resources and programs which suit your unique needs.

HOW DOES THE COUNSELLING PROGRAM WORK?

Counselling services can be offered face-to face, over the phone, through video, or online. Offices are local and appointments are made quickly, with your convenience in mind. If you have a preference for location, gender, or appointment time, we'll do our best to accommodate your preferences.

When you need to speak with someone, simply call Homewood Health - staff will ask you for some basic information (to establish your eligibility for this benefit) and will help set up an initial appointment at a time

that is convenient for you. An experienced counsellor will assess your concerns and help you develop practical solutions.

SENTIO SELF-DIRECTED iCBT

Self-Guided Online Cognitive Behavioural Therapy helping you take control of your mental health to start feeling better today.

- Mild to moderate depression, anxiety and other mental health issues
- Access therapy anytime of day from a smartphone, tablet or computer
- Over 20 treatment goals to choose from
- Video, audio, text resources and interactive exercises

INTEGRATED WELLNESS & COACHING

Proactive, Integrated Care offering coaching and online resources that will help you with your mental, physical, financial and social well-being.

- Financial
- Legal
- Nutrition
- Lifestyle Changes
- Relationships
- Elder and Family Care
- Physical wellness
- Career planning
- Workplace issues
- Pre-retirement planning
- Shift Work
- Smoking Cessation

DIGITAL MENTAL HEALTH PLATFORM

Improving your online user experience.
A simple to use, smart platform that is personalized based your unique needs and acts as a gateway to all your assistance and mental health resources.

How do I register for Homeweb?

- Step One: Visit www.homeweb.ca and click “Sign Up”.
- Step Two: Enter information into the required fields, choose an email and password, and click “Next Step”. Then, type in your firm name (name located on CINUP benefit card) and click “Find it!”. Select the correct company from the list provided.
- Step Three: Let us know how you are covered by Homewood, (e.g. through your organization or the organization of a family member), and let us know your relationship to the organization (e.g. employee, spouse, dependent, etc.). Submit the additional information required and click “Sign In” at the bottom of the page. Search, browse and get expert support.

ACCESS SPECIALIZED CARE TODAY

All calls are completely confidential. With support available 24/7.

- 1-800-663-1142 | TTY: 1-888-384-1152 | International (Call Collect): 604-689-1717
- Online at homeweb.ca

EXTENDED HEALTH CARE BENEFIT

DEFINITIONS

As used in this Benefit:

Calendar Year	means the period extending from January 1st to December 31st inclusive.
Convalescent/Rehabilitation Centre	means any facility or institution in Canada which is licensed as a convalescent hospital by the licensing body having jurisdiction for the care and treatment of sick and injured persons who require supervision of either a Physician or a registered nurse. This institution must provide nursing care 24 hours a day by a registered nurse and maintain a daily record of each patient under the care of a Physician. However, it does not include a nursing home, home for the aged, or the chronically ill, home for the mentally ill, rest home, or an institution for the care and treatment of alcoholism or drug addiction.
Day Surgery	means any surgery performed by a Physician that requires local or general anaesthesia, with the exception of any minor surgery performed in the office of the Physician.
Dentist	means a person who is licensed to practise dentistry by the appropriate authority of the jurisdiction where the services are provided.
Drugs available on prescription	means drugs prescribed by a Physician or a dental surgeon. This will also include certain drugs requiring a prescription when prescribed by other health practitioners where permitted to do so by provincial law.
Equivalent drug	means a brand or generic drug, deemed interchangeable under the provincial law applicable where the drug is sold.
Hospitalization	means: 1. to be admitted to a Hospital as an In-patient for more than 18 consecutive hours; or 2. any Hospital stay in order to receive Day Surgery.
In-patient	means a person admitted to and assigned a bed in a Hospital In-patient area on the order of a Physician.
Medical Emergency	means any acute and unexpected condition, Illness or injury requiring immediate medical treatment.
Medical Recommendation	means the order to provide medication or care given by a Physician, dental surgeon or a podiatrist duly authorized to do so in the normal performance of their profession.
Orthesis	means any orthopaedic appliance constructed of rigid material, such as metal or plastic, used to maintain a part of the body in the correct position. Elastic supports are not included in this category.

Period Of Hospitalization	means any continuous period of Hospitalization in a Canadian Hospital or successive periods of Hospitalization resulting from the same Illness or Accident and separated by less than 60 consecutive days during which the Insured Person was not hospitalized. If, during a given period, Hospitalization results from an Illness or Accident entirely unrelated to the Illness or Accident that resulted in the previous Hospitalization, this Hospitalization will be treated as a new Period Of Hospitalization.
Prosthesis	means an appliance used to replace all, or part, of a limb or organ.
Reasonable and Customary Charges	means the charges generally paid in the area where the services or supplies are provided for a like service or supply and limited to the prevailing charge in the area for the like service or supply. A like service or supply is one of the same nature and duration that requires the same skill and is performed by a provider of similar training and experience.
Stable	The health condition of an Insured Person who: 1. within 30 days prior to the trip departure date for active Employees, or 2. within 90 days prior to the trip departure date for Retirees (if covered); is not affected by any medical condition, or is affected by a medical condition that: 1. that does not require a change or no change is recommended in the treatment or dosage of prescribed drugs, 2. that does not demonstrate any symptoms that indicate a deterioration of the medical condition during the duration of the Trip, 3. that does not require a Hospitalization or to consult a specialist, 4. that does not require any medical examination or test for investigative purposes awaiting results, and 5. for which no treatment is either planned, pending or not completed.
Vehicle	means a car, a motor home or a van with a maximum load of 1,000 kilograms.

PAYMENT OF BENEFIT

Upon receipt of Proof of Claim satisfactory to the Insurer that a Member, or one of their Dependents, while insured under this Benefit, incurred Eligible Expenses, the Insurer will reimburse the portion of expenses in excess of the Deductible, where applicable, subject to the applicable Percentage of Reimbursement and the limits specified in the Benefit Schedule, and in accordance with the other applicable provisions of this Benefit and this policy.

To be eligible, the expenses must have been incurred as a result of Illness, pregnancy or an Accident, and cover care:

1. which is medically necessary to treat the Insured Person;
2. which is generally provided for an Illness or injury of similar type or seriousness; and
3. which, unless otherwise indicated, was on the prior recommendation of the attending Physician.

In addition, the Eligible Expenses will be limited to the Reasonable and Customary Charges generally paid in the area where the services are provided.

Eligible Expenses will be considered to have been incurred on the date the service or supply was provided.

COMMENCEMENT OF DEPENDENT INSURANCE

If a Dependent is hospitalized on the day their insurance would normally become effective, the effective date of insurance will be delayed, and their insurance will commence 24 hours after their discharge from the hospital. However, the newborn Child of a Member will become insured at birth.

DEDUCTIBLE

The Deductible is the amount of Eligible Expenses that the Member must pay in any Calendar Year before reimbursement will be made under this Benefit. The Deductible is specified in the Benefit Schedule.

CO-PAY

The Co-pay is the portion of Eligible Expenses that the Member must pay for each drug for which expenses were incurred before reimbursement will be made under this Benefit. The Co-pay is specified in the Benefit Schedule.

PERCENTAGE OF REIMBURSEMENT

The Percentage of Reimbursement specified in the Benefit Schedule is the percentage of Eligible Expenses in excess of the Deductible that will be reimbursed by the Insurer, in accordance with the provisions of this Benefit.

ELIGIBLE EXPENSES IN CANADA - EXTENDED HEALTH CARE

Eligible Expenses include charges for the following and must be incurred:

1. in the Member's province of residence; and
2. outside the Member's province of residence, but in Canada, for any reason other than a Medical Emergency.

Hospitalization Expenses

Hospital: Hospital charges for active treatment for each day of Hospitalization, with no limit as to the number of days, up to the maximum specified in the Benefit Schedule.

Convalescent/Rehabilitation Centre: semi-private accommodation in a licensed Convalescent or Rehabilitation Centre, provided that the Insured Person was admitted within 14 days of discharge from a Hospital to which the member was confined as an In-patient and that this stay was primarily required for rehabilitation and not custodial care, up to the maximum specified in the Benefit Schedule.

Hostel Care: If an Insured Person requires treatment or diagnostic testing be done at a Hospital located in their province of residence and is subsequently placed in a recognized medical hostel associated with that Hospital, the accommodation charges will be eligible. However, the medical hostel associated with the Hospital must be outside a 60 kilometre radius of the Insured Person's residence.

Drugs

1. Drugs that are necessary for treatment in respect of an Illness or injury and that are available only on prescription from a Physician or a dental surgeon (code "PR", "C" or "N" in the Compendium

of Pharmaceuticals and Specialties) and dispensed by a pharmacist, or by a Physician, if there is no pharmacist.

Also eligible are drugs available on prescription that are necessary for the treatment of certain pathological conditions, excluding homeopathic preparations, and for which the therapeutic indication suggested by the manufacturer in the Compendium of Pharmaceuticals and Specialties is directly linked to the treatment of the following pathological conditions:

cardiac problems; pulmonary problems; diabetes; arthritis; Parkinson's disease; epilepsy; cystic fibrosis; glaucoma.

2. Injectable drugs prescribed by a Physician for preventing or treating an Illness. Vaccines for Shingles are covered, all other vaccines are not covered.
3. Smoking cessation aids (products only), up to a lifetime maximum of $350 per Insured Person.
4. Fertility treatment (drugs only), directly referable to infertility, up to a lifetime maximum of $15,000 per Insured Person.
5. Obesity Prescription Drugs up to a lifetime maximum of $15,000 per Insured Person.
6. Status Members - drugs listed on the N.I.H.B./F.N.H.A. 'Drug Benefit List' are not eligible under CINUP. Consideration will be given to Drugs that have been declined on an exception basis through N.I.H.B./F.N.H.A.

Provincial Pharmacare / Drug Programs

Provincial Pharmacare/drug programs subsidize eligible prescription drugs and designated medical supplies in the provinces of **British Columbia, Saskatchewan and Manitoba**. To ensure proper co-ordination of benefits between your CINUP coverage and the provincial Pharmacare/drug programs, **Members in these provinces will need to provide CINUP with proof of provincial registration** if their prescription drug usage is in excess of $1500 per year. **However, certain drug treatments require provincial registration for coverage even if drug usage is below $1500**. Please register as soon as possible so that you do not experience a lapse in coverage.

You can register for provincial coverage by going to your respective provincial websites. Once the registration process has been completed, Plan Members should fax or email a copy of the written confirmation of your family's deductible. Failure to submit the confirmation will result in temporary suspension of prescription drug claims. If you have any questions, please contact the CINUP Customer Service Department at 1.800.665.1234 or contactus@cinup.ca, or fax at 1.833.702.4687.

Prior Authorization Program

All new drugs will be reviewed for efficacy and pharmaeconomic value before being added to the plan. CINUP may also take into consideration evaluation of a drug by provincial or national public payers or health technology assessment organizations before determining its eligibility.

Your plan covers drugs that are medically necessary. The Prior Authorization (PA) program applies to a small number of drugs for which prior approval is required before being covered by your plan. For a drug to be approved for coverage, you and your doctor will need to complete a PA form providing us with some medical information.

If the information you provide meets the plan’s medical criteria, then your prescription drug will be

approved for coverage. A list of drugs requiring pre-authorization as well as the PA form can be found on my-benefits (www.my-benefits.ca).

As part of its pre-authorization process, CINUP may request that a drug be purchased from a specialty preferred pharmacy network (PPN) that has been designated by CINUP. If your claim is approved and is subjected to the Specialty PPN, HealthWATCH® specialty care will contact you with instructions. Please note that if the Covered Person should choose to use another pharmacy the Covered Person is solely responsible for its cost.

HealthWATCH® specialty care can be reached at 1-855-512-3739 (8 am to 8 pm ET) for assistance.

2 Step Therapy

This plan includes a diabetic step therapy provision.

This provision permits CINUP to determine the appropriate order of glucagon-like peptide-1 (GLP-1) agonists therapies in the treatment of Diabetes based on evidence of clinical safety, efficacy and cost. The controls will apply to GLP-1 agonists approved by Health Canada for the treatment of diabetes, such as (but not limited to) Adlyxine, Mounjaro, Ozempic, Rybelsus, Trulicity, and Victoza.

Step Therapy is a program that ensures that plan members have tried first line, lower cost therapies before qualifying for reimbursement of higher cost therapies.

Health Professionals

Nursing Care: Services of a registered nurse, a licensed practical nurse or a registered nursing assistant are eligible, up to the payable amount specified in the Benefit Schedule per Insured Person, provided the patient is not confined in a Hospital and the services are medically necessary, are not rendered solely for custodial care, supervision or companionship and psychotherapy, and come within the competence of such nurse. In addition, the nurse must not be related to the member or to any of their Dependents by birth or marriage, and must not ordinarily reside in their or their Dependent's home.

Paramedical Services: Services of the practitioner disciplines specified in the Benefit Schedule and up to the maximum amount specified, provided that the practitioner is operating within their recognized field. The practitioner must be a member in good standing of their professional association that must be recognized by the Insurer. Unless otherwise indicated in the Benefit Schedule, these services do not require prior Medical Recommendation.

Ambulance

Emergency and non-emergency trips provided that:

1. the patient is non-ambulatory;
2. prior recommendation of an attending Physician is obtained;
3. the patient cannot be transported by any other means.

Non-emergency transport will be limited to a lifetime maximum of $250 per Insured Person.

In the province of employment:

1. Ground transport - Reasonable and Customary Charges;

2. Air transport - reimbursement will be limited to the amount that would otherwise have been paid for ground transport.

Outside the province of employment, but within Canada:

1. Ground transport - maximum if $250 per trip, based on the provincial rate;
2. Air transport - reimbursement will be limited to the amount that would otherwise have been paid for ground transport.

Mobility Aids

Conventional wheelchair, electric wheelchair, or scooter: Rental or purchase, at the discretion of the Insurer up to a lifetime maximum of $1,000 per Insured Person.

Walkers or crutches: Purchase or rental, at the discretion of the Insurer.

Orthopaedic Supplies

Spinal brace: Purchase, but not repair, at the discretion of the Insurer.

Brace for a limb, truss and plaster: Purchase, but not the repair or replacement, at the discretion of the Insurer.

Conventional or electric hospital bed: Purchase or rental, at the discretion of the Insurer up to a lifetime maximum of $1,000 per Insured Person.

Orthopaedic shoes or sandals: Orthopaedic shoes are defined as custom-molded shoes specifically designed for an individual to correct a foot defect, as well as open-toed shoes, in-flare or out-flare shoes, straight-laced shoes and shoes required for Denis Browne braces. The cost of modifications or adjustments to stock item footwear is also eligible; in-depth shoes and off-the-shelf shoes that are regular stock are excluded. Prescription by a physician, chiropractor, podiatrist, or chiropodist is required. Purchase up to $300 per insured person/each calendar year.

Orthesis And Prosthesis

Podiatric Orthesis or arch support: Purchase of custom made, up to a payable amount of $500 per Insured Person each Calendar Year. Biomechanical assessment by a physician, chiropractor, podiatrist, or chiropodist is required with each purchase.

Artificial limb: Purchase; the cost for the repair is also eligible; replacement is included when required due to physiological change.

Artificial eye: Purchase, including reimbursement for one polishing or one re-making of the artificial eye each Calendar Year, per Insured Person.

External breast Prosthesis: Purchase of an external breast Prosthesis when required because of total or radical mastectomy, including the purchase of 2 surgical brassieres, up to a payable amount of $200 per Insured Person for any period of 24 consecutive months.

Hearing aids: Purchase on the written prescription of an audiologist or physician, up to a payable amount of $500 per Insured Person for any period of 60 months.

Wigs: Purchase of wigs required as a result of chemotherapy or accidental injury or illness, up to a lifetime maximum of $1,000 per Insured Person.

Therapeutic Equipment

Glucometer, reflectant meter or flash glucose reader: Purchase, or rental, upon medical recommendation, up to a payable amount of $200 and one device for any period of 36 consecutive months.

Oxygen, and equipment required for its administration: Purchase or rental, at the discretion of the Insurer, up to a maximum lifetime amount of $5,000.

Apnea monitor: Purchase or rental, at the discretion of the Insurer, up to a maximum lifetime amount of $1,000 per Insured Person, including supplies.

Blood Pressure Monitors: Purchase or rental, at the discretion of the Insurer, up to a payable amount of $300 per Insured Person every 5 years.

Diabetic supplies: Purchase, at the discretion of the Insurer. Includes test strips, lancets, needles, syringes, flash glucose monitor sensors, continuous glucose monitor receiver, sensors and transmitters.

Other therapeutic equipment: Purchase or rental, at the discretion of the Insurer, provided such equipment is medically required and is intended to cure or treat the affliction, up to a lifetime payable amount of $1,000 per Insured Person. This category of equipment includes, for example, non-union bone stimulators, insulin pumps, aerosol therapy equipment and intermittent positive pressure breathing machines.

Medical Supplies

Catheters, colostomy, ileostomy or uretherostomy supplies: Purchase, up to a lifetime maximum amount of $1,000 per Insured Person.

Elastic support stockings: Purchase of medically necessary surgical elastic stockings on the written recommendations of a physician. They must have a compression factor of 20mmHG or higher - limited to 6 pair per person per calendar year.

Intra-uterine devices: Purchase, up to a lifetime maximum of $250 per Insured Person.

Gavage supplies, tracheotomy supplies, opaque glass, compression garments for treatment of burns, medicated dressings: Purchase, up to a lifetime maximum of $1,000 per Insured Person.

Medical alert bracelet: Purchase, up to $200 per Insured Person each Calendar Year.

Dental Treatment due to an Accident

The services of a dentist required to repair and replace healthy teeth as a result of an accidental blow to the mouth received while the Insured Person is covered under this Benefit or a comparable benefit in force immediately before the effective date of this Benefit, but not as a result of voluntarily or involuntarily putting food or any other object in their mouth. Dental services must be rendered within 90 days of the accident; otherwise, a treatment plan deemed satisfactory by the Insurer will be required before that deadline. No benefit is payable for services provided more than 2 years after the date of the accident.

Vision Care

Eye examinations: Including eye refraction provided they are performed by a qualified ophthalmologist or a licensed optometrist, up to the amount specified in the Benefit Schedule.

Artificial crystalline lenses: Purchase of crystalline lenses implanted surgically as a replacement for natural crystalline if the Insured Person has cataracts, up to a payable amount of $200 per Insured Person each Calendar Year.

Eyeglasses, contact lenses or laser eye surgery and their replacement, provided they are prescribed in writing by a qualified ophthalmologist or a licensed optometrist and dispensed by a qualified ophthalmologist, a licensed optometrist or a qualified optician; or laser eye surgery up to the amount specified in the Benefit Schedule. Prescription industrial safety glasses are eligible for Members only and prescription sunglasses are eligible for all Members and dependents.

Teladoc Medical Expert

Teladoc Medical Expert provides access to expert medical specialists who help you understand your medical condition and treatment options, so you can make the right choice about your care. As long as you hold an Extended Health Care Benefit you and your dependents will have unlimited access to the following Teladoc Medical Expert services:

Expert Medical Opinion: More than a second opinion regarding a medical diagnosis or treatment plan, Teladoc Medical Experts will conduct an in-depth analysis of your medical records, including imaging scans, X-rays, test results and any available pathology (which can be retested). You will receive a written summary of their findings, which includes a diagnosis and treatment recommendations that you can share with your doctor.

Personal Health Navigator: Personal Health Navigator can help you navigate the Canadian healthcare system and get you the information you need for a variety of health topics. Teladoc Medical Expert provides you with a variety of tools and resources when you're facing a medical uncertainty, and can offer advice and wellness support if you need it. You'll gain peace of mind knowing you're making an informed decision about your healthcare.

Find a Doctor: If you're searching for a local specialist let Teladoc Medical Expert do the work for you. They will search their database of top Canadian specialists and take info account your unique medical history and geographic location, matching you with the right physician for your condition.

Care Finder: If you need a specialist outside of Canada they can make it possible through their Care Finder service. They will cater the search to your unique medical history and geographic location, as well as availability of the specialist and/or facility

Accessing Teladoc Medical Expert: Contact Teladoc Medical Expert directly at 1 877 419 2378. Please have your CINUP Benefits Card ready to identify yourself using your firm and certificate numbers. When you contact Teladoc Medical Expert, you will be assigned a Member Advocate (a Registered Nurse) who will assess your medical issue, answer your questions, determine what service would best meet your needs and keep you informed about the progress of your case.

Teladoc Medical Expert is available to all CINUP insureds and their dependents as defined in your benefit plan as well as your parents and parents-in-law. You are responsible for any expenses associated with medical treatment (not covered by your provincial or health care plan), travel and lodging. Teladoc Medical Expert does not make referrals or appointments for members.

Teladoc Mental Health Navigator

The Mental Health Navigator program offers guidance and navigation to members with a mental health condition seeking an expert opinion on an existing diagnosis and treatment.

Mental Health Navigator: Mental Health Navigator provides a discreet and confidential way to seek mental health support from the comfort of your home. You are supported every step of the way by your personal navigator and expert mental health professionals including Canadian psychiatrists and psychologists. You will be provided with an assessment of your diagnosis and recommended an appropriate treatment plan.

Accessing Mental Health Navigator: Members can access this service online at Teladoc.ca, via phone by calling 1-877-419-2378, or by signing into or creating an account on the Teladoc mobile app.

Teladoc myStrength

myStrength is a self-guided platform that uses a digital-first approach to delivering evidence-based interventions to help resolve clinical conditions, build resiliency, manage stress, improve mood, or sleep better.

Convenience: Members can interact with Teladoc Health expert coaches trained in mental health engagement via text through the app. Coaches will help you navigate through the myStrength programs and offer support to better engage with myStrength.

myStrength's evidence based resources address 13 focus areas:

- Depression
- Anxiety
- Stress
- Sleep and insomnia
- Mindfulness and meditation
- Chronic pain
- Substance use disorders
- Drug, opioid and alcohol recovery
- Balancing emotions
- Nicotine
- Trauma
- LGBTQ+
- Lifestyle (pregnancy, parenting, relationships and more)

Accessing myStrength: Members can access this service online at Teladoc.ca, via phone by calling 1-877-419-2378, or by signing into or creating an account on the Teladoc mobile app.

Teladoc Mental Health Care

Mental Health Care: Mental Health Care allows you easy access to arrange confidential virtual therapy sessions with provincially licensed psychologists and therapists by phone or video. You can conveniently connect and build ongoing relationships with mental health professionals who are available seven days a week. Pick a time that is convenient for you and choose your preferred provider based on your needs.

The Mental Health Care service is only available for adults. Children under the age of 18 are not eligible.

The cost of the counselling services may be eligible under your Extended Health Care plan. Please refer to the Paramedical Services section of your Benefit Schedule for coverage details.

To help ensure the best experience for all members seeking support through the Mental Health Care service and optimize the capacity of visits, there is a service charge for missed visits or those cancelled with less than 24 hours-notice. Members will be charged the cost of the visit. Cancellation or missed appointments fees are not eligible for reimbursement under your Extended Health Care plan.

Accessing Mental Health Care: Members can access this service online at Teladoc.ca, via phone by calling 1-877-419-2378, or by signing into or creating an account on the Teladoc mobile app.

Teladoc Telemedicine

Teladoc Telemedicine service allows you to consult with a physician about non-urgent medical matters by video conference, by phone, or by app from wherever you are in Canada or the United States, 24 hours a day, 365 days a year. During your visit, you can receive a diagnosis, treatment recommendations, and even be prescribed medication when necessary.

Convenience:

• You have confidential access to a doctor via app or telephone who is available anytime.

• You get treated for non-emergency conditions like the flu, bronchitis, and much more.

• When necessary, prescriptions are sent directly to your pharmacy of choice.

Greater Access:

• Visits occur within an hour of contact, so you get the care you need when you need it, without the wait.

• The service is even available when you travel to the United States.

Clinical Quality:

• Each doctor is board-certified by the College of Family Physicians of Canada to ensure the highest standards of quality.

• Every visit provides the opportunity for a copy of your visit to be sent to your family physician.

Accessing Teladoc Telemedicine:

Simply download the Teladoc app from Apple or Google Play, complete the registration, and request a consultation either, by video conference or by phone, at 1-877-419-2378. Prior to your first consultation, you must complete an electronic health record for the doctor to review. For more information visit **teladoc.ca**

Teladoc Telemedicine services are available to all insureds and their dependents holding an Extended Health Coverage benefit. You are responsible for any expenses associated with medical treatment (not covered by your provincial or health care plan), travel and lodging.

Teladoc Telemedicine service in the U.S. can only be accessed by telephone.

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

EHN Programs:

Intensive Outpatient Program (IOPs)

The Intensive Outpatient Programs (IOPs) delivered by EHN offer the immersion of inpatient treatment with the flexibility of outpatient care.

- **Who is the program for?**
  - Employees, Spouses and eligible dependent children aged 18 and over.
- **The IOP program includes treatment for both group-based and individual.**
  - The group-based IOPs treat:
    - Concurrent Addiction and Mental Health
    - Mood and Anxiety
    - Workplace Trauma
    - Behavioral Addictions
  - The IOP program for employees consists of:
    - 8 weeks of intensive programming with
      - 9 hours of therapy per week, consisting of 8 hours of group sessions and 1 hour of individual counselling every week and
    - 10 months of aftercare

Comprehensive Teen Program

The Healthy Minds Comprehensive Teen Program is an online therapeutic program designed to help teens struggling with mental health concerns including (but not limited to) depression and anxiety. This virtual program provides a supportive and structured treatment experience that is tailored to help youth make meaningful changes to their life and wellbeing.

- **Who is the program for?**
  - Teens aged 14 to 18 (grades 9 to 12) who are struggling with mental health
  - Caregivers who are looking for education and coaching to better support their teen strategies for youth
- **The six-month program includes:**
  - 9 weeks of therapy
  - 2 hours of group sessions and 50 minutes of individual counselling per week treatment
  - Education on developing understanding and coping techniques, such as Acceptance and Commitment Therapy (ACT) and Dialectical Behaviour Therapy (DBT)
  - 4 months of bi-weekly aftercare groups for long-term recovery
  - Access to corresponding Wagon app with specialized content for teens
  - 12 hours of dedicated caregiver support and education

Wagon App

The Wagon App is provided to clients in aftercare and online programs. The app is instrumental in goal setting, daily check-in, coping tools and progress reports.

- To ensure that the programs offered are applicable to your specific needs, EHN will lead you through an intake process.
- There will be requirements for a tablet or laptop and a reasonable internet or wi-fi connection to ensure that the virtual sessions will flow seamlessly.
- The program is designed to ensure the best outcome on your road to recovery so this will require you to attend all scheduled meetings. Missed scheduled meetings will conclude your program.

To Access the Program:

By Phone: Call into EHN Canada and speak directly with an intake specialist 1.866.920.0184

By Email: Email the outpatient team to get the process started for admission.
Outpatient_admissions@EHNCANADA.com

Online: www.ehnonline.ca

TRAVELING IN CANADA FOR MEDICAL PURPOSES

The Traveling in Canada for Medical Purposes benefit protects you and your eligible dependents from the high cost of traveling within Canada to obtain medical treatment not available in your community.

The following expenses are eligible if adequate medical treatment is not available in your locale, provided transportation occurs to and from the nearest facility (greater than 600 kilometers return) equipped to provide the required treatment. Referral to a Dental Specialist are eligible. A referral letter from the physician and/or dentist is required to document the treatment is not available in your locale. Confirmation of appointment attendance is also a requirement.

Person shall mean patient covered by contract and also Attendant. If an Attendant is required, Attendant means any one medical attendant, or Spouse of the Member, or any one individual who has attained the age of the majority.

The Plan covers 100% of the expenses listed below to a combined lifetime maximum of $2,000 per patient covered by the contract:

- Round economy class travel via commercial airline, train or bus or if driving, coverage for gas expenses from home to treatment facility and the cost to return - $500 per person
- Accommodation - $100 per day per person
- All other incidentals (i.e. meals, parking, taxi) - up to $100 per day

The accommodation maximum noted above shall be considered a combined maximum where shared accommodation is appropriate for the patient and attendant i.e., the attendant is their Spouse or parent of the patient). In cases where the shared accommodation is not appropriate and a second room is required the maximum is $100 per day per person.

All expenses related to the patient and the incident will be included in the $2,000 per person lifetime maximum (ie., the spouse is the attendant, all expenses for the spouse would be covered under the patient's lifetime maximum).

ELIGIBLE EXPENSES - TRAVEL INSURANCE - AVAILABLE TO REGULAR EMPLOYEES ONLY

If an Insured Person incurs Medical Emergency expenses during the first 180 days of a stay outside their province of residence, the Insurer will reimburse the Eligible Expenses in accordance with the Benefit Schedule and the following conditions:

1. the Insured Person must be covered under government health and hospital insurance plans;
2. expenses must be eligible under the Extended Health Care Benefit; and
3. expenses must be related to a Stable health condition prior to the trip departure date.

The Member must contact the Insurer if the duration of the stay outside the province of residence is, or may be, longer than 180 days. Otherwise the Insured Person may not be covered under the Travel Insurance benefit.

Eligible Health Care Expenses

1. Hospital services and room and board charges in a semi-private room until the Insured Person is discharged from the Hospital;
2. Services of a Physician, a surgeon and an anaesthetist;
3. All other Eligible Expenses that are covered under this Benefit in the normal province of residence of the Insured Person, excluding Hospital and Convalescent Care Eligible Expenses, if insured.

Eligible Transportation Expenses

1. Expenses incurred for the repatriation of the Insured Person to their place of residence by a suitable means of public transportation to receive appropriate care as soon as their state of health allows it, provided the means of transportation originally arranged for the return trip cannot be used; repatriation must be approved and arranged by "Voyage Assistance". Furthermore, if "Voyage Assistance" recommends repatriation and the Insured Person declines, their insurance under the Travel Insurance provision will terminate.
2. Expenses incurred for the repatriation (at the same time as the repatriation provided for above) of any Immediate Family member insured under this Benefit, or any children accompanying and under the care of the plan member, if they cannot return to the point of departure by the means of transportation originally arranged for the return trip; repatriation must be approved and arranged by "Voyage Assistance".
3. Expenses incurred for the repatriation (at the same time as the repatriation provided for above) of a dog or cat accompanying the plan member up to a maximum of $500.
4. Expenses incurred for the repatriation (at the same time as the repatriation provided for above) of luggage brought with the plan member up to a maximum of $300. (Payment is for repatriation only; it does not cover the cost of lost luggage.)
5. Round-trip economy transportation for a qualified medical attendant who is not a family member, a friend, or a travelling companion, provided the presence of this attendant is ordered by the attending Physician and approved by "Voyage Assistance".
6. Round-trip economy air, bus or train transportation by the most direct route for one Immediate Family member to the Hospital where the Insured Person must be confined for at least 7 days (expenses will be reimbursed only if the Insured Person remains in Hospital for at least 7 days). This visit is eligible for reimbursement provided that the Insured Person is not accompanied by an Immediate Family member age 18 or over. The cost of living expenses for the Immediate Family member limited to $1,500. The visit must be considered beneficial to the patient by the attending Physician, and prior approval must be obtained from "Voyage Assistance".
7. Cost of returning the personal or rented Vehicle of the Insured Person if the Insured Person suffers from a disability as a result of a Medical Emergency, certified by a Physician, that prevents the member from operating this Vehicle and none of the Immediate Family members accompanying them are able to return it. The vehicle must be in good enough working condition to be returned without mechanical problems. A professional vehicle transport agency may be hired to return the Vehicle, but the return must be arranged and approved by "Voyage

Assistance". The amount reimbursed is limited to $2,500 per Trip to cover reasonable fees such as gas, meals, accommodation and an economy class ticket.

8. If the Insured Person should die, round-trip economy air, bus or train transportation by the most direct route for one Immediate Family member of the deceased to identify the body before repatriation (the trip must be pre-approved and arranged by "Voyage Assistance"). These expenses are not reimbursed if the Insured Person was accompanied by an Immediate Family member age 18 or over.
9. If the Insured Person should die, the costs of preparation and the return of the body or ashes to the place of residence by the most direct route (plane, bus or train), up to $5,000; the cost of the burial coffin is not covered. The return must be pre-approved and arranged by "Voyage Assistance".
10. If the Insured Person should die, cremation or burial at the trip location up to a maximum of $5,000; The cost of the casket or urn is not covered.

Eligible Daily Allowance

The cost of meals and accommodations for an Insured Person who must delay their return because of an Illness or bodily injury suffered by the Insured Person themself, an accompanying member of their Immediate Family or a travelling companion, as well as additional child care expenses for Children not accompanying the Insured Person. Eligible Expenses are limited to $200 per day per covered person for a maximum of 10 days and the Illness or injury must be certified by a Physician.

Eligible Long-distance Telephone Charges

Long-distance telephone charges to reach a member of the Immediate Family if the Insured Person is hospitalized, provided that the transportation allowance, provided under section d) above, to visit that person is not used and that the Insured Person is not accompanied by an Immediate Family member age 18 or over - up to $50 per day, and up to an overall maximum of $200 per Period Of Hospitalization.

Medical Decisions

Decisions by a Physician or other health care professional employed by, under contract to, or designated by "Voyage Assistance", regarding the medical need for providing any of the covered services outlined above are medical decisions based on medical factors and, as such, will be conclusive in determining the need for these services.

Voyage Assistance service

"Voyage Assistance" will take the necessary steps to provide the following services to any Insured 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 Insured Person to their home city, as soon as their state of health permits it;
6. establishing and staying in contact with the Insurer;
7. handling arrangements in the event of death;
8. repatriation of the Children of the Insured Person, if the Insured Person cannot be moved;
9. delivery of medical assistance and drugs to an Insured 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 Insured Person if they 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 Insured 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 insured must contact the travel assistance firm immediately.

Calls from:

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)

Anywhere worldwide 514.875.9170 (collect call)

RESTRICTIONS, EXCLUSIONS AND LIMITATIONS

Eligible Expenses

Eligible Expenses are subject to the limitations and maximums indicated in the Benefit Schedule or this benefit.

No reimbursement will be made under this Benefit for the following:

1. services or treatment 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, treatment or supplies that a person receives without charge or that are reimbursed under a provincial or federal law. If a person is not covered under the laws in question, the Insurer will not reimburse the expenses that would normally be covered under the hospital or health insurance legislation in force in the Insured Person's province of residence;
3. services, treatment or supplies which are experimental in nature;
4. expenses incurred for surgically implanted prostheses, except for crystalline lenses if covered under this policy;
5. services, treatment or supplies provided to the Member by the Employer;
6. wheelchairs adapted or designed for sports activities;
7. electric beds;
8. monitoring devices such as stethoscopes, sphygmomanometers and similar equipment, and domestic appliances such as air purifiers, humidifiers, air conditioners, whirlpools and other similar equipment;
9. equipment such as "Obus form" type;
10. training, exercise programs, physical fitness programs using equipment or floor exercises, floating baths, mud baths, therapeutic baths, relaxation exercises, gym exercises, stretching and strengthening exercises, postural evaluations and ear candling;

11. diapers for incontinence;
12. dental services, except those provided for in this Benefit;
13. dental services and supplies for the purposes of full mouth reconstructions, for vertical dimension correction or for any other temporomandibular joint dysfunction;
14. travel for health reasons or for medical examinations required for insurance, consultation or assessment purposes;
15. services, treatment or supplies not included in the list of Eligible Expenses;
16. Eligible Expenses which result directly or indirectly from the following:
    a. cosmetic treatment, except those provided for in this Benefit;
    b. committing, or attempting to commit a criminal offence;
    c. any cause for which payment is provided under any Workers' Compensation Act or similar legislation or under any other government plan;
    d. war, whether the war be declared or not, or service in the armed forces of any country, or participation in a riot, insurrection or civil commotion;
    e. driving a motorized Vehicle while impaired by drugs, or with an alcohol level that exceeds the limit set under the Criminal Code of Canada; the Eligible Expenses incurred for detoxification treatment are not subject to this exclusion;
17. services, treatment or supplies for the treatment of alcoholism and drug addiction;
18. non-prescription sunglasses;
19. broken appointments, transportation costs, telephone or other indirect consultations;
20. any prescription drugs or medical expenses normally covered through a government program provided in a hospital, or any other means are not covered when offered on an out-patient basis or at a private clinic (unless legislated as in the province of Quebec);
21. services, treatment or supplies which are not medically necessary, or not of a reasonable and customary nature;
22. charges for group sessions;
23. imaging techniques/diagnostic laboratory tests.

Exclusions applicable to drugs

No reimbursement will be made under this Benefit for the following:

1. contraceptives (prophylactics and contraceptive jellies and foams) except those provided for under this Benefit;
2. the following products, whether or not prescribed:
    a. shampoos and other scalp care products, including hair growth products;
    b. beauty-care products;
    c. cosmetics;
    d. so-called "natural" products and homeopathic preparations;
    e. sun-tan emulsions (sunscreens);
    f. soaps;
    g. over-the-counter laxatives;
    h. over-the-counter antacids;
    i. skin softeners;
    j. disinfectants and ordinary dressings;
    k. mineral water;
    l. any infant milk formulas;
    m. proteins and food supplements (i.e. products used to supplement or complement a diet);

3. sclerosing injections used in the treatment of varicosities, telangiectasia or dilation;
4. products and drugs used in the treatment of sexual dysfunctions except for those provided for under this Benefit;
5. products used as smoking cessation aids, except those provided for in this Benefit;
6. expenses incurred for services, products or drugs that are used to treat specific conditions other than those for which they are approved;
7. expenses incurred for services, products or drugs that are taken in a higher dose, greater quantity or at a frequency that exceeds the Insurer's established criteria.

Exclusions applicable to drugs requiring prior authorization:

No reimbursement will be made under this Benefit for drugs that do not meet the Insurer's prior authorization criteria on the date the expenses were incurred.

Drug restrictions:

1. the Insurer reserves the right to apply certain restrictions for the reimbursement of drugs for which a less expensive equivalent drug is available on the market;
2. any one prescription for drugs or medicines must not be in excess of a 34 day supply and a 100 day supply in the case of maintenance drugs.

Exclusions and limitations applicable to Travel Insurance - Applicable to Regular Employees Only
If an Insured Person fails to contact "Voyage Assistance" immediately when they require Medical Emergency services that require Hospitalization outside the country, the Insurer may reduce or deny reimbursement of a portion of the incurred Eligible Expenses. It is understood that the Insurer is not responsible for the availability or quality of such services even after repatriation.

Exclusions applicable to the Extended Health Care Benefit also apply to the Travel Insurance provision. Furthermore, the Insurer will not pay any of the benefits provided for under the Travel Insurance provision in the following circumstances:

1. if the Insured Person is not covered under government health and hospital insurance plans;
2. if the purpose of the Trip is to receive medical or paramedical treatment or Hospital services;
3. for elective, non-emergency treatment or surgery, when this service could have been provided in the province of residence of the Insured Person without endangering their life or health, even if such service is provided as a result of a Medical Emergency;
4. if the Insured Person did not agree to:
    a. the treatment prescribed by the Physician or "Voyage Assistance";
    b. change hospital or clinic;
    c. be examined for diagnostic purposes;
    d. repatriation as recommended by "Voyage Assistance";
5. for the cost of the casket or urn;
6. if a Physician advised the Insured Person not to travel;
7. for health care and Hospital expenses incurred for an Insured Person who cannot be repatriated in their province of residence and who refuses medical treatment prescribed by the Physician, and approved by "Voyage Assistance";
8. if the Insured Member’s life expectancy is less than 12 months;
9. for expenses incurred for a pregnancy, miscarriage or childbirth, or any complications thereof, will not be covered if the expenses are incurred after the first 32 weeks of the pregnancy;

10. for an accident that occurs while travelling and resulting from the Insured 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, paragliding and kite surfing;
    b. skydiving and free falling;
    c. bungee jumping;
    d. climbing and mountain climbing;
    e. freestyle skiing and off-track skiing;
    f. amateur scuba diving, if the person does not hold at least a basic scuba diving license from a certified school;
    g. combat sports;
    h. motorized race and motorized training activities;
11. for any Medical Emergency incurred in a country, region or other types of destinations such as cruises or landmarks, for which the Canadian government issued level 4 alerts, prior to the trip departure date, the following travel warning:
    a. avoid all travel;
    b. Insured Members already in a Level 4 alert location must return as soon as possible and within 14 days of the date the alert was issued;
12. if the Insured Person refuses to disclose to the Insurer necessary information regarding other insurance plans under which the member also has travel insurance coverage, or if they refuse the use of such information by the insurer;
13. if the expenses incurred are related to a health condition that was not Stable prior to the trip departure date;
14. for death or expenses directly or indirectly related to:
    a. Drug use, or
    b. Medication or alcohol abuse.

Medication abuse means intake in excess of the recommended dosage. Alcohol abuse means a blood alcohol content in excess of that allowed under the Criminal Code of Canada.

Travel Insurance benefits are limited to the maximum specified in the Benefit Schedule.

CO-ORDINATION OF BENEFITS

This Benefit is subject to the CO-ORDINATION OF BENEFITS provision in the CLAIMS section of this policy, and to the provisions below.

Total benefits payable under this Benefit and, if applicable, the MEMBER ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT and the DEPENDENT ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT if included under this policy cannot exceed the amount of Eligible Expenses incurred.

If expenses incurred by the Insured Person are eligible for payment under both this Benefit and, if applicable, the MEMBER ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT and the DEPENDENT ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT if included under this policy, such expenses will be payable under the ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS prior to any payment under this Benefit. As such, the liability of the Insurer under this Benefit will be limited to the unpaid balance of these Eligible Expenses.

BENEFIT TERMINATION

This Benefit terminates on the date the Member attains the Age Limit specified in the Benefit Schedule or on the earliest of the dates indicated in the TERMINATION OF MEMBER INSURANCE provision.

DEPENDENT BENEFIT EXTENSION AFTER MEMBER'S DEATH

In the event of the death of the Member and subject to policy provisions, insurance under this Benefit will continue for insured Dependents, without premium payment, until the earliest of the following dates:

1. 24 months following the death of the Member;
2. the date on which the Dependent ceases to be eligible as a Dependent for a reason other than the death of the Member;
3. the date on which Dependent insurance would have terminated if the Member had not died; or
4. the date on which this Benefit or policy terminates.

NOTICE AND PROOF OF CLAIM

All claims, along with any receipts, must be submitted to the Insurer within 12 months of the date the expenses were incurred, or 120 days from termination of coverage.

All claims must be signed by the Member. Claims for a spouse or dependent children can be signed by the Member's spouse, as long as the spouse is a covered dependent under this plan.

SUBROGATION

Upon providing payment for incurred expenses or loss of income, CINUP, on behalf of the Plan Sponsor, is subrogated to all rights of recovery of the Member, or any Dependents, against any person or party and may bring action in the name of the Member, or Dependent, to enforce such rights.

DRUG CLAIMS

When incurring drug expenses, the Insured Person must show their payment card to the pharmacist. With this method of payment, which is referred to as "direct", the Insured Person only pays the pharmacist for the uninsured portion of the drug expenses incurred and, therefore, the Member is not required to submit a claim to the Insurer.

DENTAL CARE BENEFIT

DEFINITIONS

As used in this Benefit:

Calendar Year	means the period from January 1st to December 31st inclusive.
Dental Hygienist	means a person licensed by an accredited dental faculty to perform dental prophylaxis.
Dentist	means a person who is licensed to practise dentistry by the appropriate authority of the jurisdiction where the services are provided.
Fee Guide	means the Dental Association Fee Guide for General Practitioners and Specialists of the Province in which the Insured Person is resident, for the Calendar Year mentioned in the BENEFIT SCHEDULE.

LATE APPLICATION

With respect to this Benefit, if the Member applies for coverage for themself or their Dependents more than 31 days after the date of their eligibility, evidence of insurability will not be required by the Insurer. However, in all cases, the Insurer will limit the amount of Eligible Expenses in accordance with the RESTRICTIONS, EXCLUSIONS AND LIMITATIONS provision under this Benefit.

PAYMENT OF BENEFIT

On receipt of Proof of Claim satisfactory to the Insurer that an Insured Person, while covered under this Benefit, incurred Eligible Expenses which were necessary and which were for services recommended by a Dentist, the Insurer will reimburse the expenses in excess of the Deductible, if any, subject to the Percentage of Reimbursement and maximums specified in the Benefit Schedule, and in accordance with other applicable policy provisions.

To be eligible, the expenses must have been performed

1. by a Dentist; or
2. by a Dental Hygienist under the supervision of a Dentist; or
3. by a licensed denturist when such services are within the scope of their license.

Eligible Expenses will be considered to have been incurred on the date the service or supply was provided. However, with respect to a bridge, crown or denture, the date of insertion of such appliance will be the date such expense was incurred, and with respect to root canal therapy, the date of the final treatment will be the date that expense was incurred.

COMMENCEMENT OF DEPENDENT INSURANCE

If a Dependent is hospitalized on the day their insurance would normally become effective, the effective date of insurance is delayed, and their insurance will commence 24 hours after their discharge from the Hospital. However, the newborn Child of a Member will be covered at birth.

DEDUCTIBLE

The Deductible is the amount of Eligible Expenses that the Member must pay in any Calendar Year before reimbursement will be made under this Benefit. The Deductible is specified in the Benefit Schedule.

PERCENTAGE OF REIMBURSEMENT

The Percentage of Reimbursement specified in the Benefit Schedule is the percentage of Eligible Expenses in excess of the Deductible that will be reimbursed by the Insurer, in accordance with the provisions of this Benefit.

ELIGIBLE EXPENSES IN CANADA

PREVENTIVE SERVICES	
Examinations	• Complete oral examination, once every 3 Calendar Years • Recall oral examination, according to the frequency specified in the Benefit Schedule • Specific oral examination • Emergency oral examination
Radiographs (X-Rays)	• Complete series of periapical films, panoramic radiographs or cephalometric films, limited to one series in any 24 months • Intra oral films, including bitewing films and radiographs to diagnose a symptom or examine progress of a particular course of treatment • Interpretation of radiographs from another source • Photography • Radiograph of the hand and wrist as a diagnostic aid for dental treatment
Lab Tests and Examinations	• Bacteriologic cultures/smears to determine pathological agents • Biopsies • Pulp vitality tests • Unmounted diagnostic casts
Case Presentation and Explanation	• Consultation with a patient

Preventive Services	• Polishing according to the frequency specified in the Benefit Schedule • Light scaling for preventive and therapeutic purposes according to the frequency specified in the Benefit Schedule • Topical application of fluoride, according to the frequency specified in the Benefit Schedule • Finishing restorations • Pit and fissure sealants limited to one application per tooth every 36 months (for dependent children under age 18 only) • Interproximal disking • Space maintainers for missing primary teeth, for Children under Age 18 • Prophylactic odontotomy/enameloplasty • Occlusal equilibration, limited to 8 units per calendar year • Oral hygiene instruction (once per lifetime)
BASIC SERVICES, ENDODONTICS AND PERIODONTICS	
Restorations	• Amalgam (silver) • Composite restorations in accordance with the LIMITATIONS provision of the Dental Care section in the Benefit Schedule • Replacement fillings done within 12 months of original placement are not eligible • Retentive pins for amalgam and composite restorations • Preformed stainless steel and polycarbonate crowns, for Children under Age 18 • Caries / trauma / pain control, separate procedure from restoration
Endodontics	• Treatment of disease of the pulp chamber and pulp canals • Root canal therapy limited to one treatment per tooth per lifetime
Periodontics	Treatment of the soft tissue (gums) and bone supporting the teeth. However the following expenses are limited: • post-operative visits • curettage performed by a Dentist • root planing • periodontal appliance to control bruxism only • adjustments to periodontal appliance to control bruxism only, limited to one adjustment per Calendar Year
Maintenance of Removable Dentures	• Repair • Structure addition (to an existing removable dentures) • Relining • Rebasing • Adjustments to dentures, 3 months after insertion • Denture adjustments including minor adjustments

Oral Surgery	• Extractions - uncomplicated and complex • Removal of residual roots • Surgical exposure of teeth • Alveoplasty, gingivoplasty, stomatoplasty and osteoplasty • Alveolar ridge reconstruction • Extension of mucous folds • Excisions • Incisions • Frenectomy • Miscellaneous surgical procedures
Other Services	• appliances to control harmful oral habits • general anaesthesia only is eligible when administered in conjunction with an Eligible Expense
MAJOR RESTORATIVE SERVICES	
Prosthodontics	Expenses incurred for a permanent initial prosthodontic appliance, such as partial or full removable denture or fixed bridge.
Removable Dentures	• Complete denture • Immediate complete denture • Complete or partial overdenture • Transitional denture • Partial denture including cast in chrome (but not in gold) • Partial denture remake • Remount with occlusal equilibration • Therapeutic tissue conditioning
FIXED PROSTHODONTICS (Bridges)	• Abutments and pontics • Repairs • Bridge removal • Recementation

Other Single Restorations	• Onlays, veneers, inlays, crowns
	  o for a tooth that is fractured due to caries or traumatic injury and cannot be filled by amalgam or composite
	  o temporary crowns are considered to be part of the final restoration
	  o replacement of an existing onlay, veneer application, inlay or crown is included if such restoration is at least 5 years old
	  o only metal crowns on molars are reimbursed
	• Porcelain repair
	• Post, pin and core once per tooth every 5 Calendar Years Retentive pins, pivots, cast posts
	• Recementation
	• Removal of an inlay or crown

ORTHODONTICS	If an Insured Person incurs Eligible Expenses that are for necessary dental treatment that has as its objective the correction of malocclusion of the teeth, as listed below, the Insurer will reimburse such expenses, in accordance with the provisions of this policy and subject to any maximum specified in the Benefit Schedule. • services for diagnostic purposes • preventive orthodontic treatment • comprehensive orthodontic treatment

ELIGIBLE EXPENSES OUTSIDE CANADA

Payment will be made for dental treatment rendered while travelling outside Canada, but only to the extent that payment would have been made under this Benefit if such treatment had been rendered in the normal province of residence of the Insured Person and provided that such treatment was rendered for emergency purposes only.

RESTRICTIONS, EXCLUSIONS AND LIMITATIONS

In the event of late application of the Member or their Dependents, in accordance with the Late Application provision under this Benefit, reimbursement will be limited to $250 per Insured Person for the first 12 months of coverage.

Reimbursement will not be made for any portion of the charge in excess of the suggested fee in the appropriate Fee Guide, as specified in the Benefit Schedule. When there are two or more courses of treatment available to adequately correct a dental condition, this plan will provide reimbursement for the treatment that incurs the lowest cost consistent with good dental care.

Reimbursement of lab fees will be limited to the reasonable and customary charge for such services in the area where the services are provided. However, in no event will the total reimbursement of lab fees exceed 60% of the suggested fee in the appropriate Fee Guide, as specified in the Benefit Schedule, for the particular dental treatment requiring the lab services.

Reimbursement of fees for composite restorations performed on posterior teeth may be limited to the fees for amalgam restorations as specified in the LIMITATIONS provision of the Dental Care section in the Benefit Schedule.

No reimbursement will be made under this Benefit for the following:

1. any dental treatment which is for cosmetic purposes when the form and function of the teeth are satisfactory and no pathological condition exists;
2. charges for nutritional counselling;
3. any dental services or supplies, including X-rays, provided for full mouth reconstruction, for vertical dimension correction, for the correction of temporomandibular joint dysfunction or for permanent splinting of teeth;
4. charges levied by a Dentist for broken appointments, completion of claim forms or advice by telephone;
5. expenses incurred for bacteriologic cultures/smears followed by a Chlorzoin treatment;
6. expenses incurred for implants;
7. expenses incurred for duplicate diagnostic casts (unmounted);
8. expenses incurred for anaesthesia administered by acupuncture;
9. any dental treatment that is not yet approved by the Canadian Dental Association or that is for experimental purposes;
10. dental services, treatment or supplies that the individual received without charge or that a government health plan prohibits from being paid;
11. services, treatment or supplies provided to the Member by the Employer;
12. any dental treatment rendered outside Canada except as specifically provided under the ELIGIBLE EXPENSES OUTSIDE CANADA provision;
13. dental services and supplies not included in the list of Eligible Expenses;
14. Eligible Expenses that result directly or indirectly from the following:
    a. committing, or attempting to commit a criminal offence;
    b. any cause for which payment is provided under any Workers' Compensation Act or similar legislation or under any other government plan;
    c. war, whether war be declared or not, or service in the armed forces of any country, or participation in a riot, insurrection or civil commotion;
15. charges for services that are not reasonable and customary;
16. any services and supplies rendered for the treatment or correction of any congenital or developmental malformation;
17. facility fees.

Exclusions Related To Prostheses And Crowns	No reimbursement will be made under this Benefit for the following: 1. expenses incurred for the replacement of dentures and appliances that are lost, mislaid or stolen; 2. prosthetics with precision attachments or stress breakers; 3. precision attachments and telescoping crown units for fixed bridgework; 4. preformed stainless steel or polycarbonate crowns, except in the case of primary teeth; 5. transfer coping for crowns.

Exclusions Related To Orthodontic Treatment	No reimbursement will be made under this Benefit for the following: 1. myofunctional therapy; 2. replacement or repair of an orthodontic appliance; 3. patient motivation (psychological evaluation and progress, per visit); 4. procedure requiring the insertion of an adjustable orthodontic appliance before the person is insured under this Benefit.

CO-ORDINATION OF BENEFITS

This Benefit is subject to the CO-ORDINATION OF BENEFITS provision in the CLAIMS section of this policy.

PRE-DETERMINATION OF BENEFIT

When the total cost of any proposed dental treatment for an Insured Person is expected to exceed $500, the Member should submit a detailed treatment plan to the Insurer before treatment commences. The Insurer will then advise the Member of the amount of reimbursement for which the Insured Person is eligible in accordance with the provisions of this policy. The treatment plan should outline the type of treatment to be provided, the anticipated treatment dates, and the cost of such treatment.

The treatment plan submitted must be completed by the Dentist who first proposed the treatment, otherwise the Member will be required to submit a new treatment plan to the Insurer for re-assessment.

BENEFIT TERMINATION

This Benefit terminates on the date the Member reaches the Age Limit specified in the Benefit Schedule or on the earliest of the dates indicated in the TERMINATION OF MEMBER INSURANCE provision.

No benefits are payable for expenses incurred after the date the insurance of the Member terminates, even if a detailed treatment plan under the PRE-DETERMINATION OF BENEFIT provision was filed and benefits were determined by the Insurer prior to such termination date.

DEPENDENT BENEFIT EXTENSION AFTER MEMBER'S DEATH

In the event of the death of the Member and subject to policy provisions, insurance under this Benefit will continue for insured Dependents, without premium payment, until the earliest of the following dates:

1. 24 months following the death of the Member;
2. the date on which the Dependent ceases to be eligible as a Dependent for a reason other than the death of the Member;
3. the date on which Dependent insurance would have terminated if the Member had not died;
4. the date on which this Benefit or policy terminates.

PROOF OF CLAIM

The Insured Person domiciled in Quebec must show their government health card and payment card to a Dentist participating in the payment card program to be reimbursed for dental expenses. A simple telephone call allows the Dentist to validate the payment card, confirm that the care provided or prescribed is covered, and obtain confirmation of the amount payable directly to the Dentist by the Insurer and the amount payable by the Insured Person. The Dentist submits the benefit claim to the service

provider and gives a copy to the Insured Person who only pays the uninsured portion of the dental expenses incurred. In the case of a Dentist who is not participating in the payment card program, the Insured Person must pay all treatment charges and submit a benefit claim to the Insurer.

For an Insured Person domiciled outside Quebec or if the Dentist uses the Electronic Data Interchange (EDI), the Member is not required to submit a claim to the Insurer. EDI allows the Dentist to validate the Insured Person's eligibility, confirm that the care provided or prescribed is covered, and obtain confirmation of the amount payable directly to the Member, or the Dentist, by the Insurer, and the amount payable by the Insured Person. The Dentist submits the benefit claim through EDI and gives a copy of the confirmation to the Insured Person. If the Dentist does not use the Electronic Data Interchange (EDI), the Insured Person must submit a benefit claim to the Insurer.

All claims, along with any receipts, must be submitted to the Insurer within 12 months of the date the expenses were incurred, or 120 days from termination of coverage.

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

SUBROGATION

Upon providing payment for incurred expenses or loss of income, CINUP, on behalf of the Plan Sponsor, is subrogated to all rights of recovery of the Member, or any Dependents, against any person or party and may bring action in the name of the Member, or Dependent, to enforce such rights.

PAYMENT OF ORTHODONTIC CLAIMS

Notwithstanding anything to the contrary under the CLAIMS provision of this policy, the payment of orthodontic claims will be made on one of the following bases:

1. If a single charge is estimated for the entire course of treatment and the Insured Person pays this charge to the orthodontist in prearranged instalments over an estimated period of treatment or in one lump sum, the Insurer will reimburse the Member each time they submit a bill, certificate or receipt that specifies the amount of expenses, the date and the nature of the treatment received; or
2. If in lieu of a single charge, a charge is made for each treatment as it is performed, the Insurer will reimburse the Member as each charge is incurred.


CINUP