NSTU
GROUP
INSURANCE
TRUST

NSTU RESERVE MEMBER GROUP INSURANCE PLANS

Public School & APSEA

2022

Directory

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NSTU Group Insurance Trustees E-mail Address:

insurance@nstu.ca

Johnson Inc. E-mail Address for NSTU Members:

nstu@johnson.ca

Website:

Additional information with respect to the following can be found on the NSTU Group Insurance Trust website at **www.nstuinsurance.ca**

- Current Trustees
- The Role of the Trustees
- Underwriter Information
- Administrator/Consultant/Broker Information

The Plan Administrator, Johnson Inc., maintains the new "My Insurance" website that enables you to view and interact with your group insurance plan. To register, go to **https://www.johnson-insurance.com/Members-Only/**. Enter your Members Only username and password in the "New to this?" section and click "Register". If you do not remember your Members Only username or password, click "Register" in the "New to this?" section. If you need further assistance please visit **pages.johnson.ca/myinsurance**.

Disclaimer

The Insurance Profile is provided solely for the purpose of explaining the principal features of the NSTU Group Insurance Plan. It does not create or confer any contractual or other rights. All rights with respect to benefits of a member of the Plan will be governed solely by the master policies issued by the underwriters.

This Booklet contains important information concerning Group Insurance coverage and; therefore, should be kept in a safe place.

Current Underwriter / Insurer NSTU Insurance Trustees

Type of Plan	Current Underwriter/Insurer
Group Optional Life Insurance Policy # 39297	Manulife Financial
Voluntary Accidental Death and Dismemberment Policy # 1JN90	SSQ Insurance Company Inc.
Group Total Care – Medical Policy # 11300 – Active	Medavie Blue Cross
Group Total Care – Dental Policy # 11300 – Active	Medavie Blue Cross
NSED Travel Plan Policy # 11580 NSED Trip Cancellation / Trip Interruption Policy # 11581	Medavie Blue Cross

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1

BENEFITS

I. Total Care - Medical

Hospital and Extended Health

Total Care provides you and your eligible dependents with extensive hospital and medical coverage while you are at work, at home or on vacation. The Plan has been designed to work together with your Government Hospital and Medical Services Insurance Plan.

Eligibility

If you elect to participate in the program, coverage will remain in effect for a full twelve (12) month period, provided you remain a reserve member of the NSTU. The premium is paid **100%** by you.

Coverage will take effect the first of the month following receipt of your application by the Administrator, Johnson Inc.

Definition of Dependents

"Spouse" means either:

(a) the member's legally married spouse; or

(b) a person living with the member on a continuous basis in a conjugal relationship that is not a legal marriage, provided such relationship has existed for at least twelve (12) consecutive months at the time of application and immediately preceding the time when the status of such person is required to be determined for the purpose of coverage and the person is publicly represented by the member as the member's spouse.

If a member has had more than one spouse, the member's spouse shall be only the person who was the member's most recent spouse, using the criteria in (a) and (b) above.

“Dependent Children” means either natural children (legitimate or illegitimate), adopted children, or stepchildren of an employee who are:

(a) under 21 years of age, unmarried and dependent upon you for maintenance and support; or

(b) under 27 years of age and unmarried and in attendance* at an institution of higher learning and dependent upon you for maintenance and support; or

(c) any functionally impaired child may remain insured past the maximum age. The child, upon reaching the maximum age, must still be incapable of self-sustaining employment and be completely dependent on you for support and maintenance.

“Over-age-Dependents” — On your dependants 21st birthday you must provide Johnson Inc. proof of full-time attendance at a post-secondary educational institution.

All dependent children between the ages of 21 and 27 attending an institution of higher learning must provide Johnson Inc. each September with proof of full-time attendance at a post-secondary educational institution.

Proof must clearly indicate your over-age dependent’s name, full-time status and the semester they are attending and can include but not limited to one of the following:

1. Timetable of courses confirming full-time status.
2. Invoice of tuition paid confirming full-time status.
3. A letter from the school confirming full-time status. (any associated charges are your responsibility).

Indicate on proof of full-time status, your name plus professional number.

Online Learning reviewed on an individual basis.*

If your over-age dependent discontinues enrollment in a formal education program or graduates, you must notify Johnson Inc. immediately to terminate over-age coverage.

Claims for over-age dependent children cannot be processed by Medavie Blue Cross until the over-age dependent is registered with Johnson Inc.

The over-age dependent can use your benefit card. An additional card can be issued upon your request.

Hospital Benefits

This benefit is designed to supplement your Government Hospital Insurance Plan. The

following services are covered:

Semi-Private — the plan pays for hospital accommodation charges **within Canada** in excess of basic ward rates up to the semi-private level. There is no limit on the number of days allowed and no dollar limit.

Exclusion:

1. Charges for hospital accommodation incurred during any time the patient is not under the active treatment and care of a Physician;
2. Charges for chronic, convalescent, respite or custodial care, regardless of whether such care is provided in a chronic care bed or active treatment bed of a hospital, and;
3. Charges for any period beyond the date which the patient can be medically discharged from the hospital as determined by the Physician.

Additional Hospital Benefits Outside Canada — in addition to hospital room charges for semi-private accommodation, the plan pays up to $1,000 per disability for ancillary hospital services provided while an in-patient in a hospital outside of Canada. (see Out-of-Province Services)

Out-Patient Hospital Services — the plan pays for any out-patient services not covered by your Government Plan. (see Out-of-Province Services)

In addition to the above coverage for Hospital expenses, the plan covers:

Professional Ambulance Services — the actual charges for licensed professional ground ambulance transportation to or from the nearest hospital able to provide the care required when, due to the medical condition of the patient, no other form of transportation can be utilized.

Where a government program or plan for ambulance services exists, coverage will be limited to ambulance user fees applicable under such government program or plan. **Charges for transportation to and from scheduled appointments are excluded.**

Diagnostic Services — the full cost of diagnostic services including the services of a private radiological (x-ray) facility. (see Out-of-Province Services)

Extended Health Benefits

This benefit provides comprehensive protection against the cost of health services and supplies not covered by Government Programs. The plan reimburses you for **80% of the usual and customary charges**, subject to the limits stated, of the following covered

expenses when ordered by the attending physician. (Extended Health Benefits are provided for expenses incurred either in or outside the province of residence.)

Home Nursing Services – Charges for Nursing Services of a Registered Graduate Nurse for medically necessary nursing care provided in a participant's home on **the written order of the attending physician (provided the Nurse is not a resident of the participant's home or related to the participant or the participant's family) AND IS SUBJECT TO PRIOR APPROVAL BY MEDAVIE BLUE CROSS. Periodic reassessment may be required. Coverage is task oriented and must constitute the practice of nursing. Services that can be performed by a person of lesser qualifications are not covered.**

Charges for the Nursing Services of a Certified Nursing Assistant or Licensed Practical Nurse / Licensed Nursing Assistant will only be allowed when a Registered Graduate Nurse is not available provided such service is approved by the attending physician and Medavie Blue Cross.

Reimbursement is based on the reasonable and customary charges within the applicable Province. There is a limit of **$10,000 in any 36 consecutive month period per insured person.**

- changing of dressings
- injections
- foot care
- catheter care

These services may not take the form of:

- housekeeping
- food preparation
- letter writing
- banking assistance
- personal care (i.e. hair care, bathing, etc.)
- other "custodial or respite care services

Critical Illness Nursing Care – Charges for the services of a Registered Nurse (RN) or Certified Nursing Assistant (CNA)/Licensed Practical Nurse (LPN) for nursing care provided in hospital or at home for an illness that is deemed to be terminal in nature. Medical documentation from the attending physician is required to determine that the medical condition is terminal in nature. **The lifetime maximum benefit is $5,000 per insured person.**

Physiotherapy – Charges for the services of a registered physiotherapist. Not all services performed by physiotherapists are considered eligible for payment. Claims must be submitted using a special physiotherapy claim form which can be obtained from your provider. The provider will complete the appropriate sections of the form, confirm that the treatment was requested by the physician (or the physician is aware of the treatment) and the form must be signed by the provider prior to claim submission. The physiotherapist must be an approved provider by Medavie Blue Cross.

Oxygen – Charges for oxygen and the rental of equipment for its administration when required due to chronic hypoxemia. This benefit is supplemental to any government program.

Prosthetic and Other Appliances – Charges for artificial limbs, eyes or other prosthetic appliances, crutches, splints, casts, braces and trusses. Replacements are covered only in the event of pathological change. Claims being submitted require physician's documentation including the recommendation and diagnosis. Charges for maintenance are included up to $200 in any 12 consecutive month period. A maximum of $200 is allowed for bite planes when necessitated by a joint dysfunction.

Breast prosthesis will be covered once in any 24 consecutive month period and surgical brassiere two (2) per 12 consecutive month period.

Wig prosthesis for alopecia totallis or hair loss resulting from chemotherapy or radiation therapy (total baldness, not male pattern alopecia) is limited to $400 in any 12 consecutive month period.

Orthopedic Shoes and Shoe Modification Supplies – Limited to one pair in any 12 consecutive month period for orthopaedic shoes; $200 for shoe modification supplies and custom molded foot supports (orthotics) in any 12 consecutive month period, commencing with the date charges are incurred.

Only those shoes or modifications that are custom fit and designed to accommodate, relieve or remedy mechanical foot defects or abnormalities, and that are supplied by a recognized orthopaedic footwear facility and not a retail shoe outlet are considered a benefit. **A written prescription including diagnosis from a medical doctor is required.**

Shoes purchased only to accommodate orthotics and/or comfortable walking shoes such as Nike, Birkenstock, Brooks, Rockport, New Balance, Saucony etc. are not covered.

Ostomy Equipment – Charges for ostomy equipment including appliance, irrigation sets and bags, but excluding deodorants, pads, adhesives, skin creams, and other supplies.

Therapeutic Medical Equipment Rental/Purchase – Charges for the rental or purchase (at the option of the Medavie Blue Cross) of medically necessary therapeutic equipment (limited to the standard level) such as:

- wheelchair;
- iron lung;
- hospital bed/bed rails (detailed information below);
- walker;
- tens machine;
- cervical collar;
- breathing appliance;
- Glucometers: Blood Glucose Monitoring Devices covered up to a maximum of $200 if recommended by the attending physician.
- Two (2) emergency anaphylactic shock kits (anakits/epipens) covered per 12 consecutive month period per insured; based on 80% of the manufacturer's suggested retail price.

When more than one level or range of equipment is available, coverage under the plan will be limited to the standard level as medically required.

At the option of the Medavie Blue Cross, insured equipment may be rented or purchased.

Subject to the specific approval of the Medavie Blue Cross, other equipment may be an insured benefit provided it is medically necessary and is an accepted method of treatment. Equipment used on a trial or experimental basis or equipment required primarily for comfort or convenience is not an insured benefit.

The insured equipment is limited to original purchase only, unless required as a result of a pathological change or independent consideration as approved by the Trustees. **There is a limit of $20,000 lifetime per insured person.**

Hospital Bed – (included under Therapeutic Medical Equipment) Coverage, if eligible, will be based on the cost of a "standard hospital bed". A request for a hospital bed must include the following:

- A written prescription from the Physician or a letter from the Occupational

Therapist (co-signed by the Physician) which indicates prognosis and diagnosis;

- Amount of time patient confined to bed on a daily basis;
- Length of time the bed is required;
- Type of bed required (i.e. electric, manual, rails, etc.); and
- Cost of the bed. (Two estimates are required, along with any literature).

Emergency Transportation – Charges for emergency transportation by air, rail or water to the nearest hospital able to provide the required care; includes return expenses of an accompanying Registered Nurse when medically necessary. Maximum is $400.00 in any 12 consecutive month period.

Blood – Charges for blood and blood plasma, when not provided by a government-sponsored plan.

Out-of-Province Physician Services – Charges for physician services which exceed allowances provided under your government medical plan and are incurred while outside your province of residence for emergency services not related to pre-existing medical conditions. (see Out-of-Province Services)

Dental Services – Services of a dentist for the repair or replacement of natural teeth when incurred as a result of an accidental injury sustained while covered for this benefit. Injury must have been caused by an external blow or force and not by something wittingly or unwittingly placed in the mouth. Services rendered within one year following the date of the accident are covered provided the participant's coverage remains in force. Charges accepted for payment will be limited to the general practice level of the Dental Association Fee Schedule of the province where the participant resides and in effect on date service is rendered.

Laboratory Tests – Charges for laboratory tests carried out by a hospital, government or other laboratory. (see Out-of-Province Services)

X-Ray Therapy – Charges for x-ray therapy, radium and radioactive isotope therapy. (excluding private MRI clinics)

Hearing Aids – Charges for the cost and installation of a hearing aid or hearing aids up to $800.00 in any 36 consecutive month period **(The contract with your Employer provides $750 in any 36 consecutive month period. The additional coverage is provided through subsidization by the NSTU Group Insurance Trust Fund)** per insured person, commencing with the date charges are incurred. Such aid or aids must be purchased after the date of a written recommendation by an otolaryngologist. Medavie Blue Cross also recognizes a licensed audiologist. This benefit is extended to provide for a second hearing aid if it is medically necessary for a member to have a hearing aid for each ear. The charges for the

second hearing aid shall be under the same conditions as the charges for the first hearing aid.

If a dependent child has an audio defect which requires additional hearing aid equipment over and above the basic benefit, claims will be reviewed on an individual basis by the Trustees in consultation with Medavie Blue Cross. The determination of the level of benefit will be the decision of the NSTU Group Insurance Trustees. Claims submitted to the Trustees must be supported by medical documentation.

Cochlear Implant Upgrades, Parts and Accessories - Provides coverage for cochlear Implant upgrades (defined as a new speech processor, cable, headpiece, batteries, charger and remote), repairs, parts, and accessories.

Eye Refraction – Usual and customary charges for an eye refraction performed by an ophthalmologist or licensed optometrist, once in any 24 consecutive month period for persons under age 10 and between ages 18 and 64, and once in any 12 consecutive month period for persons age 10 to 17.

Prescription Eyeglasses – Charges for frames and single lenses up to $155.00, or up to $170.00 for frames and bifocal or trifocal lenses. **(The contract with your Employer provides $145 for single lenses, $160 for bifocal or trifocal lenses. The additional coverage is provided through subsidization by the NSTU Group Insurance Trust Fund)**, once in any 24 consecutive month period or once in any 12 consecutive month period for dependents under age 18 commencing with the date charges are incurred for each member of the contract. ***Intra Ocular Lens Implants*** are not covered.

Eye Laser Surgery – In lieu of frames and lenses, coverage for eye laser surgery up to the dollar limit and frequency for frames and lenses, if the maximum benefits for Prescription Eyeglasses has not been used in the previous 24 months.

Contact Lenses – Charges for contact lenses up to $200.00 in any 24 consecutive month period as prescribed by an ophthalmologist for conditions such as: Keratoconus, severe corneal scarring or aphakia; provided vision cannot be improved to a satisfactory level by spectacle lenses. Please note that the Insurer requires a letter from the ophthalmologist in order to approve payment of the $200.00 benefit.

- If eyeglasses have been purchased in the same 24 consecutive month period that the required contact lenses are purchased, the amount payable shall be reduced by the amount paid under the eye glass provision.
- The purchase of contact lenses for reasons other than stated above, shall be considered the same as the purchase of eyeglasses.

Diabetic Supplies – Charges for diabetic supplies-for syringes, needles and testing supplies such as clinitest, clinistix, labstix, and ketodiastix. **Alcohol swabs, cotton balls, preci-jets, auto-injectors and infusion kits are not included as eligible expenses.**

Glucose Monitoring Systems - Charges for Continuous Glucose Monitor (CGM) System, equipment and supplies including readers, receivers, transmitters and sensors.

Urinary Collection Devices – Charges for urinary collection and retention systems including catheter tubes and pouches but excluding other supplies.

Paramedical Services* – Charges for paramedical services – **80%** of the usual and customary charges per treatment and a maximum of 20 visits per calendar year for the services of a naturopath, acupuncturist, osteopath, chiropractor, speech therapist, podiatrist/chiropodist, or occupational therapist. The provider must be one approved by Medavie Blue Cross.

Psychologist Services* – The services of a psychologist – **80%** of the usual and customary charges to a maximum of 20 visits per year. A Master of Social Work will be considered as an eligible service provider under this benefit. The provider must be one approved by Medavie Blue Cross.

Note: for therapy or counseling in groups, a reduced allowance would apply, to be determined by Medavie Blue Cross.

Massage Therapy* – The services of a registered massage therapist will be covered at **80%** of the usual and customary charges to a maximum of 20 visits per year (August – July). The provider must be one approved by Medavie Blue Cross.

* The above coverage is for office calls only. Prescriptions, medications, X-rays and appliances are not covered if ordered by the paramedical practitioner. They are covered only if ordered by an attending physician, that is, medical doctor and if, they otherwise qualify for coverage elsewhere in the contract.

Out-of-Province Services

Under Hospital and Extended Health Benefits of Total Care/Medical, the following applies:

> **"Out-of-Province benefits are only available as a result of unforeseen illness or accidental injury occurring while you are travelling outside your province of residence."**

Elective services and services related to pre-existing conditions as set out below are excluded or limited under this contract as described.

1. Services received by a person who travelled outside the home province for the purpose of obtaining hospital treatment, medical treatment or advice are not covered.
2. No coverage is provided for services that were obtained outside the province of residence at a person's election, including surgery or other treatment known to be required, that could be deferred until return to Canada.
3. Cardiovascular or peripheral-vascular surgery or other procedures are covered only when such procedures are necessitated by an acute episode of myocardial ischemia or peripheral ischemia that occurs during the term of coverage under this contract and only when such procedures cannot be delayed until return to Canada.
4. Surgery for removal of cataracts is not covered.
5. Known medical conditions, not specifically excluded, will be covered only when the service is necessitated by emergency. Services to monitor, stabilize or continue treatment of existing medical conditions are not covered.
6. Coverage for pregnancy is limited to services related to a naturally occurring miscarriage or to a premature delivery occurring before two months of the expected date of birth. All other services associated with pregnancy are excluded.

IT IS ADVISABLE THAT MEMBERS AND/OR DEPENDENTS PURCHASE INDIVIDUAL TRAVEL INSURANCE IF TRAVELLING OUTSIDE CANADA. (See NSED Group Travel Plan)

Claims Procedure

Hospital Services

There are no claim forms to complete in order to obtain hospital services. Presentation of your NSTU Total Care Benefit Card assures credit at the hospital for semi-private room coverage. The hospital will submit the claim directly to Medavie Blue Cross.

Extended Health Benefits

Electronic submission of claims or ePay has been established for many service providers. Providers can adjudicate claims online asking you to pay only the applicable co-insurance. Ask your service provider if they can submit claims directly to Medavie Blue Cross. To obtain reimbursement for other services and supplies, you can submit a claim electronically through Medavie Blue Cross' eClaims system on their secure Member Services site **medaviebc.ca/en/members/member-services-site**, by way of the Medavie Blue Cross mobile app **medaviebc.ca/en/members/medavie-mobile**, or by completing a claim form

(obtainable from Medavie Blue Cross or Johnson Inc.) and sending it directly to the insurer along with itemized receipts and the attending physician's prescription. Payment will be made directly to you and if you sign up for direct deposit on the Member Services site, your reimbursement will be automatically deposited into your bank account.

***Glucose Monitoring Systems claims are paid directly at the pharmacy and the plan covers 80% of eligible expenses. Your pharmacist will submit the claim to Medavie Blue Cross for payment of the covered benefit and notify you of any amount payable by yourself**

Coordination of Benefits

The plan includes a coordination of benefits provision.

If you are the primary cardholder, your personal claims must be submitted to Medavie Blue Cross first. If your spouse has a benefit plan, he or she must submit claims to his or her insurance provider first. You can then submit any unpaid portion to your spouse's plan for coordination of benefits, if eligible, for reimbursement. When you and your spouse have coverage from two separate plans, claims for your dependent children will be processed under the plan of the parent whose birth month falls first in the calendar year.

This provision operates in the event that you or your dependents are covered under more than one group health plan, and ensures that while a claim may be made under all plans, total reimbursement received does not exceed the actual expense incurred.

CLAIMS MUST BE SUBMITTED WITHIN ONE YEAR FROM THE DATE THE EXPENSE IS INCURRED.

Prescription Drugs

Provides you and your family with broad protection against the cost of prescription drugs dispensed on a doctor's prescription.

All over-the-counter drugs (drugs that do not by Federal or Provincial law require a prescription), except life sustaining drugs, are not covered under the Plan. Interchangeable (generic) drugs* – unless medically unsuitable, interchangeable drugs, when available, will be used in place of brand name drugs.

** Interchangeable (generic) drug coverage for prescription drugs will be limited to the cost of the least expensive product when interchangeable products are available from more than one manufacturer.*

Only drugs specified as interchangeable in the Provincial Drug Formulary are affected by this provision. These interchangeable drugs must contain the same drug and have the

same dosage that the physician has prescribed. The pharmacist is permitted to select the lower priced brand in accordance with their professional judgement.

There may be situations where the generic drug produces a severe adverse reaction or there are other legitimate concerns about the use of a generic drug in place of a brand name. In this case, the physician can request on the prescription that there be **“no substitution”** and the pharmacist can dispense the higher priced brand-name drug and the plan will cover the cost of the brand-name in place of the generic drug.

RESTRICTED DRUG LIST — ALL NEW DRUGS WILL REQUIRE APPROVAL BY A REVIEW BOARD.

The following is the current procedure for reviewing new drugs for possible inclusion on the approved prescription drug list. New drugs must first be approved for distribution and sale in Canada by Health Canada. These new drugs are then reviewed by Medavie Blue Cross with specific emphasis put on both the cost and therapeutic value of the drug as compared to other similar acting drugs that are already on the market. The Insurer then prepares a recommendation for the NSTU Group Insurance Trustees to consider. The recommendation for each drug will take one of three forms: a recommendation for general approval, a recommendation for approval on an individual basis or a recommendation for decline.

If your physician or specialist prescribes a medication on the Restricted Drug List that requires individual approval, you will be asked to provide medical information to Medavie Blue Cross for assessment. Your pharmacist will provide the appropriate form(s) to you when you present your prescription at the pharmacy or you may obtain one from Medavie Blue Cross.

Convenient Service Card Feature

When you enroll in the plan, you are issued a “NSTU Total Care Benefit Card” which entitles you and your eligible dependents to obtain prescription drugs under the plan. You must present the card to a participating pharmacy at the time the prescription is filled.

Co-Pay

Under the plan you are required to pay **$5.00** for each prescription. **Your pharmacist will submit the claim to Medavie Blue Cross for payment of the covered benefit and notify you of any amount payable by yourself which may include the co-pay or any amount not covered by your drug benefit.**

If you are being charged more than the $5.00 co-pay for each prescription, the Insurance Trustees recommend that you contact other pharmacies to get the best value.

The Plan does not cover:

- Proprietary and patent medicines, cosmetic aids;
- Mechanical appliances — canes, crutches, braces, trusses, etc. (This may be covered by Extended Health);
- Bandages, dressings, first aid supplies, prescription accessories;
- Contraceptive devices and appliances (except most prescription contraceptives);
- Preventive or immunizing preparations (except insulin and allergy serums);
- Diagnostic agents or preparations;
- Vitamin preparations except as approved;
- Experimental and research drugs;
- Dietary supplements and food products;
- Preparations routinely purchased without a prescription;
- Fertility drugs;
- Drugs determined to be non-therapeutic or not medically necessary;
- Homeopathic medications;
- Drugs obtained while a hospital in-patient or out-patient, or provided for by a qualified home care program;
- Drugs available through the Emergency Drug Release Program;
- Any portion of the drugs which are eligible for coverage under government programs; and
- Drugs which would not be charged to the patient in the absence of this insurance.

Prescription Quantities

Under the arrangement Medavie Blue Cross has with pharmacies, it is permissible for a subscriber to obtain medications for certain long-term or maintenance-type preparations in quantities sufficient for 100 days. Some of the categories of medications that may be obtained on this basis are listed below. If you or a member of your family are presently receiving any of these types or other types of medications in small quantities, and it is likely they will be required for a long period of time, it would be in your interest to discuss a more convenient supply or quantity with **your physician.**

CATEGORY

Cardiovascular Drugs	Anticonvulsant Drugs
Oral Hypoglycemic Agents	Thyroid Preparations
Antitubercular Agents	Antilipidemic Drugs
Diuretics	Therapeutic Vitamins
Antihypertensives	Antiarthritics
Potassium Replacement Therapy	

It should be understood that not all medications are appropriate in 100-day quantities.

Prescription Drugs (over age 65)

For those insured persons age 65 or over, **there is no prescription drug coverage under the Total Care/Medical** (residents of Nova Scotia are eligible to enroll in the Nova Scotia Seniors' Pharmacare Program). The prescription drug coverage cancels as of the first of month that either the member or spouse turns 65 (whichever is applicable).

For those insured members age 65 and over with a family plan and whose spouse is under 65, drugs for the **spouse only** are covered at 80% after a $25.00 deductible has been satisfied. The deductible must be satisfied each year between June 1 and May 31 of the following year. When drug receipts totalling over $25.00 have been accumulated, please forward to the Insurer for reimbursement.

Total Care - Dental

Your Dental Plan has been designed to provide reimbursement to you and your eligible dependents for Basic Preventative, Major Restorative, Prosthodontic and Orthodontic services based on the eligible amounts.

Eligibility

If you elect to participate in the program, coverage will remain in effect for a full twelve (12) month period, provided you remain as a reserve member of the NSTU. The premium is paid **100%** by you.

If you wish to change your coverage status, notification must be received within (30) days of the actual change. If notification of change in status is not received within thirty (30) days, the effective date of coverage will be September 1st, following receipt of notification. Coverage can only be cancelled during September of each year once the 12 months has been satisfied provided you are still eligible as per the guidelines.

Definition of Dependents

"Spouse" means either:

(a) the member's legally married spouse; or

(b) a person living with the member on a continuous basis in a conjugal relationship that is not a legal marriage, provided such relationship has existed for at least twelve (12) consecutive months at the time of application and immediately preceding the time when the status of such person is required to be determined for the purpose of coverage and the person is publicly represented by the member as the member's spouse.

If a member has had more than one spouse, the member's spouse shall be only the person who was the member's most recent spouse, using the criteria in (a) and (b) above.

"Dependent Children" means either natural children (legitimate or illegitimate), adopted children, or stepchildren of an employee or member who are:

(a) under 21 years of age, unmarried and dependent upon you for maintenance and support; or

(b) under 27 years of age and unmarried and in <u>attendance</u>* at an institution of higher

learning and dependent upon you for maintenance and support; or,

(c) any functionally impaired child may remain insured past the maximum age. The child upon reaching the maximum age, must still be incapable of self-sustaining employment and be completely dependent on you for support and maintenance.

“Over-age-Dependents” — On your dependants 21st birthday you must provide Johnson Inc. proof of full-time attendance at a post-secondary educational institution.

All dependent children between the ages of 21 and 27 attending an institution of higher learning must provide Johnson Inc. each September with proof of full-time attendance at a post-secondary educational institution.

Proof must clearly indicate your over-age dependent’s name, full-time status and the semester they are attending and can include but not limited to one of the following:

1. Timetable of courses confirming full-time status.
2. Invoice of tuition paid confirming full-time status.
3. A letter from the school confirming full-time status. (any associated charges are your responsibility)

Indicate on proof of full-time status, your name plus professional number.

Online learning reviewed on an individual basis.*

If your over-age dependent discontinues enrollment in a formal education program or graduates, you must notify Johnson Inc. immediately to terminate over-age coverage.

Claims for over-age dependent children cannot be processed by Medavie Blue Cross until the over-age dependent is registered with Johnson Inc.

The over-age dependent can use your benefit card. An additional card can be issued upon your request.

Basic Preventative Services

The following services are provided at **80%** of the lesser of the usual and customary charge of the dentist or the Current Dental Association Fee Schedule in effect in the member’s province of residence.

The plan will pay for services of a dental specialist at current specialist rates, when the patient has been referred by a dentist to a dental specialist for consultation and/or treatment of a condition deemed to be within the speciality of the specialist.

Diagnostic — clinical oral examinations (one recall exam every calendar year);

Preventative Services — cleaning (8 unit maximum every 12 consecutive months for scaling) and polishing, fluoride treatments (once every calendar year), pit and fissure sealants or permanent molars (up to age 18), space maintainers and protective athletic appliances (one every 24 months for children up to age 16 – one per lifetime over age 16);

Restorative Services — fillings, re-cementing inlays and crowns, removal of inlays and crowns, and cement restorations;

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

Periodontic Services — diagnosis and treatment of disease which affects the supporting tissue of the teeth, such as the gums and bones surrounding the teeth (8 unit maximum every 12 consecutive months for root planing);

Prosthodontic Maintenance Services — Removable — denture repairs, denture rebasing and relining (once in 24 months) and tissue conditioning;

Surgical Services — extraction of teeth;

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

Major Restorative Services

The following services are provided at **60%** of the lesser of the usual and customary charge of the dentist or the Current Dental Association Fee Schedule in effect in the member's province of residence, subject to a maximum payment of **$1,500 per person per calendar year;**

- Crown restorations, inlay and onlay restorations, gold fillings when teeth cannot be restored with other material (limited to one (1) in any five (5) year period.) This benefit does not include bridgework, prosthetics or crowns, inlays or onlays associated with the placement of bridges or prosthetics (see Prosthodontic Services).

Prosthodontic and Orthodontic Services

The following is a summary of the benefits:

Prosthodontic Services — The following services are provided at **50%** of the lesser of the usual and customary charge of the dentist/prosthodontist or the current Dental

Association Fee Schedule in effect in the member's province of residence, subject to a maximum payment of **$1,500 per person per calendar year.**

- Fixed bridgework (limited to one in any 5 year period);
- Partial and complete dentures (limited to one in any 5 year period);
- Restorative services including crowns, inlays and onlays associated with the placement of prosthodontics. (limited to one in any 5 year period).
- Implants and restorations over implants (limited to one in any 5 year period – combined with all crowns, bridgework and dentures).

Limitations

- Replacement is covered only if the existing denture is unserviceable and cannot be made serviceable.
- Coverage is not included for replacement of any lost, stolen or misplaced prosthodontics.

Orthodontic Services — The following services are provided at **50%** of the lesser of the usual and customary charge of the dentist/orthodontist or the current Dental Association Fee Schedule in effect in the member's province of residence, subject to a maximum payment of **$2,000 per person lifetime**.

- Coverage includes orthodontic examinations and diagnostic procedures, extractions and surgical procedures relating to orthodontic services and appliance therapy.
- Charges for orthodontic care do not become allowable until the services relating to such charges are actually rendered.

Pre-Determination Of Benefits — When a planned course of treatment is expected to result in covered dental expenses of $500 or more, a detailed description of the planned procedures with an estimate of the charges is to be submitted by the dentist to Medavie Blue Cross. Medavie Blue Cross will then confirm the level of benefits available.

Exclusions

- Charges related to services for cosmetic reasons;
- Charges for broken appointments, completion of forms or any other non-treatment services;
- Charges for services or supplies that are not dentally necessary or do not meet accepted standards of dental practice;
- Charges for services listed as included when provided to children covered under the Children's Dental Plan of the Province of Nova Scotia or other similar government programs.

How to Claim

To submit dental claims, you should first determine if your dentist is a participating dentist, i.e., one who has agreed to submit claims directly to Medavie Blue Cross for reimbursement. If so, you need only present your Total Care Benefit Card. Your dentist will submit his/her bill for that portion of the charges payable under the NSTU program directly to Medavie Blue Cross for payment.

If your dentist is a non-participating dentist, you will be required to pay for the services rendered. You can submit a claim electronically through Medavie Blue Cross' eClaims system on their secure Member Services site **medaviebc.ca/en/members/member-services-site**, by way of the Medavie Blue Cross mobile app **medaviebc.ca/en/members/medavie-mobile**, or with a completed dental claim form, together with an official receipt, to Medavie Blue Cross for reimbursement. Payment will be made directly to you and if you sign up for direct deposit on the Member Services site, your reimbursement will be automatically deposited into your bank account.

If your dentist is non-participating but agreeable to an assignment of benefits, submit a completed dental claim form to Medavie Blue Cross and payment will be made directly to your dentist, according to the terms of the NSTU dental program contract.

Coordination Of Benefits — The plan includes a coordination of benefits provision.

If you are the primary cardholder, your personal claims must be submitted to Medavie Blue Cross first. If your spouse has a benefit plan, he or she must submit claims to his or her insurance provider first. You can then submit any unpaid portion to your spouse's plan for coordination of benefits, if eligible, for reimbursement. When you and your spouse have coverage from two separate plans, claims for your dependent children will be processed under the plan of the parent whose birth month falls first in the calendar year.

This provision operates in the event that you or your dependents are covered under more than one group dental plan, and ensures that while a claim may be made under all plans, total reimbursement received does not exceed the actual expense incurred.

CLAIMS MUST BE SUBMITTED WITHIN ONE YEAR FROM THE DATE THE EXPENSE IS INCURRED.

Alternate Benefit Clause

In order to maintain reasonable costs, when more than one method of treatment may be provided, or more than one type of material or appliance can be selected that will provide

a professionally adequate result, the Insurer may elect to make payment for the less expensive method of treatment. For example, if there are 3 or more missing teeth, the Insurer may pay up to the level of a partial denture instead of a bridge.

II. Optional Group Life Insurance

This plan provides important life insurance coverage to protect you and your family in the event of death. Members must be **under age 65** to apply.

Amount Eligible — $ 10,000 – coverage is subject to you providing satisfactory medical evidence of insurability. Coverage will take effect the first of the month following approval by the underwriting company. The premium is paid 100% by you.

Coverage — This plan provides lump sum death benefits to your beneficiary(ies) in the event of your death from any cause. Coverage is on a 24 hour basis, whether or not you are working.

Suicide Clause — No Optional Life Insurance will be paid for any suicide claim within 2 years of the effective date, reinstatement date or the effective date of any increase of any amount of Optional Life Insurance.

Conversion — Providing application is made within 31 days of you ceasing to be a member, your insurance may be converted, without medical evidence, to a nonconvertible term plan maturing at age 65; or a non-renewable 1-year convertible term plan (provided the member is under age 65); or any permanent plan issued by the Insurer at the date of conversion.

Cancellation — Your Optional Life Insurance will cease on the earliest of the following:

1. Termination of employment.
2. If you should die.
3. If you enter the armed forces on a full-time basis.
4. Termination of the policy or coverage on the Group, Division, or Class to which you belong.
5. On the date you no longer make the required contribution towards the cost of your insurance, where applicable.
6. On the date you retire, unless you retire on a Nova Scotia Teachers’ Pension prior to age 65.
7. At the end of the month in which you reach age 70, if actively employed.

Dependent Life Insurance

Your spouse is insured for $10,000 and each dependent child for $5,000. If you are currently insured under the Optional Life Insurance Benefit and wish to change your coverage status from single to family, notification must be received within 31 days of actual change to avoid having to submit medical evidence of insurability.

The underwriter has the right to accept or reject dependent life coverage for all late applications subject to medical evidence of insurability.

Cancellation — Your Dependent Life Insurance will automatically terminate on the earliest of the following:

1. The date your coverage ceases.
2. The date you are no longer eligible for dependent coverage.
3. The date your dependent no longer satisfies the definition of dependent.
4. The date dependent life insurance coverage is terminated under the policy.

Definition of Dependents

"Spouse" means either:

(a) the member's legally married spouse; or

(b) a person living with the member on a continuous basis in a conjugal relationship that is not a legal marriage, provided such relationship has existed for at least twelve (12) consecutive months at the time of application and immediately preceding the time when the status of such person is required to be determined for the purpose of coverage and the person is publicly represented by the member as the member's spouse.

If a member has had more than one spouse, the member's spouse shall be only the person who was the member's most recent spouse, using the criteria in (a) and (b) above.

"Dependent Children" means either natural children (legitimate or illegitimate), adopted children, or stepchildren of an employee or member who are:

(a) under 21 years of age, unmarried and dependent upon you for maintenance and support; or

(b) under 27 years of age and unmarried and in attendance* at an institution of higher learning and dependent upon you for maintenance and support; or

(c) any functionally impaired child may remain insured past the maximum age. The child upon reaching the maximum age, must still be incapable of self-sustaining employment and be completely dependent on you for support and maintenance.

NOTE: A child of the member will be deemed to be Dependent for the purposes of this policy, from the date of birth subject to the above conditions.

Birth, as used in this provision, means the complete expulsion or extraction of a child from its mother, in which, after such expulsion or extraction, there is breathing, beating of the heart, pulsation of the umbilical cord, or unmistakable movement of voluntary muscle.

If you are not actively at work or your dependents are in a hospital at the time of enrollment, you or your dependents are not entitled to coverage. Coverage will commence when you return to work or, in the case of a hospitalized dependent, when he/she is discharged from the hospital.

"Over-age-Dependents" — On your dependants 21st birthday you must provide Johnson Inc. proof of full-time attendance at a post-secondary educational institution.

All dependent children between the ages of 21 and 27 attending an institution of higher learning must provide Johnson Inc. each September with proof of full-time attendance at a post-secondary educational institution.

Proof must clearly indicate your over-age dependent's name, full-time status and the semester they are attending and can include but not limited to one of the following:

1. Timetable of courses confirming full-time status.
2. Invoice of tuition paid confirming full-time status.
3. A letter from the school confirming full-time status. (any associated charges are your responsibility)

Indicate on proof of full-time status, your name plus professional number.

Online learning reviewed on an individual basis.

If your over-age dependent discontinues enrollment in a formal education program or graduates, you must notify Johnson Inc. immediately to terminate over-age coverage.

Spousal Life Insurance

Your spouse may apply for Spousal Life Insurance equal to your Optional Life Insurance Amount if under age 60.

The coverage is subject to “medical evidence of insurability”, which means the underwriting company has the right to accept or reject the application based on your spouse’s medical history.

Spousal Optional Life Insurance benefits will cease on the earlier of:

1. The end of the month in which spouse attains age 65.
2. The day your insurance is terminated under the Optional Life Insurance.
3. You request in writing to terminate Spousal Life coverage.
4. Your spouse no longer satisfies the definition of spouse.

Conversion Spousal Life Insurance

If your spouse’s life insurance terminates, he or she may be eligible to convert the terminated insurance to an individual policy without medical evidence. Application for the individual policy must be made, and the first premium paid within 31 days of the termination date.

If your spouse dies during the 31 day period the amount of Spousal Optional Life Insurance plus the spouse’s portion of the Dependent Optional Life available for conversion will be paid to you, even if your spouse doesn’t apply for conversion.

For more information on the conversion privilege, please contact the Administrator, Johnson Inc.

Beneficiary

The Optional Life benefits will be paid to the designated beneficiary(ies) as shown on the application or beneficiary nomination card. If there is no beneficiary designation, the benefit will be paid to your estate. Dependent Life Insurance will be payable to you (the member). The Spousal Life Insurance will be paid to you (the member) provided the insurer receives proof of your spouse’s death.

III. Voluntary Accidental Death and Dismemberment

This plan provides coverage for any accident resulting in Death, Dismemberment, Paralysis, Loss of Use of Limbs, Loss of sight, speech or hearing anywhere in the world – 24 hours a day – on or off the job.

"Spouse" means either:

(a) the member's legally married spouse; or

(b) a person living with the member on a continuous basis in a conjugal relationship that is not a legal marriage, provided such relationship has existed for at least twelve (12) consecutive months at the time of application and immediately preceding the time when the status of such person is required to be determined for the purpose of coverage and the person is publicly represented by the member as the member's spouse.

If a member has had more than one spouse, the member's spouse shall be only the person who was the Member's most recent spouse, using the criteria in (a) and (b) above.

"Dependent Children" means either natural children (legitimate or illegitimate), adopted children, or stepchildren of an employee or member who are:

(a) under 21 years of age, unmarried and dependent upon you for maintenance and support; or

(b) under 27 years of age and unmarried and in attendance* at an institution of higher learning and dependent upon you for maintenance and support; or

(c) any functionally impaired child may remain insured past the maximum age. The child upon reaching the maximum age, must still be incapable of self-sustaining employment and be completely dependent on you for support and maintenance.

NOTE: A child of the member will be deemed to be Dependent for the purposes of this policy, from the date of Birth subject to the above conditions.

"Over-age-Dependents" — On your dependants 21st birthday you must provide Johnson Inc. proof of full-time attendance at a post-secondary educational institution.

All dependent children between the ages of 21 and 27 attending an institution of higher learning must provide Johnson Inc. each September with proof of full-time attendance at a post-secondary educational institution.

Proof must clearly indicate your over-age dependent's name, full-time status and the semester they are attending and can include but not limited to one of the following:

1. Timetable of courses confirming full-time status.
2. Invoice of tuition paid confirming full-time status.
3. A letter from the school confirming full-time status (any associated charges are your responsibility).

Indicate on proof of full-time status, your name plus professional number.

On-line learning reviewed on an individual basis.*

If your over-age dependent discontinues enrollment in a formal education program or graduates, you must notify Johnson Inc. immediately to terminate over-age coverage.

What amounts are available?

A. Employee Only Plan

   $10,000

B. Employee: Family Plan

   You may select an amount of insurance in the amount of $10,000 and your family will automatically be insured for the following:

   i) Spouse

      Your Spouse will be insured for 60% of the benefit you select for yourself if you do not have any Dependent Children, or 50% of your benefit if you do have Dependent Children.

   ii) Children

      Each Dependent Child will be insured for 15% of your benefit if you have a Spouse, or 20% if you do not have a Spouse.

Enrollment

You may enroll in the program by completing an application and return to Johnson Inc.

If you have a spouse and/or eligible dependent children, you are automatically insured for Family coverage.

If you are not actively at work or your dependents are in a hospital at the time of enrollment, you or your dependents are not entitled to coverage, coverage will

commence when you return to work, or in the cast of a hospitalized dependent, when she/he is discharged from the hospital.

Coverage will commence on the first of the month following receipt of your application by Johnson Inc.

To whom are benefits paid?

Your Accidental Death Benefit will be paid to the beneficiary designated on your application. If there is no such beneficiary designation, such benefit will be paid to your Estate.

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

Repatriation Benefit;
Education Benefit;
Day-Care Benefit;
Workplace Modification and Accommodation Benefit;
Spousal Retraining Benefit;
Family Transportation Benefit;
Identification Benefit;
Extension of Family Benefit.

Schedule of Losses

When Injury results in any of the following losses within three hundred and sixty-five (365) days after the date of the Accident, the Insurer will pay:

For Loss of

Life .... The Principal Sum
The Entire Sight of Both Eyes .... The Principal Sum
Speech and Hearing in Both Ears .... The Principal Sum
One Hand and the Entire Sight of One Eye .... The Principal Sum
One Foot and the Entire Sight of One Eye .... The Principal Sum
The Entire Sight of One Eye .... The Principal Sum
Speech .... The Principal Sum
Hearing in Both Ears .... The Principal Sum
Hearing in One Ear .... Two-Third of the Principal Sum
All Toes of One Foot ....One-Third of the Principal Sum

For Loss or Loss of Use of

Both Hands .... The Principal Sum
Both Feet .... The Principal Sum
One Hand and One Foot .... The Principal Sum
One Arm .... The Principal Sum
One Leg .... The Principal Sum
One Hand .... The Principal Sum
One Foot .... The Principal Sum
Thumb and Index Finger of Same Hand ....Two-Thirds of the Principal Sum
Four Fingers of one Hand ....Two-Thirds of the Principal Sum

For Paralysis of

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

"Loss of life" means the death of the insured person.

"Loss" as above used with reference to hand or foot means complete severance through or above the wrist or ankle joint, but below the elbow or knee joint; as used with reference to arm or leg means complete severance through or above the elbow or knee joint; as used with reference to thumb means the complete severance of one (1) entire phalanx of the thumb; as used with reference to finger means the complete severance of two (2) entire phalanges of the finger; as used with reference to toes mean the complete

severance of one (1) entire phalanx of the big toe and all phalanges of the other toes; as used with reference to eye means the irrecoverable loss of the entire sight thereof.

“Loss” as above used with reference to speech means complete and irrecoverable loss of the ability to utter intelligible sounds; as used with reference to hearing means complete and irrecoverable loss of hearing.

“Paralysis” means the loss of ability to move all or part of the body.

“Quadriplegia” means the permanent Paralysis and functional loss of use of both upper and lower limbs.

“Paraplegia” means the permanent Paralysis and functional loss of use of both lower limbs.

“Hemiplegia” means the permanent Paralysis and functional loss of use of upper and lower limbs on the same side of the body.

“Loss” as above used with reference to loss of use means the total and irrecoverable loss of use, provided the loss is continuous for twelve (12) consecutive months and such loss of use is determined to be permanent at the end of such period.

Indemnity provided under this section for all Losses sustained by any one (1) Insured Person as the result of any one (1) Accident will not exceed the following:

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

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

In no event will indemnity payable for all Losses under this section exceed, in the aggregate, Two Times the Principal Sum as the result of the same Accident.

Definitions

“You” and “Your”, means the Eligible Employee and/or Member who is enrolled with the Policyholder.

“We”, “Us”, “The Insurer” and “AXA” means AXA Assurances Inc.

“Policy” means the Group Policies which are on file with the Policyholder.

“Injury” means bodily injury caused by an Accident occurring while this policy is in force as to the Insured Person whose injury is the basis of claim and resulting directly and

independently of all other causes in loss covered by this policy, 24 hours a day, anywhere in the world but in no event shall Injury mean Sickness or Disease howsoever caused unless caused by an Accident.

“Accident” means any unlooked for mishap or untoward event which is not expected or designed.

“Sickness” means an impairment of normal physiological function and includes illness and infections.

“Disease” means any unhealthy condition of the body or any part thereof.

“Principal Sum”, when referring to you, means the amount indicated on your application which you have completed and filed with the Johnson Inc.

“Principal Sum”, when referring to your Insured Dependents, means the percentages outlined in this Profile.

“Policyholder” means NSTU Group Insurance Trustees.

“Insured Person” means an Employee and/or Member and his/her Dependent(s) insured under the Policy.

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

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

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

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

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

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

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

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

Repatriation

If you or your Insured Dependent(s) sustain Loss of Life resulting from Injury not less than 50 kilometres from you or your Insured Dependent(s) normal place of residence and indemnity for such Loss becomes payable under the program, we will pay the reasonable and customary expenses actually incurred for the transportation of the body to the first resting place (including but not limited to a funeral home or the place of interment) in proximity to you or your Insured Dependent(s) normal place of residence. The repatriation benefit up to **$20,000** will be paid for expenses incurred for the return home of the body (including charges for the preparation of the body for such transportation).

Education

If you sustain Loss of Life resulting from Injury and indemnity for such loss becomes payable in accordance with the terms of this Program, we will pay the Education Benefit stated below for each of your Dependent Children for education expenses provided the child is:

(1) enrolled as a full-time student in any Institution for Higher Learning* or

(2) will enroll as a full-time student in any Institution for Higher Learning*, within 365 days of your accidental death.

Online learning reviewed on an individual basis.*

This benefit is equal to the lesser of the following amounts: (a) 5% of your Principal Sum or (b) $5,000 for each year (up to 4 consecutive years) such child remains enrolled as a full-time student in an Institution for Higher Learning.

This benefit will be paid each year immediately upon receipt of satisfactory proof that your child is enrolled as a full-time student in an Institution for Higher Learning.

If your Dependent Child satisfies the above requirements, any benefits payable will be paid to such child.

"Institution for Higher Learning" includes any university, college, CEGEP or trade school.

"Dependent Child" means a natural children, adopted children, or stepchildren. The child is unmarried, under twenty seven (27) years of age and dependent upon the Insured member for maintenance and support.

Day Care

If you or your Insured Spouse sustain Loss of Life resulting from Injury and indemnity for such Loss becomes payable in accordance with the terms of this Program, we will pay the Day-Care Benefit stated below for each of your Dependent Children who:

(1) are enrolled in a Day-Care Centre on the date of such Loss; or

(2) will enroll in a Day-Care Centre within three hundred and sixty-five (365) days after the date of your death.

This benefit is equal to lesser of the following amounts: (a) 5% of your Principal Sum or (b) $5,000, for each year your Dependent Child remains enrolled in a legally licensed Day-Care Centre (up to four consecutive years).

This benefit will be paid each year immediately upon receipt of satisfactory proof that your child is enrolled in a Day-Care Centre.

In the event that your Dependent Child does satisfy the requirements indicated above, the Day-Care Benefit will be payable to your surviving Spouse if your Spouse has custody of the child. If there is no surviving Spouse or your child does not reside with your Spouse, benefits payable under this provision will then be paid to your child's guardian who has been legally appointed to manage the person of the child.

If none of your Dependent Children satisfy the requirements as shown under either the section entitled "Education Benefit" or this section, we will pay an amount equal to 5% of your Principal Sum or $2,500, whichever is less, under one of the policies issued to the your Policyholder by the Insurer to your beneficiary.

The following definitions are applicable only to this benefit:

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

“Dependent Children” mean persons that are either natural children, adopted children, or step-children. The children are under 13 years of age and dependent upon you for maintenance and support.

Rehabilitation

If you or your Insured Spouse sustain an injury which results in a Loss payable under the section entitled “Specific Loss Accident Indemnity” under this program and such injury requires that you participate in a rehabilitation program in order to be qualified to engage in an occupation in which you would not have engaged except for such injury, the Insurer will pay the reasonable and necessary expenses actually incurred within 3 years from the date of the accident to a maximum of **$20,000**. No payment will be made for room, board or other ordinary living, travelling or clothing expenses.

Spousal Retraining

If you sustain an injury and indemnity for such loss becomes payable in accordance with the terms of this program, we will pay the reasonable and necessary expenses actually incurred, within 3 years from the date of such Loss by your spouse who engages in a formal occupational training program in order to become specifically qualified for active employment in an occupation for which your spouse, would not otherwise have sufficient qualifications, up to a maximum of **$20,000** for all such expenses. No payment will be made for room, board or other ordinary living, travelling or clothing expenses. If your spouse satisfies the requirements stated above, it is presumed that your spouse is the beneficiary.

Workplace Modification and Accommodation Benefit

In the event you sustain an injury which results in a Loss payable under the section entitled “Specific Loss Accident Indemnity” of this policy and you require special adaptive equipment and/or workplace modification in order to reasonably accommodate your return to active employment as an employee and/or member, and the Insurer will pay the reasonable and necessary expenses actually incurred by the Policyholder provided:

1. The Policyholder agrees in writing to provide the special adaptive equipment and/or make modifications to the workplace for the purpose of making it accessible and adaptable to your needs.
2. The Policyholder acknowledges in writing that the performance of the essential duties of your job may be altered.

3. The proposed special adaptive equipment and/or workplace modification must have prior written approval by the Insurer.
4. The Insurer has the right to examine you to evaluate the appropriateness of the proposed modifications.

The benefit will be paid to the Policyholder upon your return to active employment as an employee and/or member and the Insurer has been provided with written proof of the expenses incurred. The benefit is not payable if the Policyholder does not incur any cost in providing the special adaptive equipment and/or the workplace modification.

Payment by the Insurer for the total of all expenses incurred by the Policyholder will not exceed ten thousand dollars (**$10,000**) as a result of any one (1) Accident.

The above benefit will only be payable under one (1) of the policies issued to the Policyholder by the Insurer.

Child Enhancement

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

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

Family Transportation

If any Specific Loss covered under the “Specific Loss Accident Indemnity” confines you or your Insured Dependent(s) as an inpatient in a hospital or if any other Injury confines you or your Insured Dependent(s) to a hospital for 4 days and such hospital is located at least 150 kilometres from your or your Insured Dependent(s) residence, this benefit will refund expenses incurred by any Member(s) of the Immediate Family for hotel accommodation and transportation (via the most direct route) to you or your Insured Dependent(s) bedside, to a maximum of **$15,000**. Private transportation expenses are limited to **$0.35** per kilometre travelled.

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

Identification

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

1) lodging and board (up to a maximum of 3 consecutive nights) while en route and/or during the stay in the city or town where the body is located, and
2) transportation via the most direct route to this location, provided this location is not less than 150 km from the family member's usual residence.

Private transportation expenses are limited to **$0.35** per km travelled and the total maximum refundable for all expenses is limited to **$15,000**. Payment will not be made for ordinary living, travelling or clothing expenses other than stated above.

Common Disaster

If you and your Insured Spouse both sustain Loss of Life which becomes payable under the program as the result of a "Common Accident", your Spouse's amount of coverage will be increased to the same level as yours (not to exceed $10,000).

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

Seat Belt

If, at the time of the accident, you or your Insured Dependent(s) were wearing a properly fastened seat belt and driving or riding in a "vehicle" driven by a driver who has a valid driver's license and who was neither "intoxicated" nor under the "influence of drugs" (unless taken as prescribed by a physician), and a loss becomes payable under the "Specific Loss accident indemnity", the applicable amount of principal sum will be increased by **25%** for those wearing a seat belt.

Due proof of Seat Belt use must be provided as part of the written proof of loss.

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

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

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

Home Alteration and/or Vehicle Modification

If you or your Insured Dependent(s) sustain the Loss of or Loss of Use of Both Feet or Legs or becomes Quadriplegic, Paraplegic or Hemiplegic, for which indemnity becomes payable under the Policy, and you or your Insured Dependent(s) subsequently require the use of a wheelchair to be ambulatory, We will refund the reasonable and necessary expenses actually incurred during the 3 year period following the accident, to a maximum of **$20,000** per accident;

(a) for the cost of alterations to your or your Insured Dependent(s) principal residence for the purpose of making it accessible and/or;

(b) the cost of modifications to 1 motor vehicle utilized by yourself or your Insured Dependent(s), when such modifications are approved by licensing authorities where required, for the purpose of adapting it to your or your Insured Dependent(s) needs.

Hospital Indemnity

If any Loss covered under the “Specific Loss Schedule” section of the Policy confines you or your Insured dependent(s) to a Hospital and such person is under the Regular Care and Attendance of a Physician, you or your Insured Dependent(s) will receive a daily benefit of 1/30th of 1% of your Principal Sum from the 1st day of hospitalization, up to a maximum of **$2,500** per month and for a maximum duration of 365 days per accident.

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

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

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

Escalation

In the event you sustain an Injury which results in the benefit being payable under either Specific Loss Accident Indemnity or Permanent Total Disability, the Insurer will pay an Escalation benefit which is equal to 3% of the amount of benefit payable, for each year your insurance remains in force without interruption, subject to a maximum of 15%.

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

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

Extension of Family Coverage

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

Cosmetic Disfigurement

If you or an Insured Dependent(s) suffer cosmetic disfigurement due to a burn, the Insurer will pay the Cosmetic Disfigurement benefit provided that such burn is classified as a third degree burn.

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

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

If you or an Insured Dependent(s) suffer burns to more than one body part as a result of any one accident, benefits payable for all such burns will not exceed **100%** of the Principal Sum.

Cosmetic Burn Schedule

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

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

Comatose Benefit

When, as a result of Injury, you or your Insured Dependent(s) become Comatose, the Insurer will pay the Principal Sum less any other amount paid or payable under the Schedule of Losses, as the result of the same accident, provided:

1. the Insured Person becomes Comatose within 365 days after the date of the accident; and
2. the Insured Person has been Comatose for 60 consecutive days.

"Comatose" means being in a state of total unconsciousness from which the person cannot be aroused. Such person is unresponsive to any external stimuli or internal needs and continuously requires the use of life support systems.

Aircraft Coverage

You and your Insured Dependent(s) are covered while riding as a passenger, but not as a pilot, operator or member of the crew, in any aircraft provided the aircraft has a current

and valid certificate of airworthiness and is flown by a licensed pilot, except any aircraft that is owned, operated, leased or chartered by or on behalf of the Policyholder. You and your Insured Dependent(s) are also covered while flying as a passenger in any military aircraft and when boarding or alighting from or being struck by any aircraft.

Exposure and Disappearance

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

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

When does Insurance coverage terminate?

Your insurance coverage will terminate on the earliest of the following dates:

1) on the date the Policy is cancelled;
2) on the premium due date if the Policyholder fails to pay your premiums to the Insurer, except as the result of an inadvertent error;
3) on the premium due date next following the date you give notice of cancellation to the Policyholder;
4) on the premium due date next following the date you reach age 70, if actively employed and 75 years of age, if retired.

The insurance coverage for your Insured Spouse and/or Insured Dependent Children stops on the earlier of:

1) the date such person ceases to be an eligible dependent;
2) the date your insurance coverage stops.

If your insurance and/or the insurance of your Spouse or Dependent Children should terminate, you can still file a claim under the Policy for Losses arising from an accident which occurred prior to the termination date, subject to the terms and provisions of the Policy.

Coverage with respect to your Insured Spouse and/or Insured Dependent Children will be

continued while your insurance remains in force, provided payment of premium is continued.

Business Venture Benefit

You, the member, will qualify for coverage under this section if you sustains an Injury which results in a Loss payable under the section entitled “Loss Schedule”.

The Business Venture Benefit covers the Initial Costs applicable to the development of a new independent business enterprise in Canada.

The Initial Costs must be incurred by you within the second (2nd) year following the date Total Disability begins, and are subject to the lesser of a maximum of twenty percent (20%) of your Principal Sum or fifty thousand dollars ($ 50,000).

The Initial Costs will not include more than your equitable share of the expenses of facilities if you operate your own business in a partnership, or in accordance with an agreement hereunder any facilities for such operation or practice are shared by more than one person.

To qualify for benefits under this section, you must:

1. be unable to perform your Own Occupation as a result of Total Disability beginning within three hundred and sixty-five (365) days following the date of Injury;
2. remain totally disabled for a continuous period of one (1) year;
3. provide due proof of disability to the Insurer within said one (1) year period; and,
4. submit to the Insurer a Business Plan at the end of said one (1) year period.

“Initial Costs” includes land, buildings, fixtures, machinery, supplies, vehicles, pre-opening expenses, but excludes Daily Operating Costs.

“Daily Operating Costs” means expenses incurred in the operation of the Insured Member’s business for rent, electricity, heat, water, laundry, depreciation, Members’ salaries and other fixed expenses arising out of the conduct and operation of such business.

“Total Disability” means the inability of yourself, due to Injury, to perform each and every duty of his Own Occupation.

“Own Occupation” means each and every occupation or employment engaged in by you

immediately prior to the date of Injury.

“Business Plan” means a report which includes cash flow forecasts, a statement of personal assets and liabilities and market research results.

Home-Maker Weekly Indemnity

When an Insured Spouse who is neither gainfully employed nor receiving employment insurance benefits sustains an Injury and, as a result of such Injury and commencing within 30 days from the date of the Accident, becomes totally and continuously disabled and is prevented from performing any and all of his/her regular household and/or child-caring duties, the Insurer will pay $150 dollars, provided that the disability has continued for a period of 7 consecutive days, for the period the Insured spouse is so disabled, including the 7 day period, while under the Regular Care and Attendance of a Physician, subject to a maximum period payable of 26 weeks or to age 70, whichever first occurs.

Conversion Privilege

If, with the exception of policy termination, your insurance is terminated due to

(1) termination of employment,

(2) cessation of eligibility for insurance under the Policy, or

(3) cessation of total disability after which you did not return to work for the policyholder,

and the Policy is still in effect, you may convert your own insurance (but not your Spouse’s and/or Dependent Children’s), without evidence of insurability, into an individual accident policy.

You must apply prior to attainment of age 75 and within 60 days of the termination of your insurance.

The benefits provided are a Specific Loss schedule available from the Insurer at the date of conversion. The amount of insurance that may be converted cannot exceed the lesser of the amount then in effect on the date of termination. The premium is calculated at the Insurer’s manual premium rates in force at the date of conversion.

Premiums are payable annually in advance. The individual accident policy takes effect at the latest 60 days after the termination of coverage under the Policy and is issued on an annually renewable basis.

If you sustain Loss of Life resulting from Injury within the 60 day period during which conversion is available, the Insurer pays your beneficiary a death benefit equal to the maximum you were entitled to apply for under this provision.

Exclusions

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

1. suicide or intentionally self-inflicted Injury;
2. war, whether declared or not;
3. participation in a riot, insurrection, civil commotion or disturbance;
4. active full-time, part-time or temporary service in the armed forces of any country;
5. riding as a passenger or otherwise in any vehicle or device for aerial navigation, other than as provided in the section entitled “Aircraft Coverage”;
6. medical treatment or surgery, except if the medical treatment or surgery was needed because of an Accident.

In the Event of Claim

You or your beneficiary must notify the Administrator, Johnson Inc., immediately.

In the case of claim, written notice of Injury must be given to the Insurer within 30 days after the date of the accident and written proof of loss must be furnished to them within 90 days after the date of such Loss. Failure to furnish such notice or proof within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to furnish such notice or proof and that such notice or proof was furnished as soon as was reasonably possible, **but in no event later than one year after the date of the accident.**

IV. NSED Group Travel Plan

Out of Province/Canada Emergency Medical Insurance Plan

The NSED Travel Insurance Plan offers complete coverage for your travel needs in one convenient package, with options to suit your budget. The Provincial Health Plan provides limited basic coverage for travel outside of your province of Residence. If you have a medical emergency while travelling outside Canada, costs can easily escalate and will not all be covered by the government plan.

You and/or your family must be insured under the Provincial Health Insurance Plan in your Province of Residence to be eligible to join the plan. You can also cover your spouse and your eligible dependent children under the family option.

Take a few minutes now to consider the important features of this plan.

The NSED Travel Plan insures you and your immediate Family member(s) for reasonable and customary expenses arising from any sudden and unexpected sickness or injury that takes place during an insured trip and requires immediate medical treatment by a licensed physician. Subject to the maximum amounts shown below, the plan pays for eligible expenses less the amount under any other insurance plan. If you have coverage through other plan(s), Global Excel will coordinate benefits with other plan(s) in which you participate. Total reimbursement for expenses will not exceed 100% of the cost.

The NSED Travel Plan Consists Of Two Options: The Base Plan and the Supplemental Plan, the terms of which are outlined separately.

The Annual Base Plan

The Annual Base Plan is a continuous plan that provides emergency medical travel coverage for an unlimited number of trips, up to 35 consecutive days per trip during the policy year. Proof of travel is not required unless a claim occurs.

The Supplemental Plan

You may elect coverage under the Supplemental Plan for trips of longer than 35 consecutive days on a per trip basis and increase incrementally by 15 days to a maximum of a 210 day trip limit. **You are required to report the entire period of travel from the first day. The Supplemental Plan options include the Annual Base Plan Coverage.**

Pre-existing Conditions

This plan provides coverage for emergencies only and does not provide coverage for expenses incurred as a result of a pre-existing health condition, unless the condition has remained stable for a period of 6 months immediately prior to the date of purchase of trip. To be considered medically stable you must not have:

- been treated or evaluated for new symptoms or new diagnosis
- had symptoms that increased In frequency or severity, or examination findings indicating the condition has worsened
- been prescribed a new treatment or change in treatment for the condition
- been admitted to or treated in a hospital or referred to a specialist for the condition
- been awaiting new treatment, tests, consultations or referrals regarding the medical condition (does not include routine testing provided the results are within normal limits and no change in treatment is recommended)

This also does not include coverage for expenses incurred as a result of a condition caused by a change in medication within 90 days prior to departure (generally does not include routine changes in medication as part of an established treatment plan, i.e., daily/weekly adjustments of blood thinners or insulin based on blood test results OR a change to a generic product, unless the dosage is modified).

For further clarification on the pre–existing conditions clause, your call will be directed to the provider, who will discuss your medical information with you.

Eligibility

The NSED Travel Plan is available to active and retired members and eligible dependents of the NSTU. To be eligible for coverage, you must be a resident of Canada and covered under your provincial government plan.

How to Enroll

Complete an enrollment form, indicating the coverage required and return it to Johnson Inc.

If you need help in choosing the right coverage, a Johnson Inc. Service Supervisor will be pleased to assist you.

Your Annual Base Plan coverage begins the day Johnson Inc. receives your completed and

signed enrollment form. Your Supplemental Plan will commence the later of (i) the date shown on your completed signed enrollment form, or (ii) the date you depart your province of residence. Shortly after, you will receive a confirmation of coverage letter, Benefits Booklet and ID Card.

In the first year, for first time NSED members only, the Annual Base plan premiums are pro-rated from the date your coverage is effective until the policy renewal date, which is September 1st.

The Plan automatically renews each year on September 1st. You will receive written notification in advance. Your coverage will continue at renewal for the next policy year, unless you provide Johnson Inc. with written notice of termination within 30 days of the renewal date. Premiums are deducted monthly. Premiums under the Base Plan are non-refundable and non-cancellable.

*Supplemental Plan premiums for any of the per trip options includes coverage for any other trips of 35 consecutive days or less duration. Premiums are deducted monthly during the period remaining from the date coverage begins until the next policy renewal, which is September 1. No portion of the Supplemental Plan premiums will be prorated.

Extension of Coverage — Supplemental Plan Only

The agreement may be extended for one further period, providing benefits were not used during the preceding period. If benefits were used, extension is at the option of the Insurer. Enrollment form for extension must be received before expiry of the first period of coverage. The total period of coverage may not exceed one year. Please note that the Insurer only approves extensions within the last 10 days of the current policy.

Definition of Dependents

“Spouse” means either:

(a) a member’s legally married spouse; or

(b) a person living with the member on a continuous basis in a conjugal relationship that is not a legal marriage, provided such relationship has existed for at least twelve (12) consecutive months at the time of application and immediately preceding the time when the status of such person is required to be determined for the purpose of coverage and the person is publicly represented by the member as the member’s spouse.

If you have had more than one spouse, your spouse shall be only the person who was your most recent spouse, using the criteria in (a) and (b) above.

“Dependent Children” means either natural children (legitimate or illegitimate), adopted children, or stepchildren of an employee who are:

a) under 21 years of age, unmarried and dependent upon you for maintenance and support; or

b) under 27 years of age and unmarried and in attendance* at an institution of higher learning and dependent upon you for maintenance and support; or

c) any functionally impaired child may remain insured past the maximum age. The child upon reaching the maximum age, must still be incapable of self-sustaining employment and be completely dependent on you for support and maintenance.

“Over-age-Dependents” — On your dependent's 21st birthday you must provide Johnson Inc. proof of full-time attendance at a post-secondary educational institution.

All dependent children between the ages of 21 and 27 attending an institution of higher learning must provide Johnson Inc. each September with proof of full-time attendance at a post-secondary educational institution.

Proof must clearly indicate your over-age dependent’s name, full-time status and the semester they are attending and can include but not limited to one of the following:

1. Timetable of courses confirming full-time status.
2. Invoice of tuition paid confirming full-time status.
3. A letter from the school confirming full-time status (any associated charges are your responsibility).

Indicate on proof of full-time status, your name plus professional number.

On-line learning reviewed on an individual basis.*

If your over-age dependent discontinues enrollment in a formal education program or graduates, you must notify Johnson Inc. immediately to terminate over-age coverage.

If attending college or university outside Canada, a dependent is covered while travelling outside of the area of residence.

Benefits

Eligible expenses include:

Emergency Medical Expenses — This benefit covers the cost of Emergency hospital, surgical and medical treatment for the following:

- Hospital room and board including an Intensive Care or Coronary Care unit, charges for standard ward accommodation, semi-private room, or private room charges when certified as medically necessary by the attending physician;
- Other Hospital services and supplies;
- Medical, surgical or anaesthetic treatment by a licensed physician or surgeon;
- X-rays and other diagnostic tests;
- Use of an operating room, anaesthesia and surgical dressing;
- The cost of a licensed ambulance service;
- Out-patient emergency room charges;
- Drugs and medications legally requiring a licensed physician's written prescription; and
- Rental cost of a wheelchair, rental or purchase of minor medical appliances such as crutches, braces and other therapeutic medical appliances when ordered by the attending physician.

Air Emergency Transportation or Evacuation — When medically required covers the following expenses:

- Air ambulance to the nearest appropriate medical facility or to a Canadian hospital;
- Fare for transportation by stretcher to the home departure point including, when medically necessary, the return fare and approved professional charge of an accompanying Registered Nurse or other qualified medical attendant, not a relative of the Insured Person; and
- Charges In excess of booked fare or prearranged charter fare incurred as a result of a change in the planned schedule, including additional fare of an eligible Insured Person covered under this contract who was travelling with the stricken Insured Person.
- Return fare for transporting a member of the immediate family (spouse, parent, child) to attend at the side of an Insured Person who was travelling unaccompanied by an adult family member, following a critical injury or illness necessitating hospitalization. Attendance and return must occur within 10 days of discharge from hospital.

All air transportation expenses must be approved and arranged in advance by Medavie Blue Cross.

Private Nursing Expenses — Charges for services of a Registered Graduate Nurse (R.N.), for private duty nursing care provided in a Hospital or a temporary residence, when medically necessary and ordered by the attending physician. Coverage is not included for nursing service provided by a relative of the participant.

Physiotherapy — Charges for services of a registered physiotherapist when recommended by the attending physician.

Emergency Dental Expenses — This benefit covers the cost of repair of natural, vital teeth or fracture or dislocation of the jaw, as a result of injury from an external blow during the term of the contract. It also covers the cost of emergency extractions, temporary filings and replacement fillings. Coverage is limited to $1,000 per injury and must be provided during the term of coverage.

Board and Lodging — Charges for board and lodging or similar expense up to $150 per day to a maximum of $1,500 for costs incurred by a Participant or by a travelling companion, when related to a period of hospitalization of a Participant.

Repatriation — If a Participant dies while on an insured trip, the cost of transportation of the deceased Participant's remains to their province of residence, up to a maximum of $3,000 per Participant. The cost of a burial coffin is not a covered expense.

Vehicle Return — If a Participant and/or immediate family member is unable to operate their owned or rental vehicle due to sickness, injury or death while travelling outside the Participant's province of residence, this plan will arrange for the return of the vehicle and cover the expenses up to a maximum of $1,000 provided no other person travelling with the Participant insured person is able to operate the vehicle. Benefits will only be payable for return of the vehicle when pre-approved and/or arranged by Medavie Blue Cross.

- To the Participant's normal place of residence; or
- To the nearest appropriate rental agency

Benefit Maximums

The plan reimburses all usual and reasonable expenses incurred following an emergency situation resulting from an accident or an illness, up to a maximum amount payable of $2,000,000 per incident, per covered Participant and a maximum amount payable of $5,000,000 for one occurrence.

Occurrence refers to each related claim arising as a result of one accident or cause, regardless of the number of policies or covered persons involved.

All customary and reasonable expenses and services described in the Worldwide Travel Benefit are eligible if they are incurred following an emergency resulting from an accident or sudden illness which occurs outside the Participant's province of residence, provided

the Participant is covered under the Hospital and health government programs of his province of residence when the emergency occurs.

Eligible treatments and benefits are supplemental to those provided for by government plans or from any other medical reimbursement plan under which you may have coverage. All individual benefit maximums stated within this policy are expressed in Canadian currency.

In case of Emergency

If a medical emergency occurs during travel, please call (or if necessary, have your travel companion call) the Worldwide Travel Assistance phone number on the back of your ID card so they can direct you to a Preferred Provider. If possible, call BEFORE consulting for medical care.

In Canada/U.S.A. call: 1-800-563-4444
From anywhere else call collect: 1-506-854-2222

Medavie Blue Cross provides the following services:

Medical Assistance — If the participant requires hospitalization or a consultation with a physician as a result of an emergency, the travel assistance provider appointed by Medavie Blue Cross will provide the following support services:

- Direct the participant to an appropriate clinic or hospital;
- Confirm with the service provider that the participant Is covered;
- Ensure a follow-up of the medical file and communicate with the participant's family physician;
- Co-ordinate the return home of a child if the participant is hospitalized;
- Repatriation of the participant to the province of residence if the participant meets the eligibility requirements of this expense;
- Arrange for the transportation of an immediate family member to the participant's bedside if the Participant meets the eligibility requirements of this expense; and
- Co-ordinate the return of the participant's vehicle if the Participant meets the eligibility requirements of this expense.

General Assistance — In emergency situations, the travel assistance provider appointed by Medavie Blue Cross will also provide the participant with the following services:

- Transmittal of urgent messages;
- Co-ordination of claims;

- Services of an interpreter for emergency calls;
- Referral to legal counsel In the event of a serious accident;
- Settlement of formalities In the event of death;
- Assistance with the loss or theft of Identity papers; and
- Information regarding embassies and consulates.

In addition, pre-travel advice regarding visas and vaccines is available (although vaccines may not be covered under your medical plan).

Medavie Blue Cross and its travel assistance provider are not responsible for the quality of medical and hospital care provided to the participant or for the availability of such care.

Managed Care

When a medical emergency occurs, you must seek treatment from a physician and/or hospital within the managed care network as referred by Medavie Blue Cross' appointed travel assistance provider. The travel assistance provider will refer you to the physician and/or hospital within the network that is best suited to your needs.

If you do not call the travel assistance provider, your eligible expenses will be reimbursed at 80%, except in extreme circumstances where you are unable to call. In a critical emergency, have someone call the travel assistance provider on your behalf as soon as possible and they will coordinate your benefits as usual.

If you choose not to receive treatment from the Managed Care network recommended by the travel assistance provider, your eligible expense will be reimbursed at 80%.

Automatic Extension

Coverage will be automatically extended beyond your day of return if you, a travelling companion, or your immediate family member travelling with you, is confined to a hospital on your day of return due to a medical emergency. Your coverage will remain in force for as long as you, your travelling companion, or your immediate family member is hospitalized plus an additional period of 5 days following discharge from hospital.

The period of insurance coverage is automatically extended for 72 hours when:

1. The delay of a plane, bus, ship, or train in which you are a passenger causes you to miss your scheduled return to your province of residence;
2. The personal means of transportation in which you are travelling is involved in

an accident or mechanical breakdown that prevents you from returning to your province of residence on or before your day of return; or

3. You must delay your scheduled return to your province of residence by the personal means of transportation in which you are travelling, due to extreme weather conditions.

Exclusions and Limitations

The policy does not cover, provide services, or pay claims, for expenses resulting from:

1. a sickness or injury occurring while the policy is not in force as per your trip;
2. eye glasses, contact lenses, hearing aids or prescriptions for same;
3. air travel other than as a passenger in a commercial aircraft licensed to carry passengers for hire;
4. preventative, experimental or patented medicines or vaccines;
5. for elective (non-emergency) treatment or surgery which is defined as treatment or surgery (a) not required for the immediate relief of acute pain and suffering, or (b) which reasonably could be delayed until the Participant has returned to Canada or (c) which the Participant elects to have rendered or performed outside of Canada following emergency treatment for, or diagnosis of, a medical condition which (on medical evidence) would not prevent the Participant from returning to Canada prior to such treatment or surgery; also check-ups or treatment for cosmetic purposes;
6. pregnancy, childbirth or miscarriage or any complications arising from pregnancy;
7. mental or emotional disorders that do not require hospitalization; abuse of medication, drugs or alcohol; intentional self-injury, suicide or attempted suicide (whether sane or insane);
8. excludes loss, damage, cost or expense of whatsoever nature directly or indirectly caused by, resulting from or in connection with any of the following regardless of any other cause or event contributing concurrently or in any other sequence to the loss:
   a) expenses incurred while travelling in a country (or a specific region of a country) for which there is a Government of Canada travel warning, when such travel warning was issued before the departure date and the loss or expense is related to the reason for which the travel warning was issued; and
   b) insurrection, war (declared or not), the hostile action of the armed forces of any country or participation in any riot or civil commotion.
9. willful exposure to peril except in an attempt to save human life;
10. expenses covered by any Provincial or Federal Act or Acts;

11. the continued treatment, recurrence or complication of a medical condition following emergency treatment of that medical condition during your trip if the medical advisors of Medavie Blue Cross and its travel assistance provider determine that you are able to return to Canada and you chose not to return;
12. any emergency transplants including but not limited to organ transplants and bone marrow transplants;
13. cardiac procedures, including cardiac catheterization, or surgery unless approved by Medavie Blue Cross prior to being performed, except in extreme circumstances where surgery is performed on an emergency basis immediately following admission to Hospital; or
14. expenses incurred for residents travelling outside their province of residence primarily or incidentally to seek medical advice or treatment, even if such a trip is on the recommendation of a physician;
15. Any pre-existing conditions unless the condition is stable prior to travel, and when medical attention is not anticipated during the travel period.
16. Medavie Blue Cross will not cover expenses in excess of $2 million Canadian per covered participant, per incidence outside the province of residence. A maximum amount of $5 million will be paid by Medavie Blue for all claims incurred due to any one occurrence.

Coordination of Benefits

Benefits payable under this policy shall be coordinated with any other coverage(s) and are payable in excess of all other benefits in effect on the Insured Person's behalf, so that payment under this policy and any other plan, including but not limited to the Insured Person's Provincial Health Insurance Plan, individual or group policy, credit card coverage or other insurance, shall not exceed 100% of the eligible charges incurred.

Termination of Travel Benefit

The travel benefit coverage ends at the earliest of:

1. the date you cease to meet eligibility requirements; or
2. the end of the grace period for which premiums have not been paid in full; or
3. the date the policy is terminated.

If you purchased a family plan, coverage for your dependents ends either on the date you cease to be covered or on the date they no longer meet the definition of dependent, whichever occurs first. Coverage for any Participant ceases when he is no longer covered under the government health program in his province of residence.

V. NSED Trip Cancellation / Trip Interruption

This option helps protect traveller against unforeseen circumstances they may prevent or discontinue a trip and is meant to complement your NSED Travel coverage.

Eligibility

The Trip Cancellation / Interruption coverage offered through the NSTU Group Insurance Program is available to active and retired members plus their eligible dependents who are enrolled in the NSTU NSED Out of Country/Province Emergency Medical Coverage Plan. If covered for family NSED Travel you must take family Trip Cancellation/Interruption.

How To Enroll

Fully complete the enrollment form and return it to Johnson Inc. The coverage will become effective on the date Johnson Inc. receives a completed and signed enrollment form.

For members purchasing Trip Cancellation / Trip Interruption coverage for the first time, premiums are pro-rated from the date your coverage is effective until the policy renewal date (September 1st).

Coverage will renew automatically on September 1st of each year. You will be provided with written notification in advance. Coverage will continue unless Johnson Inc. is provided with written notice of termination within 30 days of the renewal date. Premiums are deducted monthly and are non-refundable and non-cancellable.

Pre–Existing Medical Conditions

This plan provides coverage for emergencies only and does not provide coverage for expenses incurred as a result of a pre-existing health condition, unless the condition has remained stable for a period of 6 months immediately prior to the date of purchase of trip. To be considered medically stable you must not have:

- been treated or evaluated for new symptoms or new diagnosis
- had symptoms that increased In frequency or severity, or examination findings indicating the condition has worsened

- been prescribed a new treatment or change in treatment for the condition
- been admitted to or treated in a hospital or referred to a specialist for the condition
- been awaiting new treatment, tests, consultations or referrals regarding the medical condition (does not include routine testing provided the results are within normal limits and no change in treatment is recommended)

Also, this does not include coverage for expenses incurred as a result of a condition caused by a change in medication within 90 days prior to departure (generally does not include routine changes in medication as part of an established treatment plan, i.e., daily/weekly adjustments of blood thinners or insulin based on blood test results OR a change to a generic product, unless the dosage is modified).

NOTE: The above exclusion applies to you, an immediate family member, a travel companion, a travel companion's immediate family member, a close friend and/or host at destination.

For further clarification on the pre–existing conditions clause, your call will be directed to the provider, who will discuss your medical information with you.

Benefits

- Annual Plan.
- Trip Cancellation – up to a maximum of $5,000 per insured person per annual coverage period.
- Trip Interruption – up to a maximum of $5,000 per insured person for each covered trip.
    - — up to a maximum of $3,500 for lodging, meals, car rental, telephone calls and taxi costs ($350 per day).
- Up to a maximum of $1,000 for baggage and personal effects during a covered trip.
    - — Personal Effects – actual cash value or $500, whichever is less.
    - — Document Replacement – up to a maximum of $200.
    - — Baggage Delay – up to $400.

This is intended for informational purposes and is not an insurance policy. It contains some information about the coverages offered for the Trip Cancellation/Trip Interruption but does not list all the conditions and exclusions that apply to the described coverage. For full benefit details please refer to policy wording which governs all situations.

2

INSURANCE SERVICES

Insurance Services at a Glance

The Trustees also provide access to home and auto insurance services through Johnson Inc. Johnson Inc. is the preferred insurance provider for Nova Scotia Teachers Union, and provides access to comprehensive coverage, "above and beyond" service and exclusive savings including:

Car Insurance

Wherever your career or life takes you, Johnson is there with you.

- First accident forgiveness
- Loss of use coverage
- Depreciation benefit
- Emergency roadside assistance
- No surcharge for members who travel to the United States
- Multi-vehicle discounts
- Multi-vehicle discounts

Home Insurance

Johnson Inc. looks beyond the things people insure to the people themselves to do what's right by you.

- Enhanced Water Coverage option*
- Discounts for bundling home and auto

Extra Benefits

Insurance is there when you need it, but Johnson Inc. also offers benefits that help you live your life the way you want.

- Interest-free payroll deduction
- Get AIR MILES® Reward Miles
- Special offers and promotions

Car & Home Insurance

Quotations and Cost-Benefit Comparisons are provided without obligation.

Toll Free: 1-877-738-7189 (mention Group Code 62)

Website: www.nstu.johnson.ca

Johnson Insurance is a tradename of Johnson Inc. (“Johnson”), a licensed insurance intermediary, and operates as Johnson Insurance Services in British Columbia. Home and auto policies are primarily underwritten, and claims handles by, Unifund Assurance Company (“Unifund”). Unifund and Johnson share common ownership. Described coverage and benefits applicable only to policies underwritten by Unifund. Auto insurance not available in BC, SK or MB. Home and auto insurance not available in NU. Eligibility requirements, limitations, exclusions or additional costs may apply, and/or may vary by province or territory. *Enhanced water coverage not available on condo or tenant policies. Bundled savings applied to home insurance policies where home and auto policies are underwritten by Unifund. Eligibility requirements, limitations and exclusions apply. Call 1-877-738-7189 for details. †AIR MILES® Reward Miles awarded only on regular home and auto insurance policies underwritten by Unifund. At the time the premium is paid, one (1) Mile is awarded for each $20 in premium (including taxes). Miles are not available in SK or MB. ®™ Trademarks of AM Royalties Limited Partnership used under license by LoyaltyOne, Co. and Johnson (for Unifund).

“My Insurance” Website

As a NSTU member, you can use the internet to access and interact with the group insurance plan in a completely secure and private environment.

The new Johnson Inc. "My Insurance" website (formerly the "Members-Only" website) will provide a more modern user experience, enhanced security features and easier access to your policy details.

How to get CONNECTED!

The new "My Insurance" website enables you to view and interact with your group insurance plan. To register, go to https://www.johnson-insurance.com/Members-Only/. Enter your Members Only username and password in the "New to this?" section and click "Register". If you do not remember your Members Only username or password, click "Register" in the "New to this?" section. If you need further assistance please visit **pages.johnson.ca/myinsurance.**

Real-Time Data

The information you will see is the most up-to-date data on your group benefit plan that we have available.

Complete Information

Each benefit listed in your online benefit statement is linked to a full benefit description, including rates and premium.

“One-Stop” Access

Through your online benefit summary, you will be able to view ALL your individual insurance information.

Unprecedented Convenience

Incorporates your coverages in one easily accessible source. Furthermore, it is available to you 24-hours-a-day, every day.

E-mail Communications

You can easily and instantly submit any questions, comments, or concerns you may have to your personally assigned Service Supervisor.

3 GLOSSARY OF TERMS

Exclusion – This plan is NOT available to any person who is receiving a Pension.

Proof of Membership – Proof of Reserve Membership must be received from the NSTU.

Payment of Premiums – Premiums are to be paid by bank deduction. A void cheque must accompany your application.

Statement of Days – At the end of each school year, each insured person must submit a statement.

Taught – The number of days taught in said school year.

Choice of Options – A Reserve Member may apply for Optional Life Insurance, Voluntary Accidental Death & Dismemberment, Total Care Medical or Total Care Dental and MEDOC® Group Travel / Trip Cancellation/Trip Interruption or any combination of the five, subject to the "time limit for application".

Cancellation of Policies – When any cheque is returned NSF, the Trustees reserve the option to cancel the policy. When a Reserve Member cancels any plan, or any plan is cancelled and subsequently the Reserve Member re-applies, the Trustees reserve the right to issue or deny the Policy regardless of whether or not the Policy is subject to evidence of insurability.

Policies will be cancelled when Reserve Membership is cancelled or expires.

THE TRUSTEES RESERVE THE OPTION TO CANCEL ANY POLICY FOR FAILURE TO COMPLY WITH THE PROVISIONS OF THE "STATEMENT OF DAYS TAUGHT" OR IF IT BECOMES APPARENT THAT A MEMBER IS NOT ACTIVELY ENGAGED IN SUBSTITUTE TEACHING.

4 RESERVE MEMBERSHIP GUIDELINES

These policy provisions were effective September 1, 1994 and amended on May 2, 2003 and August 1, 2020.

Certification must be received from the Regional Centre for Education that you applied for and were available for substitute teaching.

A substitute teacher for the purpose of being considered for the Nova Scotia Teachers Group Insurance Plans shall:

(a) be a Reserve Member of the Nova Scotia Teachers Union

(b) have taught at least (15) days in the Province of Nova Scotia in the previous and/or current school years;

(c) if application for the Group Insurance Plan is made part way through the school year, the substitute teacher must have taught at least fifteen (15) days in the Province of Nova Scotia in the previous and/or current school years to maintain benefits past August 31st.

(d) be a resident of the Province of Nova Scotia during the school year;

(e) provide the Johnson Inc. with proof of number of days substituted (proof must be In the form of a letter from Regional Centre for Education or a copy of pay stub(s)indicating days taught in the current school year); and

(f) promptly pay all premiums (see cancellation of policies).

ARTICLE 32 — Substitute Teachers

Article 32.15

When the total number of days taught and claimed by a substitute teacher in any one (1) school year equals or exceeds one hundred seventy-five (175) days, provided said days are in the same School Board, the teacher shall be reimbursed for premiums paid for Total Care provided the substitute teacher registered for and was paying the premium of the plan, during the current school year. Re-imbursement will be in accordance with the cost sharing for the Total Care Premiums and the current practice for insurance re-imbursement.