MHI RJ AVIATION ULC

Class 160
Salaried Employees

Class 162
Expatriates

Class 164
Surviving Spouses of Salaried Employees

Class 165
Retired Salaried Employees

GROUP INSURANCE PLAN

Policyholder: ***MHI RJ AVIATION ULC***

Policy No.: ***28770***

Policy Effective Date: ***June 1, 2020***

This booklet is provided for the purpose of explaining the benefits provided under the group policy.

Possession of this booklet does not confer or create any contractual rights. All rights and obligations with respect to the benefits provided under the group policy will be governed solely by the terms and conditions of such policy.

The Policyholder reserves the right to amend or suspend any coverages, including coverages for retirees, that are provided under the group policy as well as terminate the group policy in its entirety at any time with respect to active Participants (including those that may be absent due to a disability) as well as retired Participants after their retirement.

In addition, the Policyholder reserves the right to change the contribution requirements for the coverages, including coverages for retirees, provided under the group policy at any time with respect to active Participants (including those that may be absent due to a disability) as well as retired Employees after their retirement.

For questions regarding the information in this booklet or if additional information about the benefits is required, the Participant should contact his Employer.

This booklet can also be viewed on our secure website My Client Space accessible via ia.ca, if offered as part of your plan.

TABLE OF CONTENTS

SUMMARY OF BENEFITS

The SUMMARY OF BENEFITS briefly describes the coverage of the group insurance plan, based on the class the Participant belongs to.

The following pages give a full description of the GENERAL PROVISIONS and of each BENEFIT.

SPECIAL PROVISIONS

For the purposes of this booklet, the masculine form includes the feminine unless a different meaning is required from the context. In addition, the singular shall include the plural where required.

Participants are insured under the following classes:

Classes

160 – Salaried Employees

162 – Expatriates

164 – Surviving Spouses of Salaried Employees

165 – Retired Salaried Employees

An Expatriate Employee is not covered for Quebec Prescription Drug Insurance, Supplemental Health Insurance and Dental Care Insurance benefits.

GENERAL PROVISIONS

ELIGIBILITY DATE

Subject to all of the terms and conditions of the group policy, **a Permanent Full-Time or Part-Time Employee** shall become eligible on the latest of the following dates:

a) On June 1, 2020, if he is then an Employee;

or

b) On the first Day of the month following one full month of service (for Dental Care: 3 months) with the Employer.

Subject to all of the terms and conditions of the group policy, a **Retired Employee** shall become eligible on the latest of the following dates:

a) On June 1, 2020, if he is then considered a Retired Employee by the Policyholder;

or

b) On the date on which he is considered a Retired Employee by the Policyholder.

Subject to all of the terms and conditions of the group policy, a **Surviving Spouse** shall become eligible on the latest of the following dates:

a) On June 1, 2020, if he is then considered a Surviving Spouse by the Policyholder;

or

b) On the date on which he is considered a Surviving Spouse by the Policyholder.

ELIGIBILITY PERIOD

As per the Eligibility Period above.

PARTICIPANT'S LIFE INSURANCE

Classes: 160, 162, 165

Sum Insured

Classes 160, 162:

1.5 times the Annual Earnings, the result being rounded to the next higher $1,000, if not already a multiple thereof.

Maximum: $760,000 without evidence of insurability

or

$1,650,000 with evidence of insurability.

Class 165:

$4,000, less the amount of the Death Benefit from Canada Pension Plan (or Quebec Pension Plan, if applicable), but in no case less than $3,000.

Reductions, Exclusions and Limitations:

This benefit and any sum insured payable thereunder are subject to any reductions, exclusions and limitations indicated in this benefit or in the General Provisions of the group policy.

Termination:

Classes 160, 162:

The insurance under this benefit terminates on the earliest of: the Participant's date of retirement or such other earlier date indicated in this benefit or in the General Provisions of the group policy.

At retirement, the Participant is transferred to class 165.

Class 165:

The insurance under this benefit terminates on the earliest of: the Participant's death; or such other earlier date indicated in this benefit or in the General Provisions of the group policy.

PARTICIPANT'S OPTIONAL LIFE INSURANCE

Classes: 160, 162

Sum Insured

Units of $10,000

Maximum [1]: $40,000 without evidence of insurability
or
$1,650,000, with evidence of insurability

[1] *The combined amount of basic and optional life insurance must not exceed $1,650,000.*

Reductions, Exclusions and Limitations:

A Participant may obtain the maximum amount without evidence of insurability within 31 Days of his initial enrollment.

At any other time, any amount of Optional life insurance requires evidence of insurability and are subject to the insurer receiving the required evidence of insurability and providing Approval of Evidence of Insurability in accordance with all of the terms and conditions of this benefit or in the General Provisions of the group policy.

This benefit and any sum insured payable thereunder are subject to any other reductions, exclusions and limitations indicated in this benefit or in the General Provisions of the group policy.

Termination:

The insurance under this benefit terminates on the earliest of: the Participant's 70th birthday; or his date of retirement; or such other earlier date indicated in this benefit or in the General Provisions of the group policy.

DEPENDENTS' OPTIONAL LIFE INSURANCE

Classes: 160, 162

Sum Insured

Spouse:	Units of $10,000 Maximum: $40,000 without evidence of insurability [1] or $400,000 with evidence of insurability
Each Child	
– less than 24 hours:	Not applicable
– 24 hours and more:	Units of: $10,000 Maximum: $20,000 without evidence of insurability [2] or $50,000 with evidence of insurability

Reductions, Exclusions and Limitations:

All amounts of Spouse [1] or Children's [2] optional life insurance require Evidence of Insurability and are subject to the insurer receiving the required Evidence of Insurability and providing Approval of Evidence of Insurability in accordance with all of the terms and conditions of this benefit or in the General Provisions of the group policy.

[1] *A Participant may obtain $40,000 of insurance for his Spouse without evidence of insurability within the first 31 Days:*

- *of his eligibility;*
- *of his marriage;*
- *following one year of cohabitation with a common-law Spouse.*

DEPENDENTS' OPTIONAL LIFE INSURANCE (cont'd)

Classes: 160, 162

(2) *A Participant may obtain $20,000 of insurance for his Child without evidence of insurability within the first 31 Days:*

- *of his eligibility;*
- *of his marriage;*
- *following one year of cohabitation with a common-law Spouse;*
- *of the birth of his Child.*

Termination:

For each Insured Dependent, the insurance under this benefit terminates on the earliest of: the Participant's 70th birthday; or the Participant's date of retirement; or such other earlier date indicated in this benefit or in the General Provisions of the group policy.

LONG-TERM DISABILITY INSURANCE

Classes: 160, 162

Monthly Indemnity

70% of the basic monthly salary, the result being rounded to the next higher dollar.

Monthly maximum:

$10,600 without evidence of insurability [1]
or
$17,000 with evidence of insurability [1].

[1] *subject to applicable reductions*

However, the overall maximum must not exceed 80% of the gross monthly salary determined at the onset of disability.

Elimination Period: 26 weeks

Maximum Benefit Payment Period: To the Participant's 65th birthday

Period Relative to the Usual Occupation: 24 months

Benefits are taxable.

Termination:

The insurance under this benefit terminates on the earliest of: the Participant's 65th birthday, less the elimination period, or his date of retirement; or such other earlier date indicated in this benefit or in the General Provisions of the group policy.

SUPPLEMENTAL HEALTH INSURANCE

Classes: 160, 164, 165

EMERGENCY MEDICAL EXPENSES INCURRED OUTSIDE THE PROVINCE OF RESIDENCE and EMERGENCY OUT OF PROVINCE ASSISTANCE

Deductible:	Reimbursement:	Maximum per Insured Person:
none	100%	$5,000,000 per lifetime
		Duration of coverage per trip Class 160: the first 90 consecutive Days of the trip
		Classes 164, 165: the first 60 consecutive Days of the trip

HOSPITALIZATION IN THE PROVINCE OF RESIDENCE

Deductible:	Reimbursement:	Daily maximum:
none	100%	Semi-private room without limit as to the number of days or a private room, maximum $200 per Day

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

Class: 160, 164, 165

ALL OTHER MEDICAL EXPENSES INCURRED IN CANADA

Deductible:	
– Separate drug deductible:	$5 per prescribed drug
– Maximum eligible dispensing fee:	$11 per prescription
– Other expenses:	$25 per Insured Person Maximum of $50 per family
Reimbursement	
– Drugs:	100%
– Other expenses:	80% (unless otherwise specified)
Maximum:	$1,000,000 per lifetime

Reductions, Exclusions and Limitations:

This benefit and any amounts payable thereunder are subject to any reductions, exclusions and limitations indicated in this benefit or in the General Provisions of the group policy.

Termination:

Class: 160

The insurance under this benefit terminates on the earliest of: the Participant's date of retirement; or such other earlier date indicated in this benefit or in the General Provisions of the group policy.

At retirement, the Participant is transferred to Class 165.

If on the date of his death, the Participant was 55 years of age or over and had completed 2 years of service with the Employer, his Spouse is transferred to Class 164.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

Class: 160, 164, 165

Class: 164

The insurance under this benefit terminates on the earliest of: the date the insured Spouse remarries, or the date the insured Spouse publicly declares a new Spouse, or the date of the insured Spouse's death.

Class: 165

The insurance under this benefit terminates upon the Participant's death.

The Spouse is then transferred to Class 164.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

Classes 160, 164, 165

Drugs

Covered Expenses	Maximums Per Insured Person
Drugs or medicine	Covered. Generic substitution when available on the market.
Fertility drugs	Limited to one cycle per lifetime.
Over the counter drugs	$300 per Calendar Year.
Viagra	$1,000 per Calendar Year.
Weight loss drugs	Maximum of 12 months of treatment per lifetime.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

Classes: 160, 164, 165

Medical Expenses

Covered Expenses	Maximums Per Insured Person
Fees for nursing care and Room and board in a nursing home licensed to provide long-term care	Combined maximum of $25,000 per 3 consecutive Calendar Years, and a maximum of $20 per Day for long-term care provided in a nursing home.
Physician's fees (for medical certificate)	Class 160: Covered. **These expenses are reimbursed from the second certificate.** Classes 164, 165: These expenses are not covered.
Ambulance	$50 per trip. Maximum of $200 per Calendar Year. **These expenses do not include a deductible and are reimbursed at 100%.**
Oxygen	Covered.
Supplies required as a result of colostomy, ileostomy or diabetes	Covered.
Artificial limbs and eyes	Covered (subsequent to OHIP considering the claim).
Wheelchair, hospital bed, respirator / ventilator, other therapeutic appliances	Covered.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

Classes: 160, 164, 165

Medical Expenses

Covered Expenses	Maximums Per Insured Person
Breast prostheses	$1,000 per period of 3 Calendar Years.
Surgical brassieres (required with breast prostheses)	4 brassieres per Calendar Year.
Medical elastic stockings or *Jobst* stockings	4 pairs per Calendar Year. **These expenses have to be pre-approved by the insurer.**
Room and board in a rehabilitation institution or a convalescent home	$40 per Day. Combined maximum of 180 Days per period of Hospitalization due to the same cause. **These expenses do not include a deductible and are reimbursed at 100%.**
Hospice charges	$7,500 per lifetime. **These expenses do not include a deductible and are reimbursed at 100%.**
Orthopedic shoes	$400 per Calendar Year.
Diagnostic laboratory and x-ray procedure fees	Covered.
Orthoses and alterations (custom-made)	$400 per Calendar Year.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

Classes: 160, 164, 165

Medical Expenses

Covered Expenses	Maximums Per Insured Person
PSA testing	Covered. These expenses do not include a deductible and are reimbursed at 100%.
Orthopedic devices	Covered.
Intrauterine devices	One device per period of 3 Calendar Years.
Crutches, hernia belts, splints, casts, braces, trusses, slings, cervical collars and supports	Covered.
Sclerosing injections	Covered.
Glucometer	Covered.
Capillary prostheses	$500 per lifetime.
Dental care as a result of an Accidental Injury	Covered.
Paramedical fees for a physiotherapist and a physical rehabilitation therapist (medical recommendation is required)	Global maximum of 24 visits per Calendar Year. One treatment per Day per specialist.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

Classes: 160, 164, 165

Medical Expenses

Covered Expenses	Maximums Per Insured Person
Paramedical fees for a psychologist and a psychotherapist (medical recommendation is required)	Combined maximum of 24 visits per Calendar Year. One treatment per Day.
Paramedical fees for a speech therapist, a chiropractor (including x-rays), an osteopath, a podiatrist, an acupuncturist, a massage therapist, a homeopath and a naturopath	Global maximum of $500 per Calendar Year. One treatment per Day, per specialist. **These expenses do not include a deductible and are reimbursed at 100%.**
Ear moulds	$400 per Calendar Year, only for a Dependent Child under age 14.
Hearing aids	$400 per period of 2 Calendar Years. **These expenses are reimbursed at 100%.**
Vision care	Eyeglasses (frame and lenses) or contact lenses, up to a maximum of $190 for single focal, $210 for bifocal, $230 for trifocal, per period of 24 consecutive months (12 consecutive months for a Dependent Child under age 14). The trifocal benefit may be applied towards the cost of a laser eye surgery.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

Classes: 160, 164, 165

Medical Expenses

Covered Expenses	Maximums Per Insured Person
Cosmetic surgery following a non-occupational injury	Covered.

DENTAL CARE INSURANCE

Class: 160

Deductible:	None
Reimbursement	
– Preventive treatments:	100%
– Basic treatments:	100%
- periodontal scaling:	80%
– Major treatments:	50%
- preformed stainless steel or polycarbonate crown:	100%
– Orthodontic treatments:	50%
Maximum per Insured Person	
– Preventive, Basic and Major treatments:	$1,800 per Calendar Year
– Orthodontic treatments:	$2,000 per lifetime (1)

(1) *ORTHONDONTIC TREATMENTS are limited to Insured Persons under age 19 at the time treatment begins.*

Expenses for a General Dental Practitioner are reimbursed according to the Dental Surgeons Association's Fee Guide for the current year and expenses for a Dental Specialist are reimbursed according to the Dental Specialists' Fee Guide, where applicable, for the current year.

Expenses for a Dental Hygienists are reimbursed according to the Dental Hygienists Association's Fee Guide for the current year.

Expenses for a Denturist are reimbursed according to the Denturists' Fee Guide for the current year.

Expenses are subject to any limits which are stated under the Dental Care Insurance. If there is no fee guide for the reference year, the insurer will determine the level of dental expenses to be reimbursed according to the latest fee guide plus an inflationary adjustment.

DENTAL CARE INSURANCE (cont'd)

Class: 160 (cont'd)

Reductions, Exclusions and Limitations:
This benefit and any amounts payable thereunder are subject to any reductions, exclusions and limitations indicated in this benefit or in the General Provisions of the group policy.

Termination:
The insurance under this benefit terminates on the earliest of: the Participant's date of retirement; or such other earlier date indicated in this benefit or in the General Provisions of the group policy.

Special Markets Solutions, a division of Industrial Alliance Insurance and Financial Services Inc., is the insurer for the following benefits:

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE
Policy No. 100012339

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE
Policy No. 100012340

BUSINESS TRAVEL ACCIDENT GROUP INSURANCE
Policy No. 100012341

For more details, please refer to the texts of the benefits at the end of the booklet.

DEFINITIONS

Accident means any event due to a sudden and unforeseeable external cause that inflicts bodily injuries directly and independently of any other cause, all of which is certified by a Physician.

Accidental Injury means any bodily injury sustained while the insurance is in force, directly and solely due to an external, sudden, violent and unintentional cause and requiring within 30 days of the Accident the care of a Physician.

Actively at Work means:

If it is a Working Day, the Employee is deemed to be Actively at Work for his Employer if he reports to work and performs all the essential duties of his regular occupation for the total number of scheduled hours for such Working Day.

If it is a weekend, holiday or a vacation Day, the Employee is deemed to be Actively at Work for his Employer if:

a) On that Day, he would have been able to report to work for his Employer and perform all the essential duties of his regular occupation for the total number of scheduled hours had it been a Working Day; and

b) On his last Working Day, he reported to work for his Employer and performed all of the essential duties of his regular occupation for the total number of scheduled hours for that Working Day.

Approval of Evidence of Insurability means the insurer actually accepts, in writing, the risk applied for after receiving each and every document required to assess such risk.

Calendar Year means the period from any January 1st to the next December 31st, both inclusive.

Day means a Calendar Day, except if otherwise defined in the group policy.

Day Surgery means surgery which is performed in a Hospital or out-patient clinic affiliated with a Hospital and requiring local, regional or general anaesthesia, but will not include minor surgery that can be performed in the Physician's office.

Dependent means:

The Participant's Spouse, or a Child of the Participant or of the Spouse, who is insured under the group policy and who satisfies the following respective definitions:

a) Spouse

Spouse of a Participant who is not an Expatriate Employee

The person who is married to or is in a civil union with the Participant, or the person designated by the Participant, whom he declares publicly to be his Spouse and with whom he has been living on a permanent basis for at least one year, or less, if a Child is born from their union.

In all cases, a de facto separation of more than 3 months results in the loss of status as Spouse.

The Spouse must reside in the same country as the Participant.

If according to this definition, the Participant has had more than one Spouse, Spouse shall mean the person most recently qualified.

Spouse of a Participant who is an Expatriate Employee

A person who

i) is Canadian; and

ii) was a Full-time Resident of Canada immediately prior to the commencement of the absence from Canada; and

iii) had been insured under the provincial health plan of his province immediately prior to the commencement of the absence from Canada; and

iv) is married to or is in a civil union with the Participant, or the person designated by the Participant, whom he declares publicly to be his Spouse and with whom he has been living on a permanent basis for at least one year, or less, if a Child is born from their union. In all cases, a de facto separation of more than 3 months results in the loss of status as Spouse.

If according to this definition, the Participant has had more than one Spouse, Spouse shall mean the person most recently qualified.

b) Child

Child of a Participant who is not an Expatriate Employee

Any unmarried Child of the Participant or of his Spouse residing in Canada who depends on the Participant for support and maintenance and who meets at least one of the following conditions:

i) He is under 21 years of age; or

ii) He is under 25 years of age and is attending a recognized educational institution on a full-time basis; or

iii) He is mentally or physically handicapped and is incapable of earning his own living due to such handicap provided such handicap commenced while he was a child as defined in i) or ii).

Child of a Participant who is an Expatriate Employee

A person who

i) is an unmarried child of the Participant or his Spouse; and

ii) wholly depends on the Participant for support and maintenance; and

iii) is residing with the Participant or if not residing with the Participant, he is a Full-time Resident of Canada; and

iv) is under 21 years of age; or

v) is under 25 years of age and attending a recognized educational institution on a full time basis, or

vi) is mentally or physically handicapped and is incapable of earning his own living due to such handicap provided such handicap commenced while he was a child as defined in iv) or v).

Earnings means:

Annual Earnings, for class 160, the remuneration stated by the Employer, excluding overtime, bonuses, and gratuities in accordance with the standards of the Employment Insurance Act.

Annual Earnings, for class 162, means the remuneration paid by the Employer, excluding bonuses, commissions, gratuities, overtime and any other form of additional remuneration.

Monthly Earnings means the Participant's Annual Earnings divided by 12.

Indexed Pre-Total Disability Gross Monthly Earnings means the Participant's Monthly Earnings immediately prior to the date his Total Disability commenced, increased by the Consumer Price Index (as published by the Government of Canada during the immediately preceding Calendar Year) each June 1st coincident with or next following the anniversary of the date on which the Participant became entitled to a Long-Term Disability benefit.

Pre-Total Disability Gross Monthly Earnings means the Participant's Monthly Earnings immediately prior to the date his Total Disability commenced.

Pre-Total Disability Net Monthly Earnings means the Participant's Monthly Earnings immediately prior to the date his Total Disability commenced, less the deductions for Income Tax, Canada or Quebec Pension Plan, Employment Insurance and the Quebec Parental Insurance Plan.

Amount of Earnings to Be Used

Where any benefit paid under the group policy is based on the Participant's Earnings, including any of the variations of the definition of Earnings above, the amount of Earnings that will be used to determine the benefit will be the lesser of:

a) The Earnings last reported to the insurer by the Policyholder, Employer, Employer's agent, or administrators and that has been used in the calculation of the premium payable; or

b) The Participant's actual Earnings received from his Employer at the time of the event for which a claim is being made; or

c) If the Participant is not Actively at Work at the time of the event for which the claim is being made, the Earnings on the last Working Day he was Actively at Work.

Eligibility Period means the continuous period, as specified in the Summary of Benefits, ending on or after the effective date of the group policy, during which the Employee or the Expatriate Employee must be Actively at Work.

Employee means any person who is employed by the Employer on a permanent full-time basis, and who is receiving regular salary for services rendered.

Employer means the Policyholder or any entities listed as Subsidiary or Associated Companies in the Summary of Benefits of the group policy.

Expatriate Employee means an Employee who

a) is Canadian; and

b) was working in Canada immediately prior to the commencement of his assignment outside of Canada; and

c) was a Full-time Resident of Canada immediately prior to the commencement of his assignment outside of Canada; and

d) has been assigned by the Policyholder to work temporarily outside of Canada for a period of more than 90 Days; and

e) had been insured under the group policy or a previous group policy of the Policyholder as an Employee immediately prior to the commencement of his assignment outside of Canada; and

f) had been insured under the provincial health plan of his province of residence immediately prior to the commencement of his assignment outside of Canada.

An Expatriate Employee is not covered for the Quebec Prescription Drug Insurance, Supplemental Health Insurance and Dental Care Insurance benefits under the group policy.

Full-time Resident of Canada means to have a permanent residence in Canada, and to reside in the province of residence the minimum number of Days a year required to be covered under the applicable provincial health plan of that province of residence.

Hospital means an institution which:

a) Is legally licensed by the appropriate government body; and

b) Is intended for the care of bedridden patients; and

c) Provides at all times the services of Physicians and registered nurses.

Hospitalization or Hospitalized means the occupancy of a Hospital room as an admitted bedridden patient where a room and board charge has been charged in connection with the confinement. A stay of more than 24 hours under observation in a Hospital, even if no charge is made, is considered a Hospitalization. Day Surgery is considered to be a period of Hospitalization.

Illness means any deterioration in health requiring continuous and curative care actively provided by a Physician and, where required by the group policy, by a Specialist in the field of medicine which is applicable to the Illness.

Insured Person means a Participant or a Dependent of a Participant who is insured under the group policy.

The Insured Person must at all times be covered under a government health plan and live in Canada permanently (at least 182 Days a year), in order to be eligible under the Basic Prescription Drug Insurance Plan of Quebec (if applicable), the Supplemental Health Insurance and the Dental Care Insurance benefits of the group policy and to maintain his rights to coverage, unless otherwise agreed previously with the insurer or unless mention to the contrary is made in the group policy.

Legal Capacity To Work means that the Participant must have each and every license, permit or other certification required to legally work in Canada.

Medically Required means broadly accepted and recognized by the Canadian medical profession as effective, appropriate, and essential in the treatment of an Illness or injuries, including injuries due to an Accident, in accordance with Canadian medical standards.

Participant means an Employee, an Expatriate Employee or a Retiree who is insured under the group policy.

Permanent Part-Time Employment means an employment which meets the following conditions:

a) Undetermined working period: the permanent part-time employment is created for an undetermined period. It cannot be associated to an on-call or occasional position.

b) The number of hours worked per week is at least 24 hours and can be allocated as per the supervisor's request. The number of hours can differ from one day to another.

c) Fixed and determined work schedule: The Employee should have a determined work schedule, established in advance. This schedule should be constant from one week to the next. The supervisor is responsible for the schedule management.

Physician means a person who is legally licensed and authorized to practice medicine and who is operating within the scope of his license.

Policyholder means any entities listed as the Policyholder on the cover page of the group policy.

Retired Employee means any person who holds such status with the Policyholder.

Specialist means a Physician licensed by the appropriate provincial licensing authority to practice medicine with a specialization.

Surviving Spouse means a Surviving Spouse of a Salaried Employee of Division 164.

Travel Benefits means the following Supplemental Health Insurance benefits: Emergency Medical Expenses Incurred Outside The Province Of Residence, and Emergency Out of Province Assistance.

Working Day means a Day on which the Participant is scheduled to work for his Employer and perform all of the essential duties of his regular occupation for the total number of scheduled hours.

CHANGES IN GOVERNMENT PLANS

The benefits provided under the group policy are complementary to the benefits provided by government plans. Any modifications to these government plans after the effective date of the group policy will not modify the benefits provided under the group policy, unless an agreement to modify the benefits is signed by the authorized signing officers of the insurer.

Notwithstanding the preceding paragraph, the group policy will be modified to reflect any changes to the maximum insurable earnings as determined under the Employment Insurance Act. In addition, if either federal or provincial legislation mandates that an insurer provides a certain type or level of coverage or the means of providing a certain type of coverage, the group policy will be deemed to have been amended to reflect the requirements of the legislation.

MEDICAL SERVICES AND/OR SUPPLIES COVERED BY A GOVERNMENT SPONSORED PLAN OR PROGRAM

There will be no coverage under the group policy for any expenses related, directly or indirectly, to any medical services and/or supplies which would have been covered by a government sponsored plan or program if the Insured Person had not elected to receive the services and/or supplies on a private basis from a medical practitioner, medical facility, clinic or Hospital, whether private or public, unless the services and/or supplies are explicitly stated as being covered under the group policy.

INCONTESTABILITY

Where evidence of insurability is required by the insurer in order to approve

a) insurance under the group policy or insurance under a benefit for a Participant or a Dependent; or

b) an increase, addition or change in such insurance for a Participant or Dependent,

the statements provided by the Participant or Dependent as evidence of insurability will be accepted as true and will not be contested by the insurer after the latest of the following dates, provided the Participant or Dependent is alive at the time:

a) 2 years from the effective date of the insurance for which the evidence was provided; or

b) 2 years from the effective date of the increase, addition or change to the insurance; or

c) 2 years from the effective date of the last reinstatement of the insurance.

However, this restriction on the insurer's right to contest the evidence of insurability will not apply in cases of fraud or misstatements of age.

Where evidence is required to approve an increase, addition or change in the insurance, the insurer's right to void the insurance will be limited to that increase, addition or change.

LAWFUL CURRENCY

All payments hereunder will be made in the lawful currency of Canada and according to the exchange rates effective at the time the event giving entitlement to a benefit took place.

COVERAGE ELSEWHERE

A Participant who is eligible for Supplemental Health Insurance and/or Dental Care Insurance and whose Spouse is covered for comparable insurance may decline insurance under the group policy for such insurance.

However, in order to decline Supplemental Health Insurance, it is mandatory for the Participant to be covered for comparable insurance with his Spouse.

The refusal of insurance under the group policy may be in respect of the Participant and his Dependents or his Dependents only.

If the insurance under the Spouse's policy ceases because of termination of such policy or because eligibility for the insurance ceases, then application may be made to insure under the group policy those persons whose insurance has terminated.

The application must be made within 31 Days after cessation of the insurance under the Spouse's policy and the insurance under the group policy shall be effective on the Day following the date of termination of the insurance under the Spouse's policy.

AGENTS

The Policyholder and the Employer are not agents of the insurer. The insurer shall not be bound by nor be liable for any act, or failure to act, on the part of the Policyholder or the Employer.

ERRORS

Clerical or inadvertent errors by the Policyholder, Employer or insurer shall not operate to:

a) Continue insurance otherwise validly terminated.

b) Increase any existing insurance.

c) Place in force any insurance which would, but for such error, not be validly in force.

d) Otherwise prejudice the insurer in any other way.

The insurer may, retroactively and at its sole discretion, in addition to any other legal remedy it may have, exercise any or all of the following rights:

a) Reimburse to the Policyholder any premiums that have been accepted through such error.

b) Terminate or rescind any such associated insurance.

c) Reduce the amount of insurance to the amount it should have been but for the error.

d) Take such other action as may be required to correct the error.

ELIGIBILITY

Participants who are not Expatriate Employees

An Employee or a Retired Employee will become eligible to be insured under the group policy as a Participant on the date (his "eligibility date") on which he satisfies all of the following conditions:

a) He satisfies the definition of Employee or Retired Employee in the group policy; and

b) He is a Full-time Resident of Canada (does not apply to a Retired Employee); and

c) He is covered under the provincial health plan of his province of residence (does not apply to a Retired Employee); and

d) He has satisfied the Eligibility Period specified in the Summary of Benefits.

However, an Employee will not be eligible to become insured under the Long-Term Disability Insurance benefit if he will attain the termination age specified for this benefit in the Summary of Benefits before the end of the Elimination Period specified for this benefit.

Participants who are Expatriate Employees

An Employee will become eligible to be insured under the group policy as a Participant on the date (his "eligibility date") on which he satisfies the following conditions:

a) He satisfies the definition of Expatriate Employee of the group policy; and

b) He has satisfied the Eligibility Period specified in the Summary of Benefits.

However, an Expatriate Employee will not be eligible to become insured under the Long-Term Disability Insurance benefit if he will attain the termination age specified for this benefit in the Summary of Benefits before the end of the Elimination Period specified for this benefit.

The Policyholder must notify the insurer prior to the date the Employee is to leave Canada on his assignment for the Employee to be eligible for coverage under the group policy as an Expatriate Employee.

Dependents of all Participants

A person will become eligible to be insured under the group policy as a Dependent on the date (his “eligibility date”) on which he satisfies all of the following conditions:

a) He satisfies the definition of Dependent in the group policy; and

b) He is a Full-time Resident of Canada (not applicable to an Expatriate Dependent); and

c) He is covered under the provincial health plan of his province of residence (not applicable to an Expatriate Dependent); and

d) The Employee or the Retiree of whom he is a Dependent is insured under the group policy as a Participant.

APPLICATION FOR GROUP INSURANCE

An Employee who is eligible to become insured under the group policy as a Participant must complete and submit an application for himself and for each of his Dependents, on their respective eligibility dates, on forms supplied by, or satisfactory to the insurer.

EFFECTIVE DATE OF INSURANCE

Whether membership under the group policy is compulsory or voluntary, the Participant's insurance and Dependents' insurance, if any, will take effect on the person's eligibility date, if the application for group insurance has been received by the insurer on or prior to such date, or within 31 Days after such date.

If the application for group insurance is not received within 31 Days of the eligibility date, the insurance will not take effect until the date on which the insurer receives evidence of insurability and provides Approval of Evidence of Insurability.

However:

a) If the Employee was not Actively at Work on the date his insurance would otherwise become effective, the insurance will not take effect until the earliest date thereafter on which he is again Actively at Work.

b) If the Dependent is Hospitalized on the date his insurance would otherwise become effective, the insurance will not take effect until the earliest date thereafter on which he is no longer Hospitalized. (This clause shall not apply to the Life Insurance benefit or in the case of a newborn Child).

Any amount of insurance which is in excess of the non-evidence maximum(s) specified in the Summary of Benefits will not take effect until the date on which the insurer receives evidence of insurability and provides Approval of Evidence of Insurability. If the insurer does not provide Approval of Evidence of Insurability for the Participant, any future increases in the non-evidence maximum(s) will not automatically result in an increase in the Participant's insurance. The increase in the non-evidence maximum(s) will only result in an increase in the Participant's insurance if he submits evidence of his insurability and the insurer provides Approval of Evidence of Insurability.

The Participant may decline the Supplemental Health Insurance and Dental Care Insurance benefits, if he is covered for comparable coverage under the terms of the group policy or another policy.

Should the Participant decline the Supplemental Health Insurance benefit, the Participant will be covered under the group policy for Emergency Medical Expenses Incurred Outside the Province of Residence and Emergency Out of Province Assistance when the absence is related to business travel only.

TERMINATION OF INSURANCE

Participant

A Participant's insurance automatically terminates on the earliest of the following dates:

a) The date the group policy is terminated; or

b) The date on which the Participant retires, unless otherwise specified in the Summary of Benefits; or

c) The date the Participant reaches the age limit specified in the Summary of Benefits, if an age limit is indicated; or

d) The date the Participant is no longer a Full-time Resident of Canada (not applicable to an Expatriate Employee or to a Retired Employee); or

e) The date the Participant loses his Legal Capacity to Work in Canada (not applicable to an Expatriate Employee or to a Retired Employee); or

f) The date the Participant is no longer covered by his provincial health plan (not applicable to an Expatriate Employee or to a Retired Employee); or

g) The date of the Participant's death; or

h) The date the Policyholder terminates insurance for the Participant; or

i) The date on which the Participant pleads guilty or is found guilty of an offence for which he is confined in a penitentiary, prison, correctional facility, forensic psychiatric facility or any similar institution; or

j) The date the Participant ceases to qualify as an Employee or a Retired Employee, or ceases to be Actively at Work, as defined in the group policy.

Insurance may be extended to a Participant during periods the Participant has ceased to be actively at work due to, but not limited to, Illness, injury, temporary layoff or a leave of absence. The Participant should contact the Policyholder for further information.

Dependents

A Dependent's insurance automatically terminates on the earliest of the following dates:

a) The date the Participant of whom he is a Dependent ceases to be insured under the group policy; or

b) The date the Dependent ceases to meet the definition of Dependent; or

c) The date the Dependent reaches the age limit specified in the Summary of Benefits, if an age limit is indicated; or

d) The date the Dependent is no longer a Full-time Resident of Canada (not applicable to an Expatriate Dependent or to the Dependent of a Retired Employee); or

e) The date the Dependent is no longer covered by the provincial health plan (not applicable to an Expatriate Dependent or to the Dependent of a Retired Employee); or

f) The date the Policyholder terminates insurance for the Dependent.

The above terms and conditions also apply in the case of the partial cancellation of insurance for a Participant or a Dependent owing to the cancellation of insurance under one or more benefits.

NOTICE AND PROOF OF CLAIM

Notice and proof of any claim must be submitted to the insurer in the format required by the insurer. The proof of claim must include all information that the insurer requires and deems necessary as to the circumstances and extent of the loss, or which the insurer otherwise requests in order to complete its assessment of a claim. The insurer will not be liable for any claim that is not submitted in accordance with all of the terms and conditions and time limits prescribed under the group policy.

- **Supplemental Health Insurance and Dental Care Insurance:**

  Notice and proof of any claim must be submitted to the insurer within 24 months of the date of the event which gives entitlement to the benefit.

- **Life Insurance:**

  Notice of any claim must be submitted within 30 Days of the date of the event which gives entitlement to the benefit. Proof of claim must be submitted within 90 Days of the date of the event which gives entitlement to the benefit.

  Failure to submit notice and proof of any claim within the time prescribed does not invalidate the claim if the notice or proof is submitted as soon as reasonably possible, and in no event later than 12 months from the date of the event, if it is shown that it was not reasonably possible to submit notice or proof within the time so prescribed.

- **Long-Term Disability Insurance:**

  Notice of any claim must be submitted within 120 Days of the end of the Participant's Elimination Period. Proof of claim must be submitted within 30 Days of the date of the beginning of the long-term disability.

NOTICE AND PROOF OF CLAIM IN CASE OF TERMINATION

In the event of the termination of the group policy or the termination of the Participant's insurance, the notice and proof of claim for any claim other than a Long-Term Disability claim, or a Supplemental Health Insurance or Dental Care Insurance claim, must be submitted to the insurer within 90 Days of the date of the termination of the group policy and, in the case of the termination of the Participant's insurance, within 90 Days of the termination of such insurance.

Notice and proof of claim for a Long-Term Disability claim must be submitted within 180 Days of the date of the date of the termination of the group policy and, in the case of the termination of the Participant's insurance, within 90 Days of the termination of such insurance.

Notice and proof of claim for a Supplemental Health Insurance and Dental Care Insurance claim must be submitted within 90 Days of the termination of the group policy and, in the case of termination of the Participant's insurance, within 12 months of the date of the event which gives entitlement to the benefit.

FRAUDULENT CLAIMS

The insurer will undertake all necessary actions to detect and investigate fraudulent claims under the group policy.

It is a crime if a Participant should knowingly and with the intent to defraud the insurer and the group plan, file a claim that contains any false, incomplete or misleading information.

The insurer retains the right to audit all claims at any stage, including after payment has been made, for fraud or misrepresentation.

If the insurer determines that a Participant or Dependent has submitted any claim that contains false or misleading information, the insurer shall have the right, at its sole discretion, to notify the Policyholder, decline the claim or require reimbursement if the claim has been paid. In addition, and notwithstanding any other provision in the group policy, the insurer will have the right to terminate the Participant's entire insurance under the group policy including any insurance for the Participant's Dependents, and will have the right to undertake the prosecution of the Participant and/or the Dependent in accordance with provincial and/or federal law.

APPEAL PROCESS

Where the insurer has made a decision to decline or terminate a claim or insurance under the group policy, the decision to decline or terminate may be appealed as long as this right of appeal is exercised within 60 Days of the initial letter of decline or termination.

The appeal must be in writing and must include the grounds of appeal, any new information to support the appeal and any further information that may be requested by the insurer.

EXPENSES

Unless the group policy expressly states otherwise, the Participant is solely responsible for all expenses and costs related directly and indirectly to submitting a claim, proof of a claim, appeals of any kind, or any other obligation the Participant has under the group policy, including but not limited to submitting any application or appeal, or obtaining any medical reports, clinical records, test results, or any other information.

BENEFICIARY

The Participant’s beneficiary shall be the person or persons designated by the Participant, in writing, to receive the death benefit payable under the Participant's Life Insurance benefit, and if applicable, the Participant's Accidental Death and Dismemberment Insurance benefit, Participant's Optional Life Insurance benefit and Participant's Optional Accidental Death and Dismemberment Insurance

benefit. If the Participant does not designate a beneficiary, any death benefit payable under such benefits will be payable to the Participant's estate.

All benefits, other than the Participant's Life Insurance benefit, Participant's Accidental Death and Dismemberment Insurance benefit, Participant's Optional Life Insurance benefit and Participant's Optional Accidental Death and Dismemberment benefit, will be payable only to the Participant, or if the Participant is deceased at the time of the payment of the benefit, to his estate.

The Participant will be able to designate a beneficiary or change a named beneficiary by a signed written declaration, subject to the provisions of the law.

The insurer will not be responsible for the sufficiency or validity of the beneficiary designation or change of beneficiary.

If the Participant had named a beneficiary under the Policyholder's prior group policy, such designation will be applicable to the insurance provided under the group policy, unless the Participant has changed the designation in writing with the insurer. The Participant should review the beneficiary designation made under the Policyholder's prior group policy to ensure that it reflects the Participant's current intentions in regard to his insurance.

The group policy contains a provision removing or restricting the right of the group insured to designate persons to whom or for whose benefit insurance money is to be payable.

INSURER'S RIGHT TO EXAMINATION, RECORDS AND INVESTIGATION

The insurer, at its own expense and its sole discretion, shall have the right, whenever and how often it deems it necessary, to:

a) Require any medical, psychiatric, psychological, functional, vocational or any other examinations of a Participant who has submitted a claim or of any other Insured Person for whom a claim has been submitted. The insurer may designate, at its sole discretion, a Physician, a Specialist, a healthcare provider or any other examiner for such examination(s). The Participant or any other Insured Person being examined must comply with any terms and conditions of an examination that are required by such examiner; and

b) Require an autopsy, where it is not forbidden by law.

The insurer reserves the right to obtain the clinical notes and records or any other reports of a Participant who has submitted a claim or of any other Insured Person for whom a claim has been submitted, from any Physician or Specialist, including but not limited to, a psychologist, a psychiatrist, a healthcare provider or any other examiner who has treated, examined or assessed such Participant or Insured Person. The Participant and any Insured Person must cooperate fully with the insurer in obtaining any such records or reports.

The insurer, at its own expense and its sole discretion, shall have the right to conduct any investigation, or an examination under oath, of a Participant who has submitted a claim, or of any person for whom a claim has been submitted, whether or not a legal action has been commenced by such Participant or person.

SUBROGATION

Where a benefit is payable under the group policy with respect to a Participant or to a Dependent of a Participant and if such person has a right to recover damages from an individual or organization, the insurer will be subrogated to the rights to recovery of the Participant or Dependent against such individual or organization to the extent of all benefits paid in the past and all benefits payable in the future.

Without limiting the generality of this provision, the term damages will include any lump sum or periodic payments received on account of:

a) Past, present or future loss of income, wages, or Earnings; and

b) Any other benefits paid or payable under the group policy.

The Participant or Dependent shall reimburse the insurer up to the amount of any benefits paid in the past or that are payable in the future under the group policy out of the gross damages recovered whether recovered at trial, or prior to trial by way of any form of settlement, and without regard to whether the Participant or Dependent has obtained full recovery of his losses.

Where the Participant or Dependent recovers damages in a lump sum, either by way of settlement or court order, and no allocation has been made in that settlement for the benefits paid or payable by the insurer, the insurer shall be reimbursed, out of the gross damages recovered, the full amount of benefits that have been paid to the Participant or Dependent. The insurer shall also be entitled to be reimbursed an amount, as determined by the insurer, which reasonably reflects the value of the future benefits payable to the Participant or Dependent

under the group policy. The insurer's recovery in this regard shall not exceed the Participant or Dependent's gross damages recovered or gross settlement. These rights of reimbursement shall be without regard to the terms of settlement or allocation that may have been agreed to by the Participant or Dependent and the third party.

In the event that the Participant or Dependent fails to reimburse the insurer in accordance with the group policy, no future benefits will be paid by the insurer until such time as the insurer recovers:

a) The total amount of benefits paid to the Participant or Dependent; and

b) An amount that reasonably reflects, as determined by the insurer, the total amount or value of any future benefits payable to the Participant or Dependent.

The insurer's recovery in this regard shall not exceed the Participant or Dependent gross damages recovered or gross settlement.

The insurer shall also have the right to seek recovery directly from the Participant or Dependent, or exercise any other right or remedy it may have under the group policy or under the law, in the event that any overpayment has resulted from the lack of reimbursement.

The Participant shall notify the insurer as soon as any action is commenced by him or his Dependent against any third party which involves a claim for damages. The Participant or Dependent shall provide the insurer information, including copies of all relevant documentation, about any judgement or settlement of any claim against a third party which involves a claim for damages. The Participant or Dependent will ensure that the subrogated rights of the insurer are advanced in any third party action and shall instruct his solicitor accordingly. The insurer shall not be responsible for any legal fees or expenses in regards to the advancement of its subrogated claim unless it has clearly agreed to such fees and expenses in writing in advance. The insurer reserves the right to retain its own counsel and/or pursue its subrogated rights against the third party and, in this respect, the Participant and Dependent and his solicitor shall fully cooperate with the insurer in the pursuit of its claim.

The insurer's subrogated claims shall not be settled or compromised in any way without its prior written consent. Unless the prior consent of the insurer has been obtained, no such settlement of any claim against the third party shall be binding on the insurer and the insurer shall have the right to seek recovery directly from

the Participant and Dependent in accordance with its rights under the group policy or under the law.

OVERPAYMENT

If the insurer determines that a benefit has been overpaid, the Participant or any other person to whom such benefit was overpaid is liable to reimburse the insurer immediately and in full as soon as the insurer requests such reimbursement.

In the event the overpayment is not reimbursed, the insurer shall have the right, at its sole discretion and in addition to any other legal remedy it may have, to recover such overpayment by exercising any or all of the following rights:

a) Reduce to zero the disability benefit payments payable to the Participant under the group policy until such time as the overpayment is fully recovered.

b) Reduce the sum insured of any life insurance benefits payable under the group policy, or reduce any other benefits payable under the group policy, by up to 100% of the amount of the outstanding overpayment, whether such benefits are payable to the Participant, or to the Participant's estate, Dependents, eligible survivors or beneficiaries.

LIMITATION ON LEGAL ACTIONS

No action or proceeding against the insurer shall be commenced within the first 60 Days following the date on which written proof of claim is provided to the insurer in accordance with all of the terms and conditions of the group policy.

Every action or proceeding against an insurer for the recovery of insurance money payable under the group policy is absolutely barred unless commenced within the time set out in the *Insurance Act*, or other similar applicable legislation (e.g. *Limitations Act, 2002* [Ontario]; Civil Code of Quebec) in the Participant's province.

PARTICIPANT'S LIFE INSURANCE

Upon the death of the Participant while insured under this benefit, the insurer undertakes to pay to the beneficiary the sum insured as indicated in the Summary of Benefits, subject to all of the terms and conditions of this benefit and the group policy.

In the event that a Participant is in the terminal phase of an Illness, with a life expectancy of less than 12 months, an amount equal to the lesser of 50% of the sum insured and $50,000, may be paid to the Participant, subject to approval by the insurer.

DEFINITIONS

As used in this benefit:

Disability means a state of total and continuous incapacity, resulting from Illness or Accidental injury, which wholly prevents the Participant from performing:

a) the essential duties of his normal occupation during the elimination period and the following 24 months; and

b) any other occupation, jobs or work:

   i) for which he is, or becomes, qualified by his education, training or experience, considered collectively or separately; and

   ii) for which the current Monthly Earnings are 75% or more of the current Monthly Earnings for the Participant's normal occupation.

The availability of such occupation, jobs or work will not be considered in assessing the Participant's Disability.

Gainful Employment means any occupation, any employment or any other activity for compensation or profit, for which the Participant is reasonably qualified (or may so become) by training, education or experience, and from which the Participant would be able to earn at least 70% of his Indexed Pre-Total Disability Gross Monthly Earnings.

CONVERSION PRIVILEGE

A Participant whose life insurance is cancelled on or prior to his 65th birthday due to termination of:

a) His employment; or

b) His group membership; or

c) The group policy and he has been continuously insured under a life insurance benefit provided by the Policyholder for at least 5 years,

will be able to convert all or part of his life insurance to an individual life insurance policy without having to provide evidence of insurability.

The Participant may choose to convert to one of the following types of insurance:

a) Permanent; or

b) Term to age 65; or

c) One year term convertible into permanent or term to age 65 at the end of one year.

The amount that can be converted to an individual life policy will include all amounts of life insurance that the Participant was insured for under this benefit, an optional life insurance benefit and any other group insurance policy issued by the insurer, and will not exceed the lesser of:

a) The amount selected by the Participant; or

b) The amount for which the Participant was insured immediately prior to the termination of his insurance; or

c) The difference between the amount for which the Participant was insured immediately prior to the termination of his insurance, and the amount for which he is eligible under a new group insurance policy; or

d) $200,000 ($400,000 for Participants living in the Province of Quebec).

The individual life insurance policy shall not include a disability benefit, nor an accidental death and dismemberment benefit, and the premium shall be based on the insurer's rates in effect which apply to the type and amount of such policy, according to the Participant's sex and attained age.

The individual life policy will only be issued if the insurer receives a written request to that effect, together with a deposit covering the monthly premium for a one year term policy within 31 Days of the date of the termination of the Participant's life insurance, and will take effect only at the expiration of that period.

Should the Participant die during the period of 31 Days following the termination of his life insurance, the insurer shall pay an amount equal to that which he could have converted whether or not he made application for the individual life policy.

WAIVER OF PREMIUM

(This provision does not apply to Retired Employees)

a) A Participant who becomes Totally Disabled will be eligible to have his premiums waived for this benefit, if he is under age 65 and is eligible to receive a benefit under the Long-Term Disability Insurance benefit, if included in the group policy.

   If the Participant is not eligible to receive a benefit under the Long-Term Disability Insurance benefit or there is no Long-Term Disability Insurance benefit included in the group policy, he will be eligible to have his premiums waived for this benefit provided:

   i) The Participant was under 65 years of age at the onset of Totally Disability; and

   ii) The Participant became Totally Disabled as defined under this benefit, while insured under this benefit and before any termination of employment; and

   iii) The Participant has been Totally Disabled for at least 6 continuous months; and

   iv) Proof of Totally Disability, satisfactory to the insurer, was submitted to the insurer within 9 months of the onset of the Totally Disability.

b) The amount of insurance for which the waiver of premiums applies will be that which was in force on the Participant's life at the onset of the Total Disability, and will be subject to any reductions and termination indicated in the Summary of Benefits, or otherwise indicated in this benefit or in the General Provisions of the group policy, which would have been applicable to the Participant if he had been Actively at Work.

c) The Participant's premiums will begin to be waived on the earliest of the following dates:

   i) The Day following completion of the Elimination Period under the Long-Term Disability Insurance benefit, if applicable; or

   ii) The Day following a continuous period of Total Disability of 6 months.

d) The Participant whose premiums are waived under this section must provide the insurer with proof of Totally Disability, as often as the insurer may reasonably require.

e) The waiver of premiums will terminate on the earliest of the following dates:

   i) The date on which the Participant ceases to be Totally Disabled; or

   ii) The date on which the Participant fails to submit to an examination in accordance with the terms and conditions of the group policy, if required by the insurer; or

   iii) The date on which the Participant retires or reaches the normal retirement age under the Employer's pension plan, but never beyond 65 years of age; or

   iv) The date on which the Participant reaches the termination age for his life insurance benefit as indicated in the Summary of Benefits, if applicable; or

   v) The date on which the Participant fails to provide any proof of Total Disability required by the insurer; or

   vi) The date on which the Participant pleads guilty or is found guilty of an offence for which he is confined in a penitentiary, prison, correctional facility, forensic psychiatric facility or any similar institution; or

   vii) The date on which the Participant refuses to actively and continuously participate and cooperate in a Rehabilitation program, if required by the insurer.

f) If on the date the waiver of premiums terminates with respect to the Participant, he is not eligible to be insured under the Participant's Life Insurance benefit, he will be eligible to exercise the Conversion Privilege as provided for under this benefit.

EXTENSION OF LIFE INSURANCE WITHOUT PREMIUM PAYMENT

The Life Insurance benefit, for a Participant who no longer qualifies as an Employee, is extended, without premium payment, for 31 Days following termination.

REDUCTIONS

The sum insured is reduced as indicated in the Summary of Benefits. The sum insured is also subject to any applicable reductions indicated in this benefit or in the General Provisions of the group policy.

TERMINATION

The insurance under this benefit terminates as indicated in the Summary of Benefits, or such other earlier date indicated in this benefit or in the General Provisions of the group policy.

PARTICIPANT'S OPTIONAL LIFE INSURANCE

A Participant may obtain an amount of optional life insurance if he so requests it in writing to the insurer and furnishes evidence of insurability satisfactory to the insurer and the insurer provides Approval of Evidence of Insurability.

The sum insured that will be applicable to the Participant will be the amount of insurance requested as provided for in the Summary of Benefits.

Upon the death of the Participant while insured under this benefit, the insurer undertakes to pay the beneficiary the sum insured at the time of the Participant's death, subject to all of the terms and conditions of this benefit and the group policy.

NON-SMOKER STATUS

If the insurer provides reduced premium rates for non-smokers, the Participant must provide a non-smoker statement on his application card to receive such rates.

Misrepresentation of Non-Smoker Status

A Participant who states that he is a non-smoker on his application card or on his last evidence of insurability declaration, if it is more recent, when he is a smoker, will be considered to have made a misrepresentation.

If it is proven, after the Participant's death, that he had made a misrepresentation, the optional life insurance benefit of the Participant will become null and void and no optional life insurance will be payable under this benefit.

Proof of Status

The insurer reserves the right to request new proof of the Participant's non-smoker status each time evidence of insurability may be required.

EXCLUSIONS

If a Participant commits suicide, regardless of any impairment, Illness, or state of mind, less than 24 months after the date his insurance under this benefit commenced, no benefit will be payable by the insurer. The insurer will refund to the beneficiary the premiums paid in respect of the Participant's Optional Life

Insurance and such refund will constitute a full discharge of the insurer's liability under this benefit.

The 24 month period starts anew on the date:

a) The Optional Life Insurance is reinstated; or

b) The Optional Life Insurance amount is increased at the Participant's request, but only for the additional amount of insurance.

ADDITIONAL PROVISIONS

Any provisions of the Participant's Life Insurance benefit which are not inconsistent with the provisions of this benefit will form part of this benefit.

REDUCTIONS

The sum insured is reduced as indicated in the Summary of Benefits. The sum insured is also subject to any applicable reductions indicated in this benefit or in the General Provisions of the group policy.

TERMINATION

The insurance under this benefit terminates as indicated in the Summary of Benefits, or such other earlier date indicated in this benefit or in the General Provisions of the group policy.

DEPENDENTS' OPTIONAL LIFE INSURANCE

A Participant may obtain an amount of optional life insurance on his Dependents if he so requests it in writing to the insurer and furnishes evidence of insurability satisfactory to the insurer and the insurer provides Approval of Evidence of Insurability.

The sum insured that will be applicable to the Dependents will be the amount of insurance requested as provided for in the Summary of Benefits.

Upon the death of the Dependent while insured under this benefit the insurer undertakes to pay to the Participant the sum insured at the time of death, subject to all of the terms and conditions of this benefit and the group policy.

WAIVER OF PREMIUMS

A Participant whose life insurance premiums are waived in accordance with the Waiver of Premiums provision of the Participant's Life Insurance benefit will also be entitled to have the premiums for this benefit waived, under the same terms and conditions.

CONVERSION PRIVILEGE

A Participant whose Spouse's optional life insurance under this benefit is cancelled on or prior to the earlier of his 65th birthday or his Spouse's 65th birthday, due to the termination of:

a) His employment; or

b) His group membership; or

c) The group policy and his Spouse had been continuously insured under a Dependents' Life Insurance benefit provided by the Policyholder for at least 5 years,

will be able to convert all or part of his Spouse's life insurance to an individual life insurance policy without having to provide evidence of insurability.

A Spouse whose life insurance under this benefit is cancelled on or prior to the earlier of his 65th birthday or the 65th birthday of the Participant, due to the death of the Participant, will be able to convert all or part of his life insurance to an individual life insurance policy without having to provide evidence of insurability.

The Participant or Spouse, if applicable, will be able to convert the life insurance to one of the following types of insurance:

a) Permanent; or

b) Term to age 65; or

c) One year term convertible into permanent term or term to age 65 at the end of the one year.

The amount that can be converted to an individual life policy will include all amounts of life insurance and optional life insurance that the Spouse is insured for under this policy, and any other group insurance policy issued by the insurer, and will not exceed the lesser of:

a) The amount selected by the Participant or the Spouse, if applicable; or

b) The amount for which the Spouse was insured immediately prior to the termination of his insurance; or

c) The difference between the amount for which the Spouse was insured immediately prior to the termination of his insurance and the amount for which he is eligible under a new group insurance policy; or

d) $200,000 ($400,000 for Participants living in the Province of Quebec).

The individual life policy will not include a disability benefit nor an accidental death and dismemberment benefit and the premiums will be based on the insurer's rates in effect which apply to the type and amount of such policy, based on the Spouse's sex and attained age.

The individual life policy will only be issued if the insurer receives a written request to that effect, together with a deposit covering the monthly premium for a one year term policy, within 31 Days of the date of the termination of the Spouse's life insurance and will take effect only at the expiration of that period.

Should the Spouse die during the period of 31 Days following the termination of his life insurance, the insurer shall pay an amount equal to that which could have been converted to the Participant, or the Participant's estate if he is no longer living, whether or not application had been made for the individual life policy.

NON-SMOKER STATUS

If the insurer provides reduced premium rates for non-smokers, the Spouse must provide a non-smoker statement on the application card to receive such rates.

Misrepresentation of Non-Smoker Status

A Spouse who states that he is a non-smoker on the application card or on his last evidence of insurability declaration, if it is more recent, when he is a smoker, will be considered to have made a misrepresentation.

If it is proven, after the Spouse's death, that he had made a misrepresentation, the optional life insurance of the Spouse will become null and void and no optional life insurance will be payable under this benefit.

Proof of Status

The insurer reserves the right to request new proof of the Spouse's non-smoker status each time evidence of insurability may be required.

EXCLUSION

If a Dependent insured for optional life insurance commits suicide, regardless of any impairment, Illness, or state of mind, less than 24 months after the date his Optional Life Insurance commenced under this benefit no benefit will be payable by the insurer. The insurer will refund to the Participant the premiums paid in respect of such person and the refund will constitute a full discharge of the insurer's liability under this benefit.

The 24 month period starts anew on the date:

a) The Optional Life Insurance is reinstated; or

b) The Optional Life Insurance amount is increased at the Participant's request, but only for the additional amount of insurance.

REDUCTIONS

The sum insured is subject to any applicable reductions indicated in this benefit or in the General Provisions of the group policy.

TERMINATION

The insurance under this benefit terminates as indicated in the Summary of Benefits, or such other earlier date indicated in this benefit or in the General Provisions of the group policy.

LONG-TERM DISABILITY INSURANCE

Upon the Participant becoming disabled due to Illness or Accidental Injury, the insurer undertakes to pay the Participant the monthly indemnity specified herein for each month or part of a month (1/30 of the monthly indemnity for each Day) during which the disability lasts, subject to the terms and conditions hereinafter specified.

SPECIAL DEFINITION

Disability

A state of complete and continuous incapacity, resulting from Illness or Accidental Injury, which wholly prevents the Participant from performing:

a) the essential duties of his normal occupation during the elimination period and the following 24 months; and

b) any other occupation, jobs or work:

   i) for which he is, or becomes, qualified by his education, training or experience, considered collectively or separately; and

   ii) for which the current Monthly Earnings are 75% or more of the current Monthly Earnings for the Participant's normal occupation.

The availability of such occupation, jobs or work will not be considered in assessing the Participant's disability.

PARTICULARS

Beginning of Benefits

Payment of monthly indemnity begins following expiry of the elimination period specified in the Summary of Benefits.

Amount of Benefits

The amount of monthly indemnity payable under this benefit is determined according to a formula set forth in the Summary of Benefits and may not exceed the monthly maximum amount therein specified.

Reduction of Benefits

The monthly indemnity payable under this benefit will be reduced, after the application of the monthly maximum indicated in the Summary of Benefits, by any disability benefits which are payable or which would have been payable to the Participant had a satisfactory application been made under:

a) the Quebec or Canada Pension Plan, excluding benefits payable on behalf of Dependent Children;

b) a provincial automobile insurance law, if applicable;

c) a provincial crime victims compensation act, if applicable;

d) a worker's compensation act.

Moreover, the amount of monthly disability income benefits payable by the insurer is adjusted so that the sum of all income, compensation, indemnity and benefits which the Participant would or could receive, due to his disability, from: (a) the Policyholder, (b) any government body, (c) under any group insurance or pension plan to which the Policyholder contributes, and (d) any other insurance contract, may at no time exceed the OVERALL MAXIMUM, as defined in the Summary of Benefits.

Future cost of living adjustments made to amounts received from any of the above-mentioned sources will not bring about further reductions.

Since the benefits payable under the present benefit are taxable, they will be calculated as follows:

i) the indemnity payable by the insurer,

ii) less the federal and provincial taxes applicable, according to the Participant's personal exemption,

iii) less the indemnity payable by the government plan.

Termination of Benefits

The monthly indemnity ceases on the earliest of the following dates:

a) The date the maximum benefit period specified in the Summary of Benefits has been reached;

b) The date on which the Participant ceases to be disabled;

c) The date on which the Participant reaches the age of 65;

d) The date of the Participant's death;

e) The date on which the Participant fails to submit to an examination by the Physician designated by the insurer;

f) The date on which the Participant fails to provide any evidence of disability required by the insurer;

g) The date on which the Participant refuses to participate in a rehabilitation program or to engage in rehabilitation employment which the insurer and its consulting Physicians deem reasonably appropriate;

h) The date on which the Participant engages in a remunerative occupation, unless it is rehabilitation employment;

i) The date on which the Participant is incarcerated after committing a criminal offence for which he was found guilty;

j) The date on which the Participant enters the armed forces of any country on a full-time basis.

SUCCESSIVE PERIODS OF DISABILITY

If the Participant who has returned to active work again becomes disabled while the coverage is in force, within 6 consecutive months of the first disability and if such disability results from the same cause as the previous disability or from related causes, this is considered to be a continuation of the previous disability. During the elimination period, successive periods of disability from a single cause separated by 31 days or less will be considered as the same period.

However, if the Participant who has returned to active work again becomes disabled while the coverage is in force, due to an Illness or Accidental Injury totally unrelated to the previous cause of disability, the disability is considered to be a new disability and a new elimination period will apply.

EXCLUSIONS AND LIMITATIONS

a) The benefit specified herein does not cover any disability resulting from one of the following causes:

   i) Injury or Illness resulting from civil unrest, insurrection or war, whether war be declared or not, or participation in a riot, except if the Participant was performing his duties;

ii) Self-inflicted injury unless medical evidence establishes that the injury was directly related to a mental health Illness;

iii) Flight or attempted flight on board an airplane or other aircraft if the Participant is part of the crew or performs any function relating to the flight, or participates in the flight as a parachutist;

iv) Injury or Illness resulting from committing, attempting to commit, or provoking an assault or criminal offence.

b) Monthly indemnity is not payable for any Illness or Accidental Injury:

i) During any leave taken in accordance with provincial or federal legislation or during any leave taken in agreement with the Employer;

ii) During any extension of such a leave, if the Participant was entitled to and requested such extension.

However, if the Participant's benefit is kept in force during such a leave, the elimination period of the disability income benefit begins on the date the Participant would have returned to work.

c) If disability results from drug addiction or alcoholism, the monthly disability benefits will be payable provided that the Participant is following a closed treatment program approved by the insurer.

d) **For all Employees and, with the Policyholder's approval, for Expatriate Employees**, any Participant who leaves Canada and the United States for a period of over 90 consecutive days **after the beginning of benefit payments** will no longer be entitled to indemnity under the present benefit and such entitlement will be restored only upon the Participant's return, subject to all other provisions of the present benefit.

e) The insurance provided herewith does not cover any disability resulting from an Illness or Accidental Injury which occurs during a strike, lock-out or temporary layoff, if the Participant's benefit is not kept in force during the strike, lock-out or temporary layoff.

However, if the Participant's benefit is kept in force, the elimination period of the disability income benefit begins on the date the Participant would have returned to work.

f) A disability related to a condition which commenced prior to the date of coverage of the present benefit and for which the Participant received treatment within the 3 consecutive months preceding the date coverage began will not be recognized by the insurer.

This limitation will not apply to a Participant hired prior to December 1, 1995 and it will not apply to a Participant who has been actively employed at least 12 consecutive months.

g) A Participant who must hold a permit or license issued by a government licensing authority to perform his duties will not be considered disabled solely because such permit or license has been withdrawn or not renewed.

WAIVER OF PREMIUMS

A Participant who was disabled for at least the elimination period is entitled to waiver of premiums for the present benefit.

REHABILITATION PROGRAM

A Participant who was disabled for at least the elimination period and who, on the prescription and under the supervision of his Physician, registers for a rehabilitation program approved by the insurer, is eligible to receive the indemnity payable under this benefit for a maximum period of 24 months in addition to receiving the remuneration payable under this rehabilitation program.

However, the sum of the remuneration payable under the rehabilitation program and the monthly indemnity under this benefit must not exceed the monthly salary the Participant was being paid at the onset of disability. If this sum exceeds 100% of the net monthly salary determined at the onset of disability (or of the gross monthly salary if the benefit is taxable), the income payable under this benefit will be reduced so as not to exceed this salary.

TERMINATION

The insurance under this benefit terminates as indicated in the Summary of Benefits, or such other earlier date indicated in this benefit or in the General Provisions of the group policy.

SUPPLEMENTAL HEALTH INSURANCE

The insurer undertakes to reimburse health care expenses incurred due to Accidental Injury, Illness or pregnancy, subject to the terms and conditions hereinafter specified.

SPECIAL DEFINITIONS

Convalescent home, nursing home or rehabilitation institution: An institution (or a distinct part of a Hospital or other institution) which has in effect a transfer arrangement with one or more Hospitals and which is regularly engaged in providing for compensation from its patients and on an inpatient basis – skilled nursing care during the convalescent or rehabilitation stage of an injury or disease and whose charges for ward care normally are reimbursed by the provincial Hospital plan, or similar legislation, of the province or territory in which the family member resides; in particular, whose charges for ward care for the particular covered family member involved are being reimbursed by the applicable plan.

In no event, however, shall the terms convalescent home or rehabilitation institution be deemed to include any institution or part thereof which is used principally as a Hospital, a rest facility, a facility for the aged, a facility for the care of drug addicts, a facility for the care of pulmonary tuberculosis, a facility for the care of mental Illness, a facility for the care of mental retardation, or a facility for custodial care.

Hospice: Reasonable charges made by a hospice for services at home or up to 30 days in a hospice facility, received by a covered family member who is terminally ill and whose life expectancy is 6 months or less.

Hospital: Hospital means an institution providing care of short duration:

a) legally acknowledged as such;

b) intended for the care of bedridden patients; and

c) which provides at all times the services of Physicians and registered nurses.

Units set aside for convalescent or chronic care purposes in Hospitals are excluded.

Hospitalization or Hospitalized means the occupancy of a Hospital room as an admitted bedridden patient where a room and board charge has been

charged in connection with the confinement. A stay of more than 24 hours under observation in a Hospital, even if no charge is made, is considered a Hospitalization. Day Surgery is considered to be a period of Hospitalization.

Medical Emergency: A sudden and unexpected event that requires immediate medical supervision.

Original or Generic Drug: If mention is made of these two types of drugs, the *original* drug refers to the drug that was first developed and launched on the market. The *generic* drug refers to any reproduction of the original drug and is usually less expensive.

Orthesis or Orthopedic Device: A device applied to a limb or part of the body in order to correct a functional disability.

Prosthesis: A device designed to replace all or part of a limb or an organ.

Therapeutic or Medical Appliances: Appliances currently used according to the manufacturer's standards and recognized as specifically for the immediate treatment of a pathological condition following an Illness or an Accident, such as appliances for the control of pain, extended physiotherapy and the administration of medication, respiratory assistance and diagnostic devices, excluding orthopedic appliances, stethoscopes and sphygmomanometers.

HOSPITALIZATION IN THE PROVINCE OF RESIDENCE

The insurer reimburses that part of Hospital expenses incurred in the province of residence which exceeds the amount reimbursed by government plans, up to the daily maximum specified in the Summary of Benefits, and without any limit as to the number of days of Hospitalization.

EMERGENCY MEDICAL EXPENSES INCURRED OUTSIDE THE PROVINCE OF RESIDENCE

Expenses for the services and supplies listed herein will be covered, up to the maximum specified in the Summary of Benefits, when they are incurred as a result of a Medical Emergency which occurs during an Insured Person 's absence from his province of residence provided:

a) The Insured Person is insured under the Supplemental Health Insurance at the time of the Medical Emergency; and

b) The Medical Emergency occurs during the first 90 consecutive Days (Class 160) or during the first 60 consecutive Days (Classes 164, 165) of the Insured Person's absence from his province of residence.

   If, however, the absence is due to his attendance at an accredited educational institution on a full-time basis, the Medical Emergency occurs during the school year for which he is enrolled at the institution; and

c) The Insured Person's absence was due to business, a vacation or full-time attendance at an accredited educational institution; and

d) The services and supplies had to be provided before the Insured Person could return to his province of residence without endangering his health.

The following services and supplies which are received as a result of a Medical Emergency will be covered:

a) Services of a Physician;

b) Accommodation in a Hospital up to the level of benefit specified in the Hospitalization in The Province of Residence provision;

c) Medical services, appliances and supplies furnished during a Hospitalization;

d) Diagnostic, medical imaging and laboratory services;

e) Paramedical services provided during a Hospitalization;

f) Hospital out-patient services and supplies;

g) Drugs;

h) Medical appliances and supplies provided out of Hospital;

i) Professional ambulance service to transport the Insured Person to the nearest Hospital equipped to provide the required medical treatment;

j) Fees for dental surgeons for emergency dental treatments required following an external trauma resulting in damage to whole, healthy and natural teeth or when it is necessary to reduce a fracture or following dislocation of the jaw. Treatment must begin while the Insured Person is covered and end within 6 months of the Accident. The maximum reimbursement is $2,000 per Accident, per Insured Person.

For paramedical services, drugs and medical appliances, only those drugs, appliances and services which would have been covered in the Insured Person's

province of residence will be covered when they are received outside of his province of residence in a Medical Emergency.

Limitations For Emergency Medical Expenses Incurred Outside The Province of Residence

If the Insured Person should become Hospitalized outside of his province of residence due to a Medical Emergency, the Insured Person will be required to contact the insurer's medical assistance service provider as soon as the person is reasonably able to do so after the commencement of his Hospitalization. Failure to do so may result in the insurer limiting or denying the Insured Person's claim resulting from the Medical Emergency.

In addition, if during a Medical Emergency, the insurer determines that the Insured Person can be repatriated to his province of residence without endangering his health and the Insured Person refuses to be repatriated, the insurer will not be responsible for any further expenses incurred by the Insured Person due to the Medical Emergency.

No coverage will be provided under this benefit for any expenses that are incurred for a Medical Emergency if:

a) The Insured Person's medical condition was not stable before the absence from his province of residence began; and

b) The Medical Emergency results directly or indirectly from that medical condition.

The insurer determines, at its sole discretion, what stable means. In this assessment, the insurer may take into consideration medical factors, such as but not limited to the following:

a) Medical status;

b) Medical treatment, examination, consultation or Hospitalization;

c) Increase or worsening of any symptom or health problem;

d) Change in medical treatment or in medication;

e) Medical treatment or examination planned or for which results are pending for any symptom or health problem;

within a period of 90 Days prior to that absence.

Extension of coverage for Emergency Medical Expenses Incurred Outside the Province of Residence

This benefit is extended, automatically and at no cost, at the end of the maximum period of 90 consecutive Days (Class 160) or 60 consecutive Days (Classes 164, 165) per trip:

a) Up to 24 hours when the return home of the Insured Person is postponed due to a delay by the carrier or following an Accident or a mechanical problem to the Insured Person's private vehicle while in it and while returning to the starting point (claim must be supported by vouchers); or

b) During Hospitalization and 24 hours following the Insured Person's discharge from the Hospital; or

c) Up to 72 hours when the return home is delayed due to an Insured Person's Illness that began within 24 hours before the scheduled return date and requiring emergency medical care.

MEDICAL EXPENSES INCURRED IN CANADA, OTHER THAN EMERGENCY MEDICAL EXPENSES INCURRED OUTSIDE THE PROVINCE OF RESIDENCE

The following expenses are covered, but only if they were incurred after the effective date of the coverage, up to the maximums indicated in the Summary of Benefits, if applicable:

a) Services, care and treatment prescribed by a Physician, such as:

   i) Services rendered at the Insured Person's home by a registered nurse or certified nursing assistant who is unrelated to the Insured Person and who does not ordinarily reside with the latter, up to the maximum indicated in the Summary of Benefits;

   ii) Physician's fees for completing disability forms or additional information, for a Participant receiving Long-term Disability Income benefits under the group policy, if mention is made in the Summary of Benefits that these expenses are covered by the present benefit. These expenses are reimbursed from the second form or medical information request and the receipt date should be different from the date of the beginning of the disability.

   iii) Licensed ambulance service for emergency transportation to the nearest Hospital equipped to provide the required treatment, or for

transportation therefrom, when the physical condition of the Insured Person precludes the use of any other means of transportation, up to the maximum indicated in the Summary of Benefits;

iv) Oxygen and rental of equipment necessary for its administration;

v) Drugs or medicine, including oral contraceptives and fertility drugs, available in Canada prescribed by a Physician or dental surgeon and dispensed by a licensed pharmacist, except for those products listed in the article *Exclusions and Reductions* of the present benefit;

If a generic drug is available on the market, the difference between the generic and the original drug is at the Participant's charge.

Drugs and supplies available without a prescription and required as the result of a colostomy or ileostomy and for the treatment of cystic fibrosis, diabetes, parkinsonism and heart disease.

Expenses for *Viagra* are eligible provided that there is documented medical evidence indicating that erectile dysfunction has existed for a period of at least 6 months prior to prescribing this drug, up to the maximum indicated in the Summary of Benefits.

Over the counter drugs are limited to the following: non-sedating antihistaminics, antacids, enteric coated Acetylsalicylic acid, NSaid preparations, calcium supplements for therapy and laxatives when Medically Required, up to the maximum indicated in the Summary of Benefits.

Weight loss drugs are covered for a 6 month initial treatment protocol. Review at the initial 6 month period is required and the Physician might provide documentation as to validity of the treatment continuation.

Dispensing Limitations

The quantity of drugs which may be dispensed for any one prescription will be limited to that amount sufficient for up to a 100 Day period.

Certain drugs will require pre-authorization by the insurer prior to the commencement of their usage. For these drugs the Insured Person will be required to have his attending Physician provide the

insurer with information describing his medical condition, previous treatment history and the medical criteria for prescribing the drug.

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

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

vi) Supplies required as a result of a colostomy or ileostomy;

vii) Purchase of artificial limbs and eyes, including replacement but only if replacement is required because of a change in the Insured Person's physical condition, up to the maximum indicated in the Summary of Benefits;

viii) Rental or purchase, as previously approved by the insurer, of a wheelchair (excluding electric wheelchairs except for quadriplegics), a Hospital bed (excluding electric beds) and any other therapeutic appliances (excluding batteries), a respirator and a ventilator;

ix) Purchase of breast prostheses, up to the maximum indicated in the Summary of Benefits;

x) Purchase of surgical brassieres, when required with breast prostheses and up to the maximum indicated in the Summary of Benefits;

xi) Purchase of medical elastic stockings or *Jobst* stockings prescribed for the treatment of varicose veins, up to the maximum indicated in the Summary of Benefits;

xii) Room and board in a convalescent home or a rehabilitation institution designated as such by an appropriate government body, while under the supervision of a Physician or registered nurse, provided the stay begins after a Hospitalization of at least 3 Days, up to the maximum indicated in the Summary of Benefits;

xiii) Room and board charges made in a nursing home licensed to provide long term care provided:

- The Insured Person is under the regular supervision of a Physician or registered nurse; and
- The confinement was recommended by a Physician; and
- The confinement is for long-term care.

However, there will be no coverage if the long-term care is for drug or alcohol abuse or addiction.

xiv) Reasonable charges made by a hospice for services at home or up to 30 Days in a hospice facility, received by a covered family member who is terminally ill and whose life expectancy is 6 months or less, up to the maximum indicated in the Summary of Benefits;

xv) Cost of orthopedic shoes as described below, up to the maximum indicated in the Summary of Benefits:

- The cost of modifying a regular shoe or the cost of purchasing, repairing, modifying or adjusting an insert or device (custom-made) added to a regular shoe;
- The purchase price of an orthopedic shoe;

xvi) Diagnostic laboratory and x-ray fees from a commercial establishment, including PSA tests;

xvii) Purchase or rental of orthopedic appliances other than orthopedic shoes and podiatric apparatus which are obtained from a recognized establishment or laboratory and which are required as a result of a bodily injury or Illness. The purchase must be made while this coverage is in effect;

xviii) Cost of intrauterine devices, up to the maximum indicated in the Summary of Benefits;

xix) Purchase or rental of crutches and purchase of hernia belts, splints and casts (except fiberglass casts), braces, trusses, slings, cervical collars and supports;

xx) Sclerosing injection fees;

xxi) Purchase of a glucometer for an insulin-dependent Insured Person;

xxii) Purchase of capillary prostheses for Insured Persons undergoing treatment for cancer, lupus or alopecia, up to the maximum indicated in the Summary of Benefits.

b) Dental care given out of Hospital by a dentist, in accordance with the normal suggested fee for a general practitioner, and required as a result of Accidental Injury to whole, healthy, natural teeth.

Only care received within 6 months of the Accident is covered. All other dental expenses are excluded.

c) Fees for paramedical care given by one of the professionals specified in the Summary of Benefits, up to the maximums indicated in the Summary of Benefits.

Paramedical care must be given by a person duly authorized by the responsible provincial or federal organization to practice this profession in accordance with the rules of the profession.

Acupuncture treatments are eligible, for treatment of bodily injury or disease. However, any charges for treatments received in connection with pregnancy, resulting childbirth, miscarriage, dental work or treatment, eye examinations, fitting of glasses, diagnostic x-rays, drugs or medicine will not be considered for reimbursement.

If the services of the practitioner are covered by the provincial health plan, no coverage will be provided under this benefit for any amount payable for such services under the provincial plan.

X-ray fees of a chiropractor are eligible, up to the maximum indicated in the Summary of Benefits.

d) Hearings aids: Expenses incurred for the initial purchase, replacement or repair of hearing aids or any related devices (with the exception of batteries), and for the professional services given by a hearing aid

acoustician following the purchase, are reimbursed, provided they have been prescribed by a Physician or an audiologist.

Covered expenses are limited to the maximum specified in the Summary of Benefits.

e) Ear moulds for Dependent Children under age 14, up to the maximum indicated in the Summary of Benefits.

f) Vision care: The following expenses are reimbursable when prescribed by an ophthalmologist or an optometrist:

- Eyeglasses (frame and corrective lenses), or contact lenses, up to the maximum specified in the Summary of Benefits.

g) Fees for cosmetic surgery following an Accident that occurred while covered by the present benefit.

EXCLUSIONS AND REDUCTIONS

This benefit does not cover:

a) Expenses which are or would normally be payable or reimbursable under a workers' compensation act, if a claim had been submitted;

b) For an Illness or injury or any expenses resulting, directly or indirectly, from a self-inflicted injury unless medical evidence establishes that the injury was directly related to a mental health Illness;

c) Expenses resulting from injury or Illness caused by civil unrest, insurrection or war, whether war be declared or not, or participation in a riot, invasion, acts or attacks from foreign enemies, hostilities or conflicts between nations, guerrilla, campaign or military operation, rebellion, insurrection, agitation or people's uprising, disorder, piracy, terrorism or conspiracy.

However, the events previously described are covered for members travelling on business for the Company, subject to an overall maximum of $600,000 per event for all covered persons impacted by the event.

Moreover, if the member travels on business for the Company in a country for which the Canadian government has issued a recommendation to the effect that Canadians should not travel in such country, the stay is covered up an overall maximum of $600,000 per stay for all covered persons concerned;

d) Treatment or appliance to correct vertical dimension or any temporomandibular joint dysfunction;

e) Surgery or treatment which is not Medically Required, and which is given for cosmetic purposes or for any reason other than curative, or which exceeds ordinary surgery or treatment given in accordance with current therapeutic practice, and surgery or treatment which is given in relation to an operation or treatment of an experimental nature;

f) Any care or treatment included in the protocol of a research and development program for a product whose use has not been recommended by the manufacturer or which does not comply with government standards, or any other expenses incurred for care or treatment that is not recognized as normal, customary and common practice;

g) Expenses incurred for an Illness or injury resulting from the commission of or attempted commission of a criminal offence or provoking of an assault;

h) Any portion of the charge for services in excess of the reasonable and customary charge normally incurred for an Illness of the same nature and severity in the locality where the service is provided;

i) Care and services rendered free of charge or which would be free of charge were it not for benefit coverage or which are not chargeable to the Insured Person;

j) Rest cure or travel for reasons of health;

k) Eye examination, except if these expenses are covered under the present benefit;

l) All care or treatment related to fertility or infertility, except if these expenses are covered under the present benefit;

m) Purchase or rental of any comfort or massage apparatus, and of domestic accessories that are not exclusively for medical purposes;

n) Purchase of food or nutritional supplements and expenses incurred in the treatment of obesity, whether or not these are prescribed for a medical reason;

o) Expenses incurred for the administration of serums and injectable medications (vaccines administered for preventive purposes are covered by the present benefit);

p) Contraceptives (other than oral), except if these expenses are covered under the present benefit, hair growth stimulants, anabolic steroids and growth hormones;

q) The following products, except those which can only be obtained with a Physician's prescription and dispensed by a pharmacist:

- products for the care of contact lenses;
- proteins or dietary supplements, amino acids;
- baby food;
- mouthwash, bandages and throat lozenges;
- shampoos, oils, creams;
- toilet products including soaps and emollients;
- skin softeners and protectors;
- vitamins or multivitamins;
- supplements or prenatal vitamins;
- minerals;
- homeopathic products;

r) The contribution to the cost of drugs and pharmaceutical services which must be paid by the Insured Person under the Basic Prescription Drug Insurance Plan of Quebec;

s) Expenses incurred for problems related to erectile dysfunction, except if these expenses are covered under the present benefit;

t) Expenses incurred by any person who has entered the armed forces of any country on a full-time basis;

u) Drugs without therapeutic indication and intended to improve the quality of life.

v) Expenses incurred for periodic health examination, examinations required for the use of a third party, or travel for health;

w) Expenses incurred for Physician's charges for his time spent travelling, broken appointments, transportation costs, room rental charges or advice given by telephone or any other means of telecommunication;

x) Expenses incurred for any drugs which are excluded from coverage by the insurer under the Dispensing Limitations provision of this benefit;

y) Care or treatment which was provided by a healthcare provider who, or a service provider that:

i) has been charged with professional misconduct or improper practices; or

ii) is under investigation by an official body resulting from a law or regulation; or

iii) is under investigation by the insurer in regards to his professional conduct or practice; or

iv) is a member of a profession that is not regulated by an officially recognized federal or provincial regulatory body in the jurisdiction where the services were provided; or

v) in the opinion of the insurer, does not meet the insurer's standards relevant to his professional conduct or practice; or

vi) is an employee, contractor, principal, or member of

- any business, group or association who is the subject of any of the matters set out in subparagraphs (i) to (v) above; or
- any entity that is affiliated with or related to such business, group or association.

The amount of benefits is reduced by any benefit that is payable or reimbursable under a government plan, a group plan or an individual plan, or that would have been payable had the person submitted a claim.

CALCULATION OF REIMBURSEMENT

Deductible

The deductible is that portion of covered expenses which must be paid by the Participant before any benefits are payable under the present benefit. The maximum deductible required per Calendar Year is specified in the Summary of Benefits, if applicable.

Carry-over Provision

If the deductible has been satisfied in whole or in part by the payment of expenses incurred in the last 3 months of a Calendar Year, the deductible for the following year will be reduced by the amount of deductible already paid.

Reimbursement

The insurer reimburses a percentage of the covered expenses incurred in the course of a Calendar Year, after applying the deductible for that year, if applicable. Such percentage is specified in the Summary of Benefits.

Maximum Benefit Per Insured Person

The overall maximum reimbursed by the insurer for the present benefit is specified in the Summary of Benefits.

Co-ordination of Benefits

When an Insured Person is eligible to receive benefits simultaneously under this coverage and any other coverage which pays expenses for care, services and supplies which are for or by reason of health care or treatment, the coverages will be co-ordinated to ensure that payment by all the coverages do not exceed the actual expenses incurred. The term “coverage” will mean any coverage providing care, services or supplies under:

i) any group, individual or family insurance, travel insurance, creditor's or savings insurance plan,

ii) any government sponsored plan, and

iii) any non-insured employee benefit plan.

EXTENSION OF INSURANCE

If, on the date insurance would normally cease for any reason other than termination of the group policy, a Participant who is age 55 or over is disabled or a Dependent is hospitalized, reimbursement will be made for expenses incurred due to such disability, or Hospital confinement, until the earliest of the following events:

a) The 365th Day following the date coverage would normally cease. However, coverage will terminate if the disabled person becomes eligible under another group plan.

b) The date the group policy terminates.

c) For the Participant, the date the disability ceases.

d) For a Dependent, the date Hospital confinement is no longer necessary.

However, if a Participant or Dependent is pregnant on the date coverage would normally cease for any reason other than termination of this group policy, reimbursement will be made for pregnancy related expenses provided the expenses are incurred while the group policy is in effect. In no event will payment be made after termination of the group policy.

Class 160 only:

In the event of the Participant's death prior to age 55, the Spouse will continue to receive benefits based on the Participant's seniority with the Employer. The minimum period will be 3 months and the maximum period will be 9 months from the date of the Participant's death, subject to the payment of premiums.

If the Participant dies at age 55 or after and had completed a minimum of 2 years of service, Dependent coverage will be extended beyond the date of death, provided the Dependents continue to satisfy the definition of Dependents of the group policy. However, Dependent coverage will cease on the earliest of the following dates:

a) The date of the next marriage of the Spouse;

b) The date on which the Spouse publicly declares a new Spouse;

c) The date the group policy terminates.

CONVERSION PRIVILEGE

A Participant whose coverage under the group policy is cancelled due to termination of

a) His employment; or

b) His group membership,

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

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

The Participant must make application and pay all required premiums for the individual insurance contract within 60 Days of the termination date of his insurance under the group insurance plan. Failure to submit the application and

premium within such 60 Days will prevent the Participant from obtaining the insurance under the individual insurance contract.

The individual insurance contract will take effect on the date that both the application and the premium have been received by the insurer.

TERMINATION

The insurance under this benefit terminates as indicated in the Summary of Benefits, or such other earlier date indicated in this benefit or in the General Provisions of the group policy.

SUPPLEMENTAL HEALTH INSURANCE – EMERGENCY OUT OF PROVINCE ASSISTANCE

The services listed herein will be provided in connection with a Medical Emergency or personal emergency which occurs while the Insured Person is absent from his province of residence provided:

a) The Insured Person is insured under the Supplemental Health Insurance at the time of the Medical Emergency or personal emergency; and

b) The Medical Emergency or personal emergency occurs during the first 90 consecutive Days (Class 160) or during the first 60 consecutive Days (Classes 164, 165) of the Insured Person's absence from his province of residence.

   If, however, the absence is due to his attendance at an accredited educational institution on a full-time basis, the Medical Emergency or personal emergency occurs during the school year for which he is enrolled at the institution; and

c) The Insured Person's absence was due to business, a vacation or full-time attendance at an accredited educational institution; and

d) The services and supplies had to be provided before the Insured Person could return to his province of residence without endangering his health; and

e) In case of a Medical Emergency, the emergency is covered under the Emergency Medical Expenses Incurred Outside the Province of Residence section of the Supplemental Health Insurance.

The services will be provided by the insurer's medical assistance service provider. The Insured Person will be required to contact the medical assistance service provider to request the services in an emergency.

The insurer has the right to refuse a claim if the Insured Person has not contacted the medical assistance service as soon as possible in the case of a medical consultation or a Hospitalization.

In the absence of medical contraindication, the insurer may request that the Insured Person be repatriated or treated elsewhere. Repatriation must be recommended and planned by the medical assistance service provider. If an Insured Person refuses to follow a recommendation for repatriation, the insurer accepts no responsibility for expenses incurred thereafter.

SUPPLEMENTAL HEALTH INSURANCE – EMERGENCY OUT OF PROVINCE ASSISTANCE

DEFINITIONS

As used in this benefit:

Day Surgery: Surgery which is performed in a Hospital or out-patient clinic affiliated with a Hospital and requiring local, regional or general anaesthesia, but will not include minor surgery that can be performed in the Physician's office.

Immediate Family: The Insured Person's Spouse, father, mother, Child, brother or sister.

Medical emergency: A sudden or unexpected occurrence that requires immediate medical attention.

MEDICAL EMERGENCY ASSISTANCE SERVICES

The following services will be provided during a Medical Emergency:

a) 24 Hour Telephone Access

- The medical assistance service provider will provide a 24 hour hotline, 365 Days a year, staffed by multilingual co-ordinators to connect the Insured Person to a network of specialists who will handle the emergency.

b) Medical Care

The medical assistance service provider will:

- If the Insured Person is unable to locate a Physician or Hospital, provide a referral to a Physician or an appropriate Hospital;
- Upon request of the Insured Person, organize consultations with Physicians or Specialists in order to obtain the best medical care available in the area;
- Provide assistance with admittance to a Hospital;
- Confirm to Physicians and Hospitals the medical expenses that are covered under the Insured Person’s group policy.

c) Medical Transportation

The medical assistance service provider will:

- Arrange and pay for the transportation or transfer of the Insured Person by appropriate means to a Hospital as recommended by the attending Physician, and which the medical assistance service provider agrees to;
- Arrange and pay for the return of the Insured Person to his residence or to a Hospital near his residence after initial medical care has been provided, by an appropriate means of transportation, provided the return is medically necessary and permissible based on his medical condition. The medical assistance service provider will arrange for the Insured Person's return using the most appropriate means of transportation: air ambulance, helicopter, commercial airline, train or ambulance.

d) Payment of Medical Expenses and Cash Advance

- The medical assistance service provider will make the necessary arrangements to pay medical expenses which are covered under the Emergency Medical Expenses Incurred Outside of Province section of the Supplemental Health Insurance;
- When necessary in order for the Insured Person to obtain needed medical treatment, the medical assistance service provider will advance up to $10,000 (Canadian), after consultation with the insurer.
- The medical assistance service provider will pay for charges incurred due to a Hospitalization (such as parking, television rental, telephone calls, etc.), on presentation of vouchers, up to a maximum of $100 per Hospitalization.
- The medical assistance service provider will pay medical fees for a Dental Surgeon for emergency treatment required to relieve pain, up to a maximum of $200 per Insured Person.

e) Return of Deceased

- Should the Insured Person die, the medical assistance service provider will make all arrangements and pay all expenses associated with returning the body of the deceased person to the place of burial

in his province of residence, cremation or burial on site, up to a maximum of $7,500. Funeral expenses will not be covered.

- The medical assistance service provider will arrange and pay for round-trip economy class transportation for a Family member to identify the deceased, where required, prior to transportation, cremation or burial on site.

f) Return of Dependent Children

- The medical assistance service provider will organize the return of the Insured Person's Dependent Children under age 16 who are left unattended due to the Hospitalization of the Insured Person. In addition, the medical assistance service provider will arrange and pay for economy transportation for the Children, with an escort if necessary, to their usual place of residence. If the return tickets are still valid, only the additional cost incurred for the return transportation, after deducting the value of the tickets, will be paid.

g) Return of an Insured Person or a Member of the Immediate Family

- The medical assistance service provider will organize the return of the Insured Person and/or a member of the Immediate Family who has lost the use of his return ticket due to the Insured Person's Hospitalization or death. The medical assistance service provider will arrange and pay for economy transportation to return the Insured Person and/or member of the Immediate Family to his usual place of residence. If the return tickets are still valid, only the additional cost incurred for the return transportation, after deducting the value of the tickets, will be paid.

h) Visit from a Member of the Immediate Family

- The medical assistance service provider will arrange and pay for round-trip economy class transportation for a member of the Immediate Family to visit the Insured Person if the person is Hospitalized for at least 7 consecutive Days and the attending Physician feels that the visit would be beneficial to him.

i) Expenses for Commercial Accommodation and Meals

- When a return is delayed due to the Hospitalization of an Insured Person for a period of more than 24 hours or because of an Insured

Person's death, the expenses for commercial accommodation and meals incurred due to the delay by the Insured Person, by a member of the Immediate Family accompanying the Insured Person or visiting the Insured Person in accordance with h) will be reimbursed, subject to a daily maximum of $150 per person, and an overall maximum of $3,000 (maximum of 20 Days).

Receipts must be provided before Reimbursement will be made by the medical assistance service provider.

j) Vehicle Return

- The medical assistance service provider will pay up to $1,000 to return the Insured Person's vehicle, either private or rental, to the Insured Person's residence or the nearest appropriate vehicle rental location.

k) Emergency Drugs

- Should an Insured Person require drugs for the treatment of a medical condition and such drugs are not available locally, the medical assistance service provider will co-ordinate a search for the drugs and once located arrange for the delivery of the drugs. The Insured Person will be responsible for the cost of the drugs unless the drugs are covered under the Supplemental Health Insurance.

PERSONAL EMERGENCY TRAVEL ASSISTANCE SERVICES

The following services will be provided during a personal emergency:

a) Telephone Interpretation Service

- The medical assistance service provider will provide the Insured Person with telephone interpretation services in most foreign languages.

b) Messages

- The medical assistance service provider will relay a message, upon request, from the Insured Person to his home, office or elsewhere, or hold messages for the Insured Person or the members of his Immediate Family for up to 15 Days.

c) Legal Assistance

- The medical assistance service provider will assist the Insured Person in finding local legal aid when required, and will also help the Insured Person obtain a cash advance from his credit cards, family and friends, in order to pay for any bail or legal fees.

d) Travel Information

- The medical assistance service provider will provide the Insured Person with travel information related to transportation, vaccinations and precautionary measures before, during and after the Insured Person's trip.

e) Lost Baggage or Travel Documents

- If the Insured Person loses or has his travel documents and/or baggage stolen, the medical assistance service provider will help him contact the appropriate authorities.

EXCLUSIONS AND REDUCTIONS

In addition to the exclusions and reductions outlined in the Exclusions and Reductions provision of the Supplemental Health Insurance, the Medical Emergency Assistance Services provided under this benefit will be subject to the limitations, exclusions and terms and conditions that are applicable under the Emergency Medical Expenses Incurred Outside the Province of Residence provision of the Supplemental Health Insurance.

LIABILITY

The medical assistance service provider and insurer will not be held responsible for the provider's failure to provide medical assistance or for delays caused by strikes, civil wars, wars, invasions, intervention by enemy powers, hostilities (whether war is declared or not), rebellions, insurrections, acts of terrorism, military operations or coups, riots or uprisings, radioactive fallout, or any other situation beyond its control.

The Physicians, Hospitals, clinics, lawyers and other authorized practitioners or institutions to which the medical assistance service provider directs Insured Persons are independent contractors and act on their own behalf and are not

employees, agents or subordinates of the medical assistance service provider or the insurer.

The medical assistance service provider and the insurer are not responsible and assume no liability for the negligence or other acts or omissions by the Physicians, Hospitals, clinics, lawyers or other authorized practitioners or institutions to which the Insured Person is directed by the medical assistance service provider.

REIMBURSEMENT

If a cash advance was made by the insurer or its medical assistance provider to cover a charge that had been made, or if a charge was paid by the insurer or its medical assistance provider, and the Participant submits such charge as a covered expense under the Supplemental Health Insurance at a later date, the Participant will only be reimbursed the difference between the eligible amount of the covered expense and the amount of the cash advance or the amount already paid by the insurer or its medical assistance provider, subject to the Deductible and Reimbursement level that are applicable to the expense.

If a cash advance to cover an expense had been made or an expense had been paid and (i) such expense is not a covered expense under the Emergency Medical Expenses Incurred Outside the Province of Residence provision of the Supplemental Health Insurance or (ii) the amount advanced or paid was in excess of the insurer's responsibility under the group policy, the Participant will be responsible for reimbursing the insurer the cash advancement or the excess amount, whichever is applicable, within 90 Days of the Insured Person returning to his province of residence. Should the Participant fail to pay back the cash advance or excess amount, the insurer will have the right to reduce future health claims or any other claims by the Participant or his Dependents under the group policy by the amount owing.

AUTOMATIC EXTENSION

This benefit will be automatically extended at no cost at the end of the maximum period of 90 consecutive Days per trip:

- Up to 24 hours when the return home is postponed due to a delay by the carrier or the result of an Accident or a mechanical problem to the Insured

Person's private vehicle while in it and while returning to the starting point (claim must be supported by vouchers); or

- During Hospitalization and 24 hours following the Insured person's discharge from the hospital; or
- Up to 72 hours when the return home is delayed due to an Insured Person's Illness that began within 24 hours before the scheduled return date and requiring emergency medical care.

DENTAL CARE INSURANCE

The insurer undertakes to reimburse the Participant's dental care expenses, subject to the terms and conditions hereinafter specified.

SPECIAL DEFINITIONS

Dental hygienist: A person licensed by the provincial licensing authority to work as a practitioner specializing in the cleaning of teeth and assisting the patient in proper oral health.

Denturist: A person licensed by the appropriate provincial licensing authority to work as a practitioner supplying and fitting dentures.

Expenses Incurred: Any fee corresponding to a professional procedure already performed. Expenses are considered to be incurred only when treatment has actually been given, even if a treatment plan has been submitted to and approved by the insurer.

For dentures, expenses are considered to be incurred only on the date such dentures are installed.

General Practitioner: A dentist who practices dentistry without specialization.

Specialist: A person licensed by the provincial licensing authority to practice dentistry with specialization.

DENTAL EXPENSES

"Eligible expenses" means fees incurred for treatment given by a General Practitioner or by a Specialist or a Dental Hygienist on the recommendation of a General Practitioner. Such expenses must be incurred while this coverage is in force. Expenses incurred in Canada are limited to the normal rate suggested for general practitioners of the province of residence of the Insured Person.

Expenses incurred for treatment provided by a Denturist are limited to the normal suggested fee for denturists of the province of residence of the Insured Person.

These expenses are reimbursed according to the Fee Guide of the year indicated in the Summary of Benefits.

The following expenses are covered if so stated in the Summary of Benefits:

Preventive Treatments

a) Diagnostic services
   - i) Complete oral exam – primary dentition (once every year)
   - ii) Complete oral exam – mixed dentition (once every year)
   - iii) Complete oral exam – permanent dentition (once every year)
   - iv) Recall oral exam (once every 6 months)
   - v) Emergency exam
   - vi) Specific oral area exam
   - vii) House call
   - viii) Hospital call
   - ix) Special office visit

b) Consultations
   - i) Treatment planning – per unit of time
   - ii) With patient
   - iii) With another dentist

c) Radiographs
   - i) Complete series periapical films adult dentition (once every 3 years)
   - ii) Complete series periapical films primary or mixed dentition (once every 3 years)
   - iii) Single periapical film
   - iv) 2 periapical films
   - v) 3 periapical films
   - vi) 4 periapical films
   - vii) 5 periapical films
   - viii) 6 periapical films

ix) 7 periapical films

x) 8 periapical films

xi) 9 periapical films

xii) 10 periapical films

xiii) Single occlusal film

xiv) 2 occlusal films

xv) 3 occlusal films

xvi) 4 occlusal films

xvii) Posterior bitewing – single film (once every 6 months)

xviii) Posterior bitewings – 2 films (once every 6 months)

xix) Posterior bitewings – 3 films (once every 6 months)

xx) Posterior bitewings – 4 films (once every 6 months)

xxi) Extra oral – single film

xxii) Extra oral – 2 films

xxiii) Extra oral – 3 films

xxiv) Extra oral – 4 films

xxv) Sinus examination

xxvi) Sialography

xxvii) Use of radiopaque dye to demonstrate lesions

xxviii) Temporomandibular joint film

xxix) Each additional above 4 films

xxx) Panoramic film (once every 3 years)

xxxi) Cephalometric films – first film

xxxii) Cephalometric films – 2 films

xxxiii) Cephalometric films – 3 films

xxxiv) Cephalometric films – 4 films

xxxv) Cephalometric films – each additional above four films

xxxvi) Interpretation of radiographs from another source (per unit of time)

xxxvii) Tomography

xxxviii) Hand and wrist (as diagnostic aid for dental treatment)

d) Tests and laboratory examinations

i) Bacterial cultures (non-endodontic)

ii) Dental caries susceptibility test

iii) Biopsy – soft tissue

iv) Biopsy –hard tissue

v) Cytological exam

vi) Pulp vitality test

e) Preventive services

i) One unit of scaling and one unit of polishing (or prophylaxis [light scaling and polishing] when the service is performed in Quebec) – primary dentition (once every 6 months)

ii) One unit of scaling and one unit of polishing (or prophylaxis [light scaling and polishing] when the service is performed in Quebec) – mixed dentition (once every 6 months)

iii) One unit of scaling and one unit of polishing (or prophylaxis [light scaling and polishing] when the service is performed in Quebec) – permanent dentition (once every 6 months)

iv) Polishing only, not involving scaling (once every 6 months)

v) Topical fluoride (once every 6 months), or
Supervised fluoride brush-in (once every 3 months)

vi) Nutritional counselling (once every 3 years)

vii) Oral hygiene instruction (once every 3 years)

viii) Oral hygiene reinstruction (once every 6 months)

ix) Plaque control (once only – maximum $20)

x) Caries pain control
xi) Occlusal equilibration (8 units of time every 12 months)
xii) Space maintainer – stainless steel band with wire attachment
xiii) Space maintainer – stainless steel crown with wire attachment
xiv) Cast space maintainer
xv) Cast space maintainer with intra-alveolar attachment
xvi) Removable acrylic space maintainer
xvii) Appliance maintenance

Basic treatments

a) Restorative services
i) Amalgam – primary teeth, one surface
ii) Amalgam – primary teeth, 2 surfaces
iii) Amalgam – primary teeth, 3 surfaces
iv) Amalgam – primary teeth, 4 surfaces
v) Amalgam – primary teeth, 5 surfaces
vi) Amalgam – permanent anterior and bicuspid teeth, one surface
vii) Amalgam – permanent anterior and bicuspid teeth, 2 surfaces
viii) Amalgam – permanent anterior and bicuspid teeth, 3 surfaces
ix) Amalgam – permanent anterior and bicuspid teeth, 4 surfaces
x) Amalgam – permanent anterior and bicuspid teeth, 5 surfaces
xi) Amalgam – permanent molar teeth, one surface
xii) Amalgam – permanent molar teeth, 2 surfaces
xiii) Amalgam – permanent molar teeth, 3 surfaces
xiv) Amalgam – permanent molar teeth, 4 surfaces
xv) Amalgam – permanent molar teeth, 5 surfaces
xvi) Retentive pins – one pin

xvii) Retentive pins – 2 pins

xviii) Retentive pins – 3 pins

xix) Retentive pins – 4 pins

xx) Retentive pins – 5 pins

xxi) Silicate

xxii) Acrylic or composite

xxiii) Acrylic or composite – acid etch

xxiv) Prefabricated veneer application

xxv) Acrylic or composite, posterior, one surface

xxvi) Acrylic or composite, posterior, 2 surfaces

xxvii) Acrylic or composite, posterior, 3 surfaces

xxviii) Acrylic or composite, posterior, 4 surfaces

xxix) Acrylic or composite, posterior, one surface, acid etch

xxx) Acrylic or composite, posterior, 2 surfaces, acid etch

xxxi) Acrylic or composite, posterior, 3 surfaces, acid etch

b) Endodontic services

i) Root canal therapy – one canal

ii) Root canal therapy – one canal, partially developed root

iii) Root canal therapy – 2 canals

iv) Root canal therapy – 3 canals, partially developed root

v) Root canal therapy – 4 canals

vi) Root canal therapy – 4 canals, partially developed root

vii) Pulp mummification

NOTE: Includes pulpectomy, biomechanical preparation, chemotherapeutic treatment and obliteration (lifetime maximum of $750 per tooth).

c) Denture services

i) Minor denture adjustments

ii) Repair complete upper denture

iii) Repair complete lower denture

iv) Repair partial upper denture

v) Repair partial lower denture

vi) Repair complete upper denture – impression needed

vii) Repair complete lower denture – impression needed

viii) Repair partial upper denture – impression needed

ix) Repair partial lower denture – impression needed

x) Maxillary partial denture additions

xi) Mandibular partial denture additions

xii) Denture scaling and polishing

xiii) Reline maxillary complete denture – self-polymerizing (transitional measure) (once every 3 years)

xiv) Reline mandibular complete denture – self-polymerizing (transitional measure) (once every 3 years)

xv) Reline maxillary removable partial denture – self-polymerizing, unilateral or bilateral (transitional measure) (once every 3 years)

xvi) Reline mandibular removable partial denture – self-polymerizing, unilateral or bilateral (transitional measure) (once every 3 years)

xvii) Reline complete upper denture – lab processed (once every 3 years)

xviii) Reline complete lower denture – lab processed (once every 3 years)

xix) Reline partial upper denture – lab processed (once every 3 years)

xx) Reline partial lower denture – lab processed (once every 3 years)

xxi) Rebase complete upper denture – lab processed (once every 3 years)

xxii) Rebase complete lower denture – lab processed (once every 3 years)

xxiii) Rebase partial upper denture – lab processed (once every 3 years)

xxiv) Rebase partial lower denture – lab processed (once every 3 years)

xxv) Remake maxillary removable partial denture using existing framework (once every 3 years)

xxvi) Remake mandibular removable partial denture using existing framework (once every 3 years)

xxvii) Tissue conditioning, maxillary complete denture

xxviii) Tissue conditioning, mandibular complete denture

xxix) Tissue conditioning, maxillary partial denture

xxx) Tissue conditioning, mandibular partial denture

d) Surgical

i) Removal single erupted tooth

ii) Removal each additional tooth – same surgical site

iii) Removal single erupted tooth – complicated

iv) Removal tooth – soft tissue coverage

v) Removal of impacted tooth – partial bony impaction

vi) Removal of impacted tooth – complete bony impaction

vii) Removal of impacted tooth – unusual position or age factor (including supernumerary)

viii) Removal or residual roots – soft tissue coverage

ix) Removal or residual roots – hard tissue coverage

e) Anaesthesia

f) Periodontal services

Periodontal scaling not covered under Preventative Services and root planning – 8 units per Calendar Year

Major Services

a) Miscellaneous

i) Duplicate radiographs

ii) Diagnostic casts unmounted

iii) Diagnostic casts unmounted – duplicate

iv) Diagnostic casts mounted (no face bow)

v) Diagnostic casts mounted (with face bow)

vi) Diagnostic casts – orthodontic

vii) Diagnostic casts mounted (gnathologic procedures)

viii) Transverse axis location and transfer

ix) Pantographic records

x) Single diagnostic photograph

xi) Two diagnostic photographs

xii) Three diagnostic photographs

xiii) More than three diagnostic photographs

xiv) Diagnostic casts equilibration – per unit of time

xv) Diagnostic casts equilibration – extensive dentistry – per unit of time

xvi) Diagnostic wax-up to evaluate cosmetics

xvii) Diagnostic wax-up of cusp-fossa relationships

xviii) Diagnostic split cast mounting

xix) Diagnostic split cast mounting – extensive dentistry

b) Preventive services

i) Finishing restorations – per unit of time

ii) Pit and fissure sealants – first tooth

iii) Each additional tooth in same quadrant

iv) Protective athletic appliance (processed)

v) Interproximal discing of teeth

vi) Soldered lingual arch – 2 molar bands

vii) Soldered lingual arch – replace missing anterior teeth

viii) Lingual arch with locking wires – 2 molar bands with tubes

c) Restorative

i) Gold foil

ii) Inlay, metal – one surface

iii) Inlay, metal – 2 surfaces

iv) Inlay, metal – 3 surfaces

d) Retentive pins in inlays

i) One pin

ii) 2 pins

iii) 3 pins

iv) 4 pins

v) 5 pins

vi) Inlay, porcelain (includes temporization)

e) Crowns

i) Preformed stainless steel – primary anterior tooth

ii) Preformed stainless steel – primary posterior tooth

iii) Preformed stainless steel – permanent anterior tooth

iv) Preformed stainless steel – permanent posterior tooth

v) Preformed polycarbonate crown– primary anterior tooth

vi) Acrylic – processed

vii) Acrylic processed to metal

viii) Acrylic (or plastic) transitional, direct

ix) Acrylic (or plastic) transitional, indirect

x) Porcelain

xi) Porcelain fused to metal base (porcelain veneer)

xii) Metal (full cast)

xiii) Metal (¾ cast)

xiv) Metal transitional, direct

xv) Cast metal post and core – separate procedure

xvi) Cast metal post and core – separate procedure – 2 sections

xvii) Cast metal post and core – separate procedure – 3 sections

xviii) Cast metal post and core – concurrent with impression

xix) Cast metal post and core concurrent with impression for crown – 2 sections

xx) Cast metal post and core concurrent with impression for crown – 3 sections

xxi) Metal transfer coping (thimble) separate procedure

xxii) Metal transfer coping (thimble) concurrent with impression

xxiii) Recement inlays or crowns – per unit of time

xxiv) Removal of crown or inlays – per unit of time

xxv) Prefabricated metal post and core

xxvi) Prefabricated metal post and cast core

xxvii) One additional prefabricated post and core

xxviii) 2 additional prefabricated post and core

xxix) Pin-reinforced amalgam core/post for crown restoration

xxx) Pin-reinforced composite core/post for crown restoration

xxxi) Cement restoration

xxxii) Transitional restoration of fractured anterior – per unit of time

f) Endodontics

i) Pulp capping – traumatic exposure

ii) Pulp capping – indirect – as separate procedure

iii) Vital pulpotomy – permanent anterior or bicuspid

iv) Vital pulpotomy – permanent molar

v) Vital pulpotomy – primary tooth

vi) Vital pulpotomy – primary tooth concurrent with restoration

vii) Apexification – one canal

viii) Apexification – 2 canals

ix) Apexification – 3 canals

x) Apexification – 4 or more canals

xi) Insertion of dentogenic media, one canal – per unit of time

xii) Insertion of dentogenic media, 2 canals – per unit of time

xiii) Insertion of dentogenic media, 3 canals – per unit of time

xiv) Insertion of dentogenic media, 4 canals or more – per unit of time

xv) Apical curettage and/or root resection, one root – uncomplicated

xvi) Apical curettage and/or root resection, one root – complicated

xvii) Apical curettage and/or root resection, 2 roots (separate procedure)

xviii) Apical curettage and/or root resection, 3 or more roots (separate procedure)

xix) Apical curettage and/or root resection in conjunction with endodontics

xx) Apical curettage and/or root resection in conjunction with endodontics – one root complicated

xxi) Apical curettage and/or root resection in conjunction with endodontics – 2 roots

xxii) Apical curettage and/or root resection in conjunction with endodontics – 3 or more roots

xxiii) Retro-filling, one root

xxiv) Retro-filling, one root, complicated

xxv) Retro-filling, one root on the lateral aspect of root

xxvi) Retro-filling, 2 roots

xxvii) Retro-filling, 3 roots

xxviii) Amputation of one root

xxix) Amputation of 2 roots

xxx) Gingival curettage

xxxi) Alveolectomy

xxxii) Banding of tooth to maintain sterile operating field

xxxiii) Hemisection – bicuspid

xxxiv) Hemisection – maxillary molar

xxxv) Hemisection – mandibular molar

xxxvi) Canal and/or pulp chamber enlargement – per unit of time

xxxvii) Chemical bleaching only – per unit of time

xxxviii) Intentional removal, apical filling and reimplantation – single root

xxxix) Intentional removal, apical filling and reimplantation – 2 roots

xl) Intentional removal, apical filling and reimplantation – 3 roots

xli) Removal of root filling material or foreign bodies from previously treated root canals

xlii) Endosseous implants – single root – direct implant

xliii) Endosseous implants – single root – oblique implant

xliv) Endosseous implants – 2 roots – direct implant

xlv) Emergency pulpectomy – primary tooth

xlvi) Emergency pulpectomy – permanent tooth – one canal

xlvii) Emergency pulpectomy – permanent tooth – 2 canals

xlviii) Emergency pulpectomy – permanent tooth – 3 or more canals

xlix) Trephination through crown into root canal

l) Smoothing traumatized tooth

li) Relieving traumatic occlusion – as separate procedure

lii) Reimplantation of totally luxated tooth – including root canal

liii) Repositioning of traumatically displaced tooth – per unit of time

g) Periodontal

i) Application of displacement dressing (packing) – per unit of time

ii) Management of acute infections and other oral lesions – per unit of time

iii) Desensitization of tooth surface – per unit of time

iv) Gingival curettage – per surgical site

v) Gingivoplasty – per surgical site

vi) Gingivectomy – per surgical site

vii) Osseous surgery – osteotectomy and/or osteoplasty, including flap entry and closure – per surgical site

viii) Flap approach with curettage of osseous defect – per surgical site

ix) Osseous grafts – single site

x) Osseous grafts – multiple sites

xi) Pedicle soft tissue grafts

xii) Free soft tissue grafts – per surgical site

xiii) Vestibuloplasty – per surgical site

xiv) Post surgical treatments – periodontal – per unit of time

xv) Provisional splinting – intracoronal – per unit of time

xvi) Provisional splinting – extra coronal – per unit of time

xvii) Periodontal scaling not covered under Preventative services and root planing – per unit of time

xviii) Special periodontal appliances (including occlusal guards) – per unit of time

h) Dentures

Payment will only be made for a denture or other prosthetic appliance once in any five-year period while the Employee or Dependent is covered under the plan. Replacement of an existing denture will only be made if it is unsatisfactory and cannot be made satisfactory.

Payment for a complete upper or a complete lower denture will be based on a standard or routine denture.

i) Complete upper denture

ii) Complete lower denture

iii) Complete upper and lower dentures

iv) Immediate upper denture

v) Immediate lower denture

vi) Immediate upper and lower dentures

vii) Transitional complete upper denture

viii) Transitional complete lower denture

ix) Transitional complete upper and lower dentures

x) Transitional partial upper denture

xi) Transitional partial lower denture

xii) Upper partial – acrylic base with wrought clasps

xiii) Lower partial – acrylic base with wrought clasps

xiv) Upper partial – acrylic base with gold/chrome clasps/rests

xv) Lower partial – acrylic base with gold/chrome clasps/rests

xvi) Upper partial – wrought bar with rests/clasps

xvii) Lower partial – wrought bar with rests/clasps

xviii) Upper partial with chrome cobalt palatal connector/rests/clasps/ acrylic base

xix) Lower partial with chrome cobalt lingual connector/rests/clasps/ acrylic base

xx) Upper partial with palatal connector/rests/clasps/chrome cobalt base/tooth borne

xxi) Lower partial with lingual connector/rests/clasps/chrome cobalt base/tooth borne

xxii) Upper and lower partial dentures with chrome cobalt connector/ rests/clasps

xxiii) Altered cast impression technique

xxiv) Complete upper denture with lower partial denture/cast chrome cobalt lingual connector/rests/clasps/acrylic base

xxv) Complete lower denture with upper partial denture/cast chrome cobalt lingual connector/rests/clasps/acrylic base

xxvi) Upper partial denture with precision attachments

xxvii) Lower partial denture with precision attachments

xxviii) Upper partial denture with stress breaker attachments

xxix) Lower partial denture with stress breaker attachments

xxx) Removable unilateral chrome cobalt partial denture – one piece casting

xxxi) Upper and lower denture – remount and equilibration procedures

xxxii) Upper denture – remount and equilibration procedures

xxxiii) Lower denture – remount and equilibration procedures

xxxiv) Duplicate maxillary complete denture, poured teeth and base technique

xxxv) Duplicate mandibular complete denture, poured teeth and base technique

i) Extensive or complicated restoration of teeth
   - i) Fixed prosthodontic evaluation
   - ii) Metal cast pontic
   - iii) Slotted facing (Steel's or Williams' facing)
   - iv) Porcelain fused to metal pontic
   - v) Porcelain pontic – aluminous
   - vi) Acrylic processed to metal pontic
   - vii) Acrylic pontic processed – indirect
   - viii) Acrylic pontic, transitional, acid etched to adjacent teeth
   - ix) Reverse pin pontic
   - x) Master cast hinge – bow transfer
   - xi) Master cast gnathological wax-up
   - xii) Master cast split-cast mounting – per unit of time
   - xiii) Metal inlay – 2 surfaces – broken stress technique
   - xiv) Metal inlay – 3 surfaces or more – broken stress technique
   - xv) Metal onlay

j) Repairs
   - i) Replace broken pin facing – per unit of time
   - ii) Replace broken facing – post intact – per unit of time
   - iii) Replace broken facing – post broken – per unit of time
   - iv) Replace broken facing with acrylic – per unit of time
   - v) Replace broken tru pontic – per unit of time
   - vi) Removal of fixed bridge – reinserted – per unit of time
   - vii) Removal of fixed bridge – not to be reinserted – per unit of time
   - viii) Recementation of fixed bridge – per unit of time

k) Crowns
   i) Acrylic crown – processed – indirect, transitional
   ii) Acrylic crown – direct, transitional – per unit of time
   iii) Acrylic processed to metal crown
   iv) Porcelain crown – aluminous
   v) Porcelain fused to metal
   vi) Metal ¾ cast crown
   vii) Metal full cast crown
   viii) Telescoping crown unit
   ix) Precision attachments

l) Splinting
   i) Splinting – extensive, complicated restorative dentistry
   ii) Intra-oral indexing for soldering purposes – per unit of time

m) Retentive pins in abutments
   i) One pin
   ii) 2 pins
   iii) 3 pins
   iv) 4 pins
   v) 5 pins
   vi) Provisional coverage – extensive, complicated dentistry

n) Surgical services
   i) Surgical exposure of tooth, uncomplicated – soft tissue coverage
   ii) Surgical exposure of tooth, complex – hard tissue coverage
   iii) Surgical exposure of tooth including orthodontic attachment
   iv) Transplantation of a tooth
   v) Surgical repositioning of a tooth

vi) Enucleation of an unerupted tooth and follicle

vii) Alveoloplasty in conjunction with multiple tooth removal – per unit of time

viii) Alveoloplasty independent procedure – per unit of time

ix) Gingivoplasty and/or stomatoplasty independent procedure – per unit of time

x) Gingivoplasty and/or stomatoplasty in conjunction with tooth removal – per unit of time

xi) Excision torus palatinus

xii) Excision torus mandibularis, unilateral

xiii) Excision torus mandibularis, bilateral

xiv) Removal of multiple exostosis, quadrant

xv) Removal of multiple exostosis, arch

xvi) Resection of benign tumor of soft tissue – 1 cm or under

xvii) Resection of benign tumor of soft tissue – over 1 cm

xviii) Excision of cyst – 1 cm or under

xix) Excision of cyst – over 1 cm

xx) Incision and drainage – soft tissue – intra-oral

xxi) Trephination and drainage – hard tissue – intra-oral

xxii) Assisting surgeon at reduction

xxiii) Simple fracture of mandible (closed reduction)

xxiv) Open reduction – mandible

xxv) Simple fracture of maxilla (closed reduction)

xxvi) Open reduction – maxilla

xxvii) Fracture of alveolus fracture including debridement

xxviii) Repair of uncomplicated soft tissue lacerations – 2 cm or less

xxix) Repair of uncomplicated soft tissue lacerations – 2 to 4 cm

xxx) Upper labial frenectomy

xxxi) Lower labial frenectomy

xxxii) Lingual frenectomy

xxxiii) Treatment of dislocation of mandible (uncomplicated)

xxxiv) Sialolithomy – removal of salivary calculus

xxxv) Immediate recovery of dental root or foreign body from antrum by antrostomy

xxxvi) Immediate closure of oro-antral opening by another dentist

xxxvii) Independent and delayed recovery of foreign body from antrum by antrostomy

xxxviii) Antrum lavage – oral approach

xxxix) Antrum lavage – nasal approach

xl) Closure of oro-antral fistula – sliding buccal flap

xli) Closure of oro-antral fistula – gold plate

xlii) Closure of oro-antral fistula – sliding palatal flap

xliii) Control of secondary hemorrhage

xliv) Minor post surgical treatment by treating dentist

xlv) Major post surgical treatment by treating dentist – per unit of time

xlvi) Minor post surgical treatment by other than treating dentist

xlvii) Major post surgical treatment by other than treating dentist – per unit of time

o) Adjunctive services

NOTE: Maximum of once every 3 years.

i) Emergency services not otherwise specified

ii) Unusual time and responsibility – per unit of time

iii) Psychological management of uncooperative patient

iv) Hypnosis and dental psychotherapy

v) Written and/or telephone report (depending upon details)

vi) Completing ODA/CDA claim forms

vii) Providing written treatment plan upon request

viii) Completion of prepaid claim forms (special)

ix) Unreasonable telephone time – per unit of time

x) Office time forwarding records, pretreatment

xi) House call

xii) Special office visit

xiii) Missed or cancelled appointment

xiv) Identification – per unit of time

xv) Full or part time participation in civil disaster – per unit of time

xvi) Professional visits out of office – per unit of time

xvii) Written odontology report

xviii) Therapeutic intra-muscular drug injection

xix) Therapeutic intravenous drug injection

xx) Other drugs and/or medications

xxi) Special consultation appointment – per unit of time

xxii) Court appearance as an expert witness

Orthodontic Treatments

Treatments are limited to Insured Persons under 19 years of age at the time treatment begins.

i) Observation – per appointment

ii) Observation and adjustment (including reduction of proximal surfaces) per unit of time

iii) Repairs

iv) Alterations

v) Re-cementations

vi) Separation – except where included in fabrication of appliance – per unit of time

vii) Space regaining – maxillary – removable

viii) Space regaining – mandibular – removable

ix) Crossbite correction – maxillary appliance – removable

x) Crossbite correction – mandibular appliance – removable

xi) Dental arch expansion – maxillary – removable

xii) Dental arch expansion – mandibular – removable

xiii) Rapid maxillary expansion – removable

xiv) Closure of diastemas – maxillary

xv) Closure of diastemas – mandibular

xvi) Simple alignment of incisor teeth – maxillary

xvii) Simple alignment of incisor teeth – mandibular

xviii) Monobloc or activator

xix) Space regaining – maxillary – fixed or cemented

xx) Space regaining – mandibular – fixed or cemented

xxi) Crossbite correction – anterior – maxillary – fixed or cemented

xxii) Crossbite correction – anterior – mandibular – fixed or cemented

xxiii) Crossbite correction – posterior – maxillary – fixed or cemented

xxiv) Crossbite correction – posterior – mandibular – fixed or cemented

xxv) Dental arch expansion – lingual arch – maxillary

xxvi) Dental arch expansion – lingual arch – mandibular

xxvii) Headgear

xxviii) Rapid maxillary expansion

xxix) Closure of diastemas – maxillary

xxx) Closure of diastemas – mandibular

xxxi) Simple alignment of incisor teeth – maxillary

xxxii) Simple alignment of incisor teeth – mandibular

xxxiii) Space regaining – maxillary – fixed or cemented – unilateral

xxxiv) Space regaining – mandibular – fixed or cemented – unilateral

xxxv) Crossbite correction – posterior – 2 molar bands – unilateral

xxxvi) Motivation of patient – psychological approach

xxxvii) Removable appliance – maxillary

xxxviii) Removable appliance – mandibular

xxxix) Fixed appliance – maxillary

xl) Fixed appliance – mandibular

xli) Myofunctional therapy – per unit of time

xlii) Retention appliance – removable – maxillary

xliii) Retention appliance – removable – mandibular

EXCLUSIONS AND REDUCTIONS

a) This benefit does not cover:

i) Treatment or appliance related directly or indirectly to full mouth reconstruction, to correct vertical dimension or any temporomandibular joint dysfunction;

ii) Services rendered by a dental hygienist and not administered under the supervision of a dentist;

iii) Dental services covered under the health benefit, if such benefit is part of the group policy, or under any other group insurance contract;

iv) Services and supplies relating to any appliance worn in the practice of a sport;

v) Expenses which are payable or reimbursable under a worker's compensation act, or would normally have been if a claim had been submitted;

vi) For services and supplies resulting, directly or indirectly, from a self-inflicted injury unless medical evidence establishes that the injury was directly related to a mental health Illness;

vii) Care or services resulting from civil unrest, insurrection or war, whether war be declared or not, or participation in a riot;

viii) Services which are not Medically Required, which are given for cosmetic purposes or which exceed ordinary services given in accordance with current therapeutic practice;

ix) Care or services rendered free of charge or which would be free of charge were it not for coverage or which are not chargeable to the Insured Person;

x) Care or services related to implants;

xi) Expenses incurred by any person who has entered the armed forces of any country on a full-time basis;

xii) Examinations required for use of a third party;

xiii) Treatment which is not generally recognized by the dental profession as an effective, appropriate and essential form of treatment for the dental condition.

xiv) Replacement of an appliance which has been lost, mislaid or stolen;

xv) Personalization or characterization of dentures;

xvi) Supplies which were first prescribed or recommended while the person was not a covered family member.

b) The amount of benefits is reduced by any benefit that is payable or reimbursable under a government plan or a group plan, or that would have been payable had the person submitted a claim.

c) **Treatment Plan** - If the total cost of a treatment is expected to exceed $500, a treatment plan must be submitted to the insurer who will determine, before commencement of treatment, the amount of eligible expenses.

"Treatment plan" means a written description of the treatment which, in the opinion of the dentist, will be required, including x-rays in support of such opinion, and specification of the probable date and cost of treatment.

PAYMENT OF BENEFITS

Proof

Before paying benefits, the insurer may require, as proof and at no expense to the insurer, a complete diagram showing the Insured Person's state of dentition prior to the beginning of the treatment for which a claim is submitted. The insurer may also, if deemed necessary, require laboratory or Hospital reports, x-rays, casts, molds or models used for examination purposes, or any other similar evidence.

CALCULATION OF REIMBURSEMENT

Deductible

The deductible is that portion of eligible expenses which must be paid by the Participant before any benefits are payable. The maximum deductible required per Calendar Year is specified in the Summary of Benefits, if applicable.

Carry-over Provision

If the deductible has been satisfied in whole or in part by the payment of expenses incurred in the last 3 months of a Calendar Year, the deductible for the following year will be reduced by the amount of deductible already paid.

Reimbursement

The insurer reimburses a percentage of eligible expenses incurred in the course of a Calendar Year, after applying the deductible for that year, if applicable. Such percentage is specified in the Summary of Benefits.

Maximum Benefit Per Insured Person

The global maximum amount reimbursed by the insurer for the present benefit is specified in the Summary of Benefits.

Extension of Benefits

If, within the 30 Days immediately following the termination of his coverage, an Insured Person receives the dental care specified hereafter, the insurer shall pay the benefits to which he would otherwise have been entitled had the coverage

not terminated, provided the group policy is in force at the time the treatment is rendered:

a) Complete or partial removable dentures, provided the initial impressions were taken prior to the termination of the coverage;

b) Fixed dentures, gold foil restorations, inlays and onlays, and crowns, provided the tooth was prepared prior to the termination of the coverage;

c) Endodontic treatment provided the tooth had been opened for root canal therapy prior to the termination of the coverage.

Co-ordination of Benefits

When an Insured Person is eligible to receive benefits simultaneously under this coverage and any other coverage which pays expenses for care, services and supplies which are for or by reason of dental care or treatment, the coverages will be co-ordinated to ensure that payment by all the coverages do not exceed the actual expenses incurred. The term “coverage” will mean any coverage providing care, services or supplies under:

i) any group, individual or family insurance, travel insurance, creditor's or savings insurance plan,

ii) any government sponsored plan, and

iii) any non-insured employee benefit plan.

EXTENSION OF DEPENDENTS' INSURANCE AT THE PARTICIPANT'S DEATH

Eligible expenses incurred after the date coverage ceased will not be reimbursed, regardless of whether or not a treatment plan has been filed with the insurer, unless the expenses are the result of the following situation:

Coverage ceased due to the death of the Participant, and, within 90 Days following the death, a Dependent of the deceased Participant has dental work done which is part of a series of planned dental treatment which had begun, or for which definite dental appointments had been made, while the Participant was living.

In no event will payment be made after termination of the group policy.

CONVERSION PRIVILEGE

A Participant whose coverage under the group policy is cancelled due to termination of

a) his employment; or

b) his group membership,

will be able to convert his dental care insurance coverage to an individual insurance contract without having to submit evidence of insurability to the insurer, provided he is also converting his supplemental health insurance. Failure to convert his supplemental health insurance will prevent the Participant from converting his dental care insurance.

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

The Participant must make application and pay all required premiums for the individual insurance contract within 60 Days of the termination date of his insurance under the group insurance plan. Failure to submit the application and premium within such 60 Days will prevent the Participant from obtaining the insurance under the individual insurance contract.

The individual insurance contract will take effect on the date that both the application and the premium have been received by the insurer.

COPY OF CONTRACT AND ENROLLMENT MATERIAL

A Participant may request from the insurer a copy of the group policy, his enrollment form and any written documents (provided as evidence of insurability) that may have been provided to the insurer in relation to his insurance under the policy. The insurer will provide the first copy of the policy, enrollment form and relevant written documents without charge to the Participant. Any additional copies will be subject to a charge set by the insurer.

SUBMITTING CLAIMS

Health and Dental Claims

The Participant must submit a completed claim form with the original receipts (if applicable) to the following address:

For Participants residing in Quebec

Industrial Alliance Insurance and Financial Services Inc.
Group Insurance
Health/Dental Claims Department
P.O. Box 800 - Station Maison de la Poste
Montreal, Quebec, H3B 3K5

For Participants residing outside Quebec

Industrial Alliance Insurance and Financial Services Inc.
Group Insurance
Health/Dental Claims Department
P.O. Box 4643, Station "A"
Toronto, Ontario, M5W 5E3

It is important that Participants keep photocopies of their receipts. In addition, Participants should keep a copy of the Explanation of Benefits (EOB) which will be attached to their claim cheques. Participants may need these documents to co-ordinate benefits with another insurer or for their income tax returns.

Disability Claims

The Participant must submit a completed claim form to the following address:

For Participants residing in Quebec

Industrial Alliance Insurance and Financial Services Inc.
Group Insurance
Disability Claims Department
P.O. Box 800, Station Maison de la Poste
Montreal, Quebec, H3B 3K5

For Participants residing outside Quebec

Industrial Alliance Insurance and Financial Services Inc.
Group Insurance
Disability Claims Department
522 University Ave., Suite 400
Toronto, Ontario, M5G 1Y7

IMPORTANT NOTICE
For Persons Hospitalized Outside their Province of Residence

The Insured Person is required to contact Industrial Alliance Insurance and Financial Services Inc. (hereafter "the Company") Medical Assistance Service Provider at the following number as soon as the person is reasonably able to do so after the commencement of Hospitalization. Failure to do so may result in the Company limiting or denying the Insured Person's claim.

From within Canada or the United States	1-800-203-9024	(toll free)
From outside Canada or the United States	514-499-3747	(collect)

PROTECTING PERSONAL INFORMATION

Industrial Alliance Insurance and Financial Services Inc. (hereafter "the Company") is committed to protecting the privacy of a Participant's (including his or her Dependent's) personal information that it collects while providing services under the Group Plan issued to the Policyholder. The Company recognizes and respects a person's right to privacy concerning his or her personal information.

When a Participant enrolls under the Group Plan, the Company will establish a confidential file containing the personal information collected. The file will be kept at the Company's offices.

Access to the file will be limited to the Company's employees, agents and service providers who require access in the performance of their jobs, individuals to whom the Participant has granted access, and persons authorized by law.

At the Company, the personal information that is collected is used to perform administrative services with respect to the Group Plan. Administrative services include, but are not limited to,

- Determining eligibility under the Group Plan or a particular benefit;
- Enrolling Participants under the Group Plan;
- Adjudicating claims;
- Underwriting (includes determining the rates applicable to the Group Plan).

Participant's Right to Access His or Her Personal Information

A Participant has the right to access his or her personal information and to request, in writing, that any inaccurate information be corrected. In addition, the Participant can request that any outdated or unnecessary information be deleted.

If the Company has medical information about the Participant which was not obtained directly from the Participant, the Company will release the information to the Participant only through the Participant's Physician.

To request access to his or her personal information or to have his or her name removed from the list to be shared within the Company, the Participant must send a written request to:

Industrial Alliance Insurance and Financial Services Inc.
Access Officer
1080 Grande Allée West
P.O. Box 1907, Station Terminus
Quebec City, Quebec G1K 7M3

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Policy No. 100012339 issued by Special Markets Solutions, a division of Industrial Alliance Insurance and Financial Services Inc.

Classes 160, 162

COVERAGE

You are covered for any injury sustained as the result of an accident anywhere in the world - 24 hours per day - on or off the job.

AMOUNT OF INSURANCE

Your amount of insurance (Principal Sum) is an amount equal to the amount of your current Basic Group Life Insurance.

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

BENEFITS

Accidental Death, Dismemberment and Specific Loss Indemnity

The "loss" or "loss of use" must occur within 365 days of the date of the accident. These benefits are payable on a lump sum basis and in addition to any other benefits you may receive.

Life	100%
Both Arms or Both Hands	100%
Both Feet	100%
Entire Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and Entire Sight of One Eye	100%
One Foot and Entire Sight of One Eye	100%
Speech and Hearing in both Ears	100%
One Arm or One Leg	80%
One Hand or One Foot	75%
Entire Sight of One Eye	75%
Speech or Hearing in both Ears	75%
Hearing in One Ear	66 2/3%
Thumb and Index Finger of Either Hand	33 1/3%
Four Fingers of Either Hand	33 1/3%
All Toes of One Foot	25%
Quadriplegia (total paralysis of all four limbs)	200%
Paraplegia (total paralysis of the lower limbs)	200%
Hemiplegia (total paralysis of one side of the body)	200%

Bereavement Benefit ($1,000)

If an injury results in loss of life, the Company will pay the reasonable and necessary expenses actually incurred by the Spouse and Dependent Children for up to six (6) sessions of grief counselling, by a professional counsellor.

Comatose Benefit

If an injury does not cause loss of life but results in a coma or comatose state within 12 months after the date of the accident, the Company will pay 1% of the principal sum (less any sum paid under the Accidental Death, Dismemberment and Specific Loss Indemnity) for each month the coma or comatose state continues. Payments commence at the end of the waiting period of 31 days and are subject to a maximum of 100 consecutive months.

Continuation of Coverage

Coverage can be continued while the insured is on an approved leave of absence, maternity/parental leave, lay-off, strike/lockout or disability as per the Policyholder's current Group Life policy, subject to continued payment of premiums.

Conversion Option

Upon termination of active employment with the Policyholder, an insured may convert his/her insurance to an individual accident insurance plan, with no evidence of insurability, for an amount of principal sum equal to or lower than the amount of principal sum in force at the time of termination. Application for conversion must be made within 90 days. Premiums become payable annually in advance. This benefit is restricted to Canadian residents only.

Cosmetic Disfigurement Benefit ($25,000)

If an insured suffers a third degree burn, the Company will pay a percentage of the principal sum, depending on the area of the body which was burned according to the following table:

Cosmetic Disfigurement Benefit ($25,000) (cont'd)

Body Part	Area Classification (A)	Maximum Allowable Percentage for Area Burned (B)	Maximum Percentage of Principal Sum Payable (C)
		%	%
Face, Neck, Head	11	9.0	99.0
Hand and Forearm	5	4.5	22.5
Either Upper Arm	3	4.5	13.5
Torso (front or back)	2	18.0	36.0
Either Thigh	1	9.0	9.0
Either Lower Leg (below knee)	3	9.0	27.0

The maximum percent of principal sum payable (C) is determined by multiplying the area classification (A) by the maximum allowable percent for area burned (B). This table only represents the maximum percent of the principal sum payable for any one accident. If the insured suffers burns in more than one area, as a result of any one accident, benefits will not exceed the maximum amount stated above.

Day Care Benefit ($5,000)

If injury results in loss of life, the Company will pay 5% of the principal sum for each year the dependent child is enrolled in a legally licensed day care (not to exceed four years) for each dependent child who is under 13 years of age and enrolled in a legally licensed day care centre on the date of, or within 12 months following the accident.

Education Benefit ($5,000)

If injury results in loss of life, the Company will pay 5% of the principal sum for each year to any dependent child who, on the date of the accident, was enrolled as a full-time student in any institution of higher learning beyond the secondary school level (not to exceed four years). If, at the time of loss, none of the dependent children are eligible for the Education Benefit, the Company shall pay an additional amount of $2,500 to the designated beneficiary.

Exposure and Disappearance

If, as the result of an accident, an insured is unavoidably exposed to the elements and if, as a result of such exposure and within 12 months after the date of the accident, the insured suffers a loss for which indemnity would otherwise have been payable hereunder, such loss will be deemed to be the result of injury.

Where, due to the accidental wrecking, sinking or disappearance of a conveyance in which an insured was riding, the insured disappears, and if the body of the insured is not found within 12 months after the date of such wrecking, sinking or disappearance, it will be presumed, subject to there being no evidence to the contrary and subject to all other terms and conditions of the policy, that the insured suffered loss of life as a result of injury.

Family Transportation Benefit ($15,000)

If injury results in confinement as an inpatient in a hospital, and such injury results in a loss being payable under the Accidental Death, Dismemberment and Specific Loss Indemnity, and the hospital is located at least 100 km from the insured's residence, the Company will pay the expenses actually incurred by a member of the immediate family for hotel accommodation and transportation by the most direct route to the confined insured. If transportation occurs in a vehicle or device other than one operated under a license for the conveyance of passengers for hire, then reimbursement of transportation expenses will be limited to a maximum of $0.35 per kilometre travelled.

Funeral Expense Benefit ($5,000)

If injury results in loss of life, an additional amount is payable for funeral expenses actually incurred.

Home Alteration and Vehicle Modification Benefit ($15,000)

If injury requires the use of a wheelchair to be ambulatory, the Company will pay the cost of alterations to the insured's principal residence and/or the cost of modification to one motor vehicle utilized by the insured, provided such injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity.

Hospital Indemnity Expense ($2,500)

A daily benefit of 1/30 of 1% of the insured's principal sum, subject to the above-mentioned monthly maximum, will be payable when the insured is in a hospital if such period of hospitalization is necessary for the treatment of an injury which results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity of the policy and begins while insurance is in force.

A period of hospitalization necessary for an injury other than for a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity will be covered as stated above, provided such hospitalization is of at least a four-day period.

Identification Benefit ($5,000)

If injury results in loss of life, and requires body identification, the Company will pay the expenses actually incurred by a member of the immediate family for lodging, board and transportation by the most direct route, provided the body is located not less than 150 kilometres from the member of the immediate family's residence and the identification of the body is required by the police or a similar law enforcement agency having authority over such matters. If transportation occurs in a vehicle or device other than one operated under the license for the conveyance of passengers for hire, then reimbursement of transportation expenses will be limited to a maximum of $0.35 per kilometre travelled.

Permanent Total Disability

If an injury totally and permanently disables an insured within 12 months of the date of the accident, preventing the insured from engaging in any and every occupation, the Company will pay, provided such disability has continued for a period of 12 consecutive months and is total, continuous and permanent at the end of this period, the principal sum less any amounts already paid under the Accidental Death, Dismemberment and Specific Loss Indemnity as the result of the same accident.

Psychological Therapy Benefit ($5,000)

If injury results in a loss payable to an insured under the Accidental Death, Dismemberment and Specific Loss Indemnity and results in the insured requiring psychological therapy, as prescribed by a physician, the Company will pay the reasonable and necessary expenses actually incurred.

Rehabilitation Benefit ($15,000)

If injury requires that the insured undergo special training in order to be qualified to engage in a special occupation in which the insured would not have engaged except for such injury, the Company will pay the reasonable and necessary expense incurred for such training within three years of the date of the accident, provided such injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity.

Repatriation Benefit ($15,000)

If injury results in loss of life, the Company will pay the expense incurred for shipment of the body to the city of residence of the deceased.

Seat Belt Benefit ($50,000)

If injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity, the principal sum will be increased by 10% if, at the time of the accident, the insured was driving or riding in a vehicle and wearing a properly fastened seat belt.

Spousal Retraining Benefit ($15,000)

If injury results in loss of life, the Company will reimburse the spouse for the actual expenses incurred for a formal occupational training program in order to become qualified for active employment in an occupation in which the spouse would not otherwise have sufficient qualifications.

Waiver of Premium

In the event of total disability and waiver of premium has been approved and accepted by the group life carrier, then premium under this plan will be waived until the earlier of: death, recovery, attainment of age 65 or the date the policy is cancelled.

Workplace Modification and Accommodation Benefit ($5,000)

If injury requires special adaptive equipment and/or workplace modification for an insured to return to active full-time employment, the Company will pay the cost provided the policyholder agrees in writing to provide such modification and accommodation to the workplace for the purpose of making it accessible and adaptable to the needs of such insured; and the policyholder acknowledges in writing that the performance of the essential duties of such insured's occupation may be altered.

Aircraft Coverage (Passenger)

Coverage is extended to include injury sustained in consequence of riding as a passenger and not as a pilot or member of the crew; in boarding or alighting from or being struck by; or making a forced landing with or from any fixed-wing aircraft having a current and valid airworthiness certificate, or in the process of getting it and which is operated by a person holding a current and valid pilot's license of a rating authorizing him to pilot such aircraft.

The extended insurance afforded by this part does not apply to any loss fatal or non-fatal, caused by or resulting from Injury sustained while the Insured Person is:

(a) flying in any aircraft while it is being used for or in connection with acrobatic or stunt flying or racing;

(b) flying in any aircraft while it is being used for or in connection with crop dusting or seeding or spraying, pipe or power line inspection, any form of hunting, bird or fowl herding, banner towing, unless previously consented to in writing by the Company.

The above-noted exclusions do not apply to endurance tests, demonstration or any test for experimental purpose, nor to carry passengers for hire and for any flight which requires a special permit or waiver from the authority having jurisdiction over civil aviation, even though granted.

Limited Air Travel Coverage

Coverage includes injury sustained in consequence of riding as a passenger and not as a pilot or member of the crew, in; boarding or alighting from; being struck by; or making a forced landing with or from:

(a) any aircraft having a current and valid airworthiness certificate and which is operated by a person holding a current and valid pilot's license of a rating authorizing him to pilot such aircraft, or
(b) any transport-type aircraft operated by the Canadian Armed Forces or by the similar air transport service of any duly constituted governmental authority of the recognized government of any nation anywhere in the world, provided the aircraft is not being used for test or experimental purposes.

Notwithstanding (a) and (b) above, coverage excludes injury sustained while and in consequence of riding as a passenger, pilot, operator or member of the crew, in or on; boarding or alighting from; being struck by; or making a forced landing with or from any aircraft owned, operated or leased by the policyholder.

EXCLUSIONS

- active full-time service in the armed forces of any country;
- suicide or any attempt thereat or intentionally self-inflicted Injury, while sane or insane;
- injury sustained in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as provided in parts titled “Limited Air Travel Coverage” and “Aircraft Coverage”.

TERMINATION OF INSURANCE

Coverage will terminate immediately on the earliest of:

(a) the policy termination date;
(b) the premium due date if the Policyholder fails to pay the insured’s premium, except as a result of an inadvertent error;
(c) the premium due date coinciding with or immediately following the date an insured retires;
(d) the premium due date next following the date an insured is ineligible for coverage, except as provided under the part titled “Continuation of Coverage”.

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

BENEFICIARY

Indemnity payable in the event of the loss of life of an insured is payable to the beneficiary or beneficiaries designated in writing by the insured on his enrollment card on file with the Policyholder, or if there is no such beneficiary designation with respect to the insured, such indemnity is payable in accordance with the beneficiary designation in effect under the Policyholder's current Basic Group Life insurance policy and if there is no such beneficiary designation with respect to the insured, such indemnity is payable to the estate of the insured. All other indemnities payable are payable to the insured, with the exception of indemnities payable under the following parts:

- Bereavement Benefit
- Day Care Benefit
- Education Benefit
- Family Transportation Benefit
- Funeral Expense Benefit
- Identification Benefit
- Repatriation Benefit
- Spousal Retraining Benefit
- Workplace Modification and Accommodation Benefit

In the situation where the policy replaces an existing policy issued to the Policyholder, the designation recorded under the replaced policy will be deemed to be valid and of full force and effect under this policy until changed in writing by the insured.

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

This summary is for information purposes only. For further details, refer to the Master Policy which is on file with the Policyholder. The Master Policy sets forth in detail the terms and conditions of the Plan and all rights and obligations are determined in accordance with the Master Policy issued by Special Markets Solutions, a division of Industrial Alliance Insurance and Financial Services Inc., not this summary.

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Policy No. 100012340 issued by Special Markets Solutions, a division of Industrial Alliance Insurance and Financial Services Inc.

Classes 160, 162

COVERAGE

If you elect to participate, you will be covered for injuries sustained as the result of an accident anywhere in the world - 24 hours per day - on or off the job. You may also elect to insure your family.

AMOUNT OF INSURANCE

You may select any principal sum of insurance from a minimum of $5,000 in units of $5,000 to a maximum of $1,650,000 for yourself, combined with your Basic Accidental death and dismemberment Group insurance.

You may select any principal sum of insurance from a minimum of $5,000 in units of $5,000 to a maximum of $400,000 for your spouse
You may select any principal sum of insurance from a minimum of $5,000 in units of $5,000 to a maximum of $50,000 for each of your dependent children.

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

BENEFITS

Accidental Death, Dismemberment and Specific Loss Indemnity

The “loss” or “loss of use” must occur within 365 days of the date of the accident. These benefits are payable on a lump sum basis and in addition to any other benefits you may receive.

Life	100%
Both Arms or Both Hands	100%
Both Feet	100%
Entire Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and Entire Sight of One Eye	100%
One Foot and Entire Sight of One Eye	100%
Speech and Hearing in both Ears	100%
One Arm or One Leg	80%
One Hand or One Foot	75%
Entire Sight of One Eye	75%
Speech or Hearing in both Ears	75%
Hearing in One Ear	66 2/3%
Thumb and Index Finger of Either Hand	33 1/3%
Four Fingers of Either Hand	33 1/3%
All Toes of One Foot	25%
Quadriplegia (total paralysis of all four limbs)	200%
Paraplegia (total paralysis of the lower limbs)	200%
Hemiplegia (total paralysis of one side of the body)	200%

Bereavement Benefit

If an injury results in loss of life of a participant, the Company will pay the reasonable and necessary expenses actually incurred by the spouse and dependent children of the participant for up to six (6) sessions of grief counselling, by a professional counsellor. The maximum amount payable is $1,000 if the participant has selected single coverage. The maximum amount payable is $2,000.00 per family if the participant has selected coverage for his spouse and /or dependent children.

Comatose Benefit

If an injury does not cause loss of life but results in a coma or comatose state within 12 months after the date of the accident, the Company will pay 1% of the principal sum (less any sum paid under the Accidental Death, Dismemberment and Specific Loss Indemnity) for each month the coma or comatose state continues. Payments commence at the end of the waiting period of 31 days and are subject to a maximum of 100 consecutive months.

Continuation of Coverage

Coverage can be continued as described under the Policyholder's current Group Life policy, subject to continued payment of premiums.

Conversion Option

Upon termination of active employment with the Policyholder, a participant may convert his/her insurance only (and not that of his/her insured spouse or insured dependent children) to an individual accident insurance plan, with no evidence of insurability, for an amount of principal sum equal to or lower than the amount of principal sum in force at the time of termination. Application for conversion must be made within 90 days. Premiums become payable annually in advance. This benefit is restricted to Canadian resident Participants only.

Cosmetic Disfigurement Benefit ($25,000)

If an insured suffers a third degree burn, the Company will pay a percentage of the principal sum, depending on the area of the body which was burned according to the following table:

Cosmetic Disfigurement Benefit ($25,000) (cont'd)

Body Part	Area Classification (A)	Maximum Allowable Percentage for Area Burned (B)	Maximum Percentage of Principal Sum Payable (C)
		%	%
Face, Neck, Head	11	9.0	99.0
Hand and Forearm	5	4.5	22.5
Either Upper Arm	3	4.5	13.5
Torso (front or back)	2	18.0	36.0
Either Thigh	1	9.0	9.0
Either Lower Leg (below knee)	3	9.0	27.0

The maximum percent of principal sum payable (C) is determined by multiplying the area classification (A) by the maximum allowable percent for area burned (B). This table only represents the maximum percent of the principal sum payable for any one accident. If the insured suffers burns in more than one area, as a result of any one accident, benefits will not exceed the maximum amount stated above.

Day Care Benefit ($5,000)

If injury results in loss of life of a participant, the Company will pay 5% of the principal sum for each year the dependent child is enrolled in a legally licensed day care (not to exceed four years) for each dependent child who is under 13 years of age and enrolled in a legally licensed day care centre on the date of, or within 12 months following the accident.

Education Benefit ($5,000)

If injury results in loss of life of a participant, the Company will pay 5% of the principal sum for each year to any dependent child who, on the date of the accident, was enrolled as a full-time student in any institution of higher learning beyond the secondary school level (not to exceed four years). If, at the time of loss, none of the dependent children are eligible for the Education Benefit, the Company shall pay an additional amount of $2,500.00 to the designated beneficiary.

Exposure and Disappearance

If, as the result of an accident, an insured is unavoidably exposed to the elements and if, as a result of such exposure and within 12 months after the date of the accident, the insured suffers a loss for which indemnity would otherwise have been payable hereunder, such loss will be deemed to be the result of injury.

Where, due to the accidental wrecking, sinking or disappearance of a conveyance in which an insured was riding, the insured disappears, and if the body of the insured is not found within 12 months after the date of such wrecking, sinking or disappearance, it will be presumed, subject to there being no evidence to the contrary and subject to all other terms and conditions of the policy, that the insured suffered loss of life as a result of injury.

Extended Family Benefit

If an injury results in loss of life of a participant, and his/her spouse and dependent children are insured under this plan at the time of the death, this insurance may be continued for the insured spouse and insured dependent children for up to 6 months with no further payment or premium.

Family Transportation Benefit ($15,000)

If injury results in confinement as an inpatient in a hospital, and such injury results in a loss being payable under the Accidental Death, Dismemberment and Specific Loss Indemnity, and the hospital is located at least 100 km from the insured's residence, the Company will pay the expenses actually incurred by a member of the immediate family for hotel accommodation and transportation by the most direct route to the confined insured. If transportation occurs in a vehicle or device other than one operated under a license for the conveyance of passengers for hire, then reimbursement of transportation expenses will be limited to a maximum of $0.35 per kilometre travelled.

Funeral Expense Benefit ($5,000)

If injury results in loss of life, an additional amount is payable for funeral expenses actually incurred.

Home Alteration and Vehicle Modification Benefit ($15,000)

If injury requires the use of a wheelchair to be ambulatory, the Company will pay the cost of alterations to the insured's principal residence and/or the cost of modification to one motor vehicle utilized by the insured, provided such injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity.

Hospital Indemnity Expense ($2,500)

A daily benefit of 1/30 of 1% of the insured's principal sum, subject to the above-mentioned monthly maximum, will be payable when the insured is in a hospital if such period of hospitalization is necessary for the treatment of an injury which results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity of the policy and begins while insurance is in force.

A period of hospitalization necessary for an injury other than for a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity will be covered as stated above, provided such hospitalization is of at least a four-day period.

Identification Benefit ($5,000)

If injury results in loss of life, and requires body identification, the Company will pay the expenses actually incurred by a member of the immediate family for lodging, board and transportation by the most direct route, provided the body is located not less than 150 kilometres from the member of the immediate family's residence and the identification of the body is required by the police or a similar law enforcement agency having authority over such matters. If transportation occurs in a vehicle or device other than one operated under the license for the conveyance of passengers for hire, then reimbursement of transportation expenses will be limited to a maximum of $0.35 per kilometre travelled.

Permanent Total Disability

If an injury totally and permanently disables an insured within 12 months of the date of the accident, preventing the insured from engaging in any and every occupation, the Company will pay, provided such disability has continued for a period of 12 consecutive months and is total, continuous and permanent at the end of this period, the principal sum less any amounts already paid under the Accidental Death, Dismemberment and Specific Loss Indemnity as the result of the same accident.

Psychological Therapy Benefit ($5,000)

If injury results in a loss payable to an insured under the Accidental Death, Dismemberment and Specific Loss Indemnity and results in the insured requiring psychological therapy, as prescribed by a physician, the Company will pay the reasonable and necessary expenses actually incurred.

Rehabilitation Benefit ($15,000)

If injury requires that the participant undergo special training in order to be qualified to engage in a special occupation in which the participant would not have engaged except for such injury, the Company will pay the reasonable and necessary expense incurred for such training within three years of the date of the accident, provided such injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity.

Repatriation Benefit ($15,000)

If injury results in loss of life, the Company will pay the expense incurred for shipment of the body to the city of residence of the deceased.

Seat Belt Benefit ($50,000)

If injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity, the principal sum will be increased by 10% if, at the time of the accident, the insured was driving or riding in a vehicle and wearing a properly fastened seat belt.

Spousal Retraining Benefit ($15,000)

If injury results in loss of life of a participant, the Company will reimburse the spouse for the actual expenses incurred for a formal occupational training program in order to become qualified for active employment in an occupation in which the spouse would not otherwise have sufficient qualifications.

Waiver of Premium

In the event a participant becomes totally disabled and the Waiver of Premium Benefit has been approved and accepted by the Group Life carrier, then premium under this plan will be waived until the earlier of: death, recovery, attainment of age 65 or the date the policy is cancelled.

Workplace Modification and Accommodation Benefit ($5,000)

If injury requires special adaptive equipment and/or workplace modification for a participant to return to active full-time employment, the Company will pay the cost provided the policyholder agrees in writing to provide such modification and accommodation to the workplace for the purpose of making it accessible and adaptable to the needs of such participant; and the policyholder acknowledges in writing that the performance of the essential duties of such participant's occupation may be altered.

Aircraft Coverage (Passenger)

Coverage is extended to include injury sustained in consequence of riding as a passenger and not as a pilot or member of the crew; in boarding or alighting from or being struck by; or making a forced landing with or from any fixed-wing aircraft having a current and valid airworthiness certificate, or in the process of getting it and which is operated by a person holding a current and valid pilot's license of a rating authorizing him to pilot such aircraft.

The extended insurance afforded by this part does not apply to any loss fatal or non-fatal, caused by or resulting from Injury sustained while the Insured Person is:

(a) flying in any aircraft while it is being used for or in connection with acrobatic or stunt flying or racing;

(b) flying in any aircraft while it is being used for or in connection with crop dusting or seeding or spraying, pipe or power line inspection, any form of hunting, bird or fowl herding, banner towing, unless previously consented to in writing by the Company.

Aircraft Coverage (Passenger) (Cont'd)

The above-noted exclusions do not apply to endurance tests, demonstration or any test for experimental purpose, nor to carry passengers for hire and for any flight which requires a special permit or waiver from the authority having jurisdiction over civil aviation, even though granted.

Limited Air Travel Coverage

Coverage includes injury sustained in consequence of riding as a passenger and not as a pilot or member of the crew, in; boarding or alighting from; being struck by; or making a forced landing with or from:

(a) any aircraft having a current and valid airworthiness certificate and which is operated by a person holding a current and valid pilot's license of a rating authorizing him to pilot such aircraft, or
(b) any transport-type aircraft operated by the Canadian Armed Forces or by the similar air transport service of any duly constituted governmental authority of the recognized government of any nation anywhere in the world, provided the aircraft is not being used for test or experimental purposes.

Notwithstanding (a) and (b) above, coverage excludes injury sustained while and in consequence of riding as a passenger, pilot, operator or member of the crew, in or on; boarding or alighting from; being struck by; or making a forced landing with or from any aircraft owned, operated or leased by the policyholder.

EXCLUSIONS

- active full-time service in the armed forces of any country;
- suicide or any attempt thereat or intentionally self-inflicted Injury, while sane or insane;
- injury sustained in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as provided in parts titled "Limited Air Travel Coverage" and "Aircraft Coverage".

TERMINATION OF INSURANCE

Coverage will immediately terminate on the earliest of:

A. For the participant: (a) the policy termination date; (b) the premium due date if the Policyholder fails to pay the participant's premium, except as a result of an inadvertent error; (c) the premium due date coinciding with or immediately following the date a participant attains age 70; (d) the premium due date next following the date a participant is ineligible for coverage, except as provided under the part titled "Continuation of Coverage".

B. For the insured spouse and/or insured dependent child: (a) the date such person becomes ineligible for coverage; and (b) the date the participant's insurance is terminated.

BENEFICIARY

Indemnity payable in the event of the loss of life of a participant is payable to the beneficiary or beneficiaries designated in writing by the participant on his enrolment card on file with the Policyholder, or if there is no such beneficiary designation with respect to the participant, such indemnity is payable in accordance with the beneficiary designation in effect under the Policyholder's current Basic Group Life insurance policy and if there is no such beneficiary designation with respect to the participant, such indemnity is payable to the estate of the participant. All other indemnities payable, including those payable for the insured spouse and/or insured dependent children, are payable to the participant, with the exception of indemnities payable under the following parts:

- Bereavement Benefit
- Day Care Benefit
- Education Benefit
- Family Transportation Benefit
- Funeral Expense Benefit
- Identification Benefit
- Repatriation Benefit
- Spousal Retraining Benefit
- Workplace Modification and Accommodation Benefit

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

In the situation where the policy replaces an existing policy issued to the Policyholder, the designation recorded under the replaced policy will be deemed to be valid and of full force and effect under this policy until changed in writing by the participant.

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

This summary is for information purposes only. For further details, refer to the Master Policy which is on file with the Policyholder. The Master Policy sets forth in detail the terms and conditions of the Plan and all rights and obligations are determined in accordance with the Master Policy issued by Special Markets Solutions, a division of Industrial Alliance Insurance and Financial Services Inc., not this summary.

BUSINESS TRAVEL ACCIDENT GROUP INSURANCE

Policy No. 100012341 issued by Special Markets Solutions,
a division of Industrial Alliance Insurance and Financial Services Inc.

Classes 160, 162

COVERAGE AND AMOUNT OF INSURANCE

Your amount of insurance (Principal Sum) is 7 times your annual salary, rounded to the next higher $1,000 if not already a multiple thereof, to a maximum of $500,000 if an injury is sustained as the result of an accident while travelling on business of the Policyholder.

Coverage begins at the start of a business trip when you leave your home or your place of regular employment - whichever happens last - and continues until you return home or to your place of employment - whichever happens first. During this time, you are covered against all accidents 24 hours a day. *Everyday travel to and from work and bona fide leave of absence or vacations are excluded.* Benefits are payable in addition to any other insurance you may have.

BENEFITS

Accidental Death, Dismemberment and Specific Loss Indemnity

The “loss” or “loss of use” must occur within 365 days of the date of the accident. These benefits are payable on a lump sum basis and in addition to any other benefits you may receive.

Life	100%
Both Arms or Both Hands	100%
Both Feet	100%
Entire Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and Entire Sight of One Eye	100%
One Foot and Entire Sight of One Eye	100%
Speech and Hearing in both Ears	100%
One Arm or One Leg	75%
One Hand or One Foot	66 2/3%
Entire Sight of One Eye	66 2/3%
Speech or Hearing in both Ears	66 2/3%
Hearing in One Ear	33 1/3%
Thumb and Index Finger of Either Hand	33 1/3%
Four Fingers of Either Hand	33 1/3%
All Toes of One Foot	25%
Quadriplegia (total paralysis of all four limbs)	200%
Paraplegia (total paralysis of the lower limbs)	200%
Hemiplegia (total paralysis of one side of the body)	200%

Aircraft Coverage (Passenger)

Coverage is extended to include injury sustained in consequence of riding as a passenger and not as a pilot or member of the crew; in boarding or alighting from or being struck by; or making a forced landing with or from any fixed-wing aircraft having a current and valid airworthiness certificate, or in the process of getting it and which is operated by a person holding a current and valid pilot's license of a rating authorizing him to pilot such aircraft.

The extended insurance afforded by this part does not apply to any loss fatal or non-fatal, caused by or resulting from Injury sustained while the insured is:

(a) flying in any aircraft while it is being used for or in connection with acrobatic or stunt flying or racing;

(b) flying in any aircraft while it is being used for or in connection with crop dusting or seeding or spraying, pipe or power line inspection, any form of hunting, bird or fowl herding, banner towing, unless previously consented to in writing by the Company.

The above-noted exclusions do not apply to endurance tests, demonstration or any test for experimental purpose, nor to carry passengers for hire and for any flight which requires a special permit or waiver from the authority having jurisdiction over civil aviation, even though granted.

Exposure and Disappearance

If, as the result of an accident, an insured is unavoidably exposed to the elements and if, as a result of such exposure and within 12 months after the date of the accident, the insured suffers a loss for which indemnity would otherwise have been payable hereunder, such loss will be deemed to be the result of injury.

Where, due to the accidental wrecking, sinking or disappearance of a conveyance in which an insured was riding, the insured disappears, and if the body of the insured is not found within 12 months after the date of such wrecking, sinking or disappearance, it will be presumed, subject to there being no evidence to the contrary and subject to all other terms and conditions of the policy, that the insured suffered loss of life as a result of injury.

Limited Air Travel Coverage

Coverage includes injury sustained in consequence of riding as a passenger and not as a pilot or member of the crew, in; boarding or alighting from; being struck by; or making a forced landing with or from:

(a) any aircraft having a current and valid airworthiness certificate and which is operated by a person holding a current and valid pilot's license of a rating authorizing him to pilot such aircraft, or
(b) any transport-type aircraft operated by the Canadian Armed Forces or by the similar air transport service of any duly constituted governmental authority of the recognized government of any nation anywhere in the world, provided the aircraft is not being used for test or experimental purposes.

Notwithstanding (a) and (b) above, coverage excludes injury sustained while and in consequence of riding as a passenger, pilot, operator or member of the crew, in or on; boarding or alighting from; being struck by; or making a forced landing with or from any aircraft owned, operated or leased by the policyholder.

Permanent Total Disability

If an injury totally and permanently disables an insured within 12 months of the date of the accident, preventing the insured from engaging in any and every occupation, the Company will pay, provided such disability has continued for a period of 12 consecutive months and is total, continuous and permanent at the end of this period, the principal sum less any amounts already paid under the Accidental Death, Dismemberment and Specific Loss Indemnity as the result of the same accident.

EXCLUSIONS

- active full-time service in the armed forces of any country;
- suicide or any attempt thereat or intentionally self-inflicted Injury, while sane or insane;
- injury sustained in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as provided in parts titled “Limited Air Travel Coverage” and “Aircraft Coverage”.

TERMINATION OF INSURANCE

Coverage will terminate immediately on the earliest of:

(a) the policy termination date;

(b) the premium due date if the Policyholder fails to pay the insured's premium, except as a result of an inadvertent error;

(c) the date an insured reaches 70 years of age;

(d) the date an insured is ineligible for coverage.

BENEFICIARY

Indemnity payable in the event of the loss of life of an insured is payable to the beneficiary or beneficiaries designated in writing by the insured on his enrollment card on file with the Policyholder, or if there is no such beneficiary designation with respect to the insured, such indemnity is payable in accordance with the beneficiary designation in effect under the Policyholder's current Basic Group Life insurance policy and if there is no such beneficiary designation with respect to the insured, such indemnity is payable to the estate of the insured. All other indemnities payable are payable to the insured.

In the situation where the policy replaces an existing policy issued to the Policyholder, the designation recorded under the replaced policy will be deemed to be valid and of full force and effect under this policy until changed in writing by the insured.

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

This summary is for information purposes only. For further details, refer to the Master Policy which is on file with the Policyholder. The Master Policy sets forth in detail the terms and conditions of the Plan and all rights and obligations are determined in accordance with the Master Policy issued by Special Markets Solutions, a division of Industrial Alliance Insurance and Financial Services Inc., not this summary.

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