BELL TECHNICAL SOLUTIONS INC.

Policy No.: 28188

Classes 570, 580, 590, 650, 660, 670

GROUP INSURANCE PLAN

Policyholder: ***BELL TECHNICAL SOLUTIONS INC.***

Policy No.: ***28188***

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

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(underwritten with Special Markets Solutions, a division of Industrial Alliance Insurance and Financial Services Inc.)

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

570 – Ontario - Regular Non-Unionized Temporary Employees – Drugs Plan

580 – Ontario - Regular Non-Unionized Temporary Employees – Enhanced Plan (STD 66 2/3%)

590 – Ontario - Regular Non-Unionized Temporary Employees – Enhanced Plan (STD 80%)

650 – Ontario - Regular Unionized Temporary Employees – Drugs Plan

660 – Ontario - Regular Unionized Temporary Employees – Enhanced Plan (STD 66 2/3%)

670 – Ontario - Regular Unionized Temporary Employees – Enhanced Plan (STD 80%)

SPECIAL PROVISIONS (cont'd)

RULES AND GUIDELINES
WITH REGARDS TO CLASS CHANGES

- **Membership rules for a temporary employee eligible to the plan as of January 1, 2010**

  A participant who becomes eligible as a temporary employee may apply for drug coverage. This choice is optional.

  After one year's service, if the participant still has a temporary status, he may either keep his drug coverage, if applicable, choose an enhanced coverage, or choose not to participate to the plan. This choice is irrevocable unless a major event occurs (marriage, union, divorce, separation, death of spouse, birth or adoption of a first child, spouse's loss of coverage following termination of employment) which would cause a change in family status.

  When a participant becomes permanent, he will be transferred to classes 530, 540, 610, 620, 680* or 690*, according to his option for Short-term Disability Income Insurance.

  ** Classes 680 and 690 shall be considered classes of permanent employees according to the collective agreement.*

- **Option Changes for Short-Term Disability Income Insurance**

  A participant may only request an option change for Short-Term Disability Income Insurance after a period of 3 years.

GENERAL PROVISIONS

ELIGIBILITY DATE

Subject to all other provisions of the group policy, a temporary employee becomes eligible to drug coverage only on his first day of service with the employer (one year of continuous service for enhanced coverage).

NORMAL RETIREMENT AGE

For the purpose of the group policy, the normal retirement age shall be the first day of the month coincident with or next following the participant's 65th birthday.

PARTICIPANT'S LIFE INSURANCE

Classes 580, 590, 660, 670 only

Sum Insured

One times the annual salary, the result being rounded to the next higher $1,000, if not already a multiple thereof.

Maximum: $800,000

Minimum benefit: $30,000

Reduction:

This benefit is reduced by 50% on the participant's 65th birthday.

Termination:

This benefit terminates on the participant's date of retirement.

PARTICIPANT'S OPTIONAL LIFE INSURANCE

Classes 580, 590, 660, 670 only

Sum Insured

Units of $10,000

Maximum: $200,000

All amounts of optional life insurance require evidence of insurability.

Termination:

This benefit terminates on the participant's 65th birthday or the date of retirement, if earlier.

DEPENDENTS' LIFE INSURANCE

Classes 580, 590, 660, 670 only

Sum Insured

Spouse: [1]	$5,000
Each child upon a live birth:	$2,500

[1] **Reduction:**

This benefit is reduced by 50% on the participant's 65th birthday.

Termination:

This benefit terminates on the participant's date of retirement.

SPOUSE'S OPTIONAL LIFE INSURANCE

Classes 580, 590, 660, 670 only

Sum Insured

Units of $10,000

Maximum: $100,000

All amounts of optional life insurance require evidence of insurability.

Termination:

This benefit terminates on the insured person's 65th birthday or the participant's date of retirement, if earlier.

SHORT-TERM DISABILITY INCOME INSURANCE

Classes 580, 660:

Weekly Indemnity

66 2/3% of the weekly salary, the result being rounded to the next higher dollar, if not already a multiple thereof.

Weekly maximum: $1,400

Classes 590, 670:

Weekly Indemnity

80% of the weekly salary, the result being rounded to the next higher dollar, if not already a multiple thereof.

Weekly maximum: $1,400

Classes 570, 650: Not applicable

Reductions: The amount payable will be subject to the reductions stated in the benefit.

Elimination Period:	– Accident:	0 days
	– Hospitalization:	0 days
	– Illness:	7 consecutive calendar days
Elimination Period for **employees age 65 and over** of classes 660, 670:	– Accident:	7 consecutive calendar days
	– Hospitalization:	7 consecutive calendar days
	– Illness:	7 consecutive calendar days

For the purpose of determining the elimination period, any disability resulting from an accident which starts more than 30 days after the accident will be considered to be a disability resulting from an illness.

SHORT-TERM DISABILITY INCOME INSURANCE (cont'd)

Maximum Benefit Period: 26 weeks

Employees age 65 and over of classes 660, 670:

The maximum benefit period will be limited to 15 weeks per disability. An employee who had already been on disability leave must have been back to work for at least 90 days before once again being eligible for the Short-Term Disability Income Insurance. The insurer will not pay more than 26 weeks of Short-Term Disability Income Insurance for all disabilities combined of a same employee.

Benefits are taxable and are payable on a calendar day basis.

Termination:

Classes 580, 590:

This benefit terminates on the participant's 65th birthday or the date of retirement, if earlier.

Classes 660, 670:

This benefit terminates on the participant's 71th birthday or the date of retirement, if earlier.

LONG-TERM DISABILITY INCOME INSURANCE

Classes 580, 590, 660, 670 only

Monthly Indemnity

60% of the monthly salary, the result being rounded to the next higher dollar, if not already a multiple thereof.

Monthly maximum: $6,000

However, the overall maximum must not exceed 85% of the pre-disability gross monthly salary.

Reductions: The amount payable will be subject to the reductions stated in the benefit.

Elimination Period: 182 days

Payment of benefits will begin after satisfaction of the maximum benefit period provided under the Short-Term Disability Income Insurance benefit, if such benefit is included under the group policy.

Maximum Benefit Period: To the participant's 65th birthday

Benefits are taxable.

Termination:

This benefit terminates on the participant's 65th birthday or the date of retirement, if earlier.

SUPPLEMENTAL HEALTH INSURANCE
Classes 580, 590, 660, 670

HOSPITALIZATION IN THE PROVINCE OF RESIDENCE

Deductible:	Reimbursement:	Daily maximum:
none	100%	Semi-private room rate

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

ALL OTHER MEDICAL EXPENSES INCURRED IN CANADA

Deductible	
– Drugs [(1)]:	None
– Other expenses:	$25 per insured person, maximum of $50 per family
Reimbursement	
– Drugs [(1)]	
- individual protection:	90% of the first $7,000 of eligible expenses per insured person, per calendar year, and 100% of the excess. This amount includes all eligible drugs under the present plan.
- family protection:	90% of the first $14,000 of eligible expenses per family, per calendar year, and 100% of the excess. This amount includes all eligible drugs under the present plan.
– Diabetic supplies :	100%
– Other expenses:	100%
Maximum:	Unlimited

[(1)] *If the drug is a brand name product which has a generic equivalent, the amount payable will be based on the lowest priced interchangeable product.*

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

Termination:

This benefit terminates on the participant's date of retirement.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)
Classes 580, 590, 660, 670

Medical Expenses

Covered Expenses	Maximums Per Insured Person
All covered expenses included under the Medical Expenses Incurred in Canada section of the Supplemental Health Insurance benefit, other than those listed below	Unlimited.
Fees for nursing care	$10,000 per calendar year.
Antismoking aids	$500 per calendar year.
Obesity treatment drugs	$1,800 per calendar year.
Medical elastic stockings	3 pairs per calendar year.
Room and board in a convalescent home	Semi-private room rate; unlimited maximum.
Orthopedic shoes and alterations	$300 per calendar year.
Foot orthoses	$400 per pair.
Diagnostic laboratory (including prenatal tests) and x-ray procedure fees	$1,000 per calendar year
Ultrasounds	$300 per calendar year.
Glucometers	$300 per period of 5 years.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)
Classes 580, 590, 660, 670

Medical Expenses (cont'd)

Covered Expenses	Maximums Per Insured Person
Wheelchairs repairs	$250 per lifetime
Medical appliances and supplies	$10,000 per lifetime.
Blood pressure monitor and sphygmomanometer	Combined maximum of $500 per calendar year.
Substance abuse treatment facility	$80 per day; lifetime maximum of $2,500.
Wigs	$300 per lifetime.
Fees for the following paramedical practitioners: physiotherapists*, physical rehabilitation therapists* and physiatrists* * *upon medical recommendation*	Eligible maximum (1) of $35 per visit (2) and one treatment per day.
Fees for the following paramedical practitioners: psychologists and social workers	Combined maximum of $1,500 per calendar year.
Fees for the following paramedical practitioners: chiropractors (including x-rays)	Eligible maximum (1) of $30 per visit (2) and one treatment per day.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)
Classes 580, 590, 660, 670

Medical Expenses (cont'd)

Covered Expenses	Maximums Per Insured Person
Fees for the following paramedical practitioners: speech therapists*, audiologists* and occupational therapists* * *upon medical recommendation*	Maximum of $1,000 per calendar year for each practitioner and one treatment per day.
Fees for the following paramedical practitioners: naturopaths and homeopaths (including prescribed homeopathic products)	Eligible maximum [(1)] of $35 per visit [(3)] and one treatment per day.
Fees for the following paramedical practitioners: dieticians* * *upon medical recommendation*	Eligible maximum [(1)] of $25 per visit [(3)] and one treatment per day.
Fees for the following paramedical practitioners: osteopaths	Eligible maximum [(1)] of $35 per visit. Maximum of $1,000 per calendar year and one treatment per day, including one x-ray per calendar year.
Fees for the following paramedical practitioners: podiatrists [(4)] and chiropodists	Eligible maximum [(1)] of $45 per visit. Combined maximum of $1,000 per calendar year and one treatment per day, including one x-ray per practitioner, per calendar year.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)
Classes 580, 590, 660, 670

Medical Expenses (cont'd)

Covered Expenses	Maximums Per Insured Person
Breast prostheses, artificial eyes and myoelectric and electric artificial prostheses	$5,000 per prosthesis.
Hearing aids	$600 per period of 48 consecutive months.
Eye examinations	One examination per period of 12 consecutive months. **Eye examinations are not subject to the deductible and are reimbursed at 100 %.**

SUPPLEMENTAL HEALTH INSURANCE (cont'd)
Classes 580, 590, 660, 670

Medical Expenses (cont'd)

Eyeglasses (including sunglasses and safety glasses) and contact lenses	Eyeglasses (including sunglasses and safety glasses) and contact lenses up to a maximum of $50 per period of 12 consecutive months. However, eyeglasses and contact lenses, if medically necessary, are covered up to a maximum of $200 per lifetime for non-surgical treatment of keratoconus, and a maximum of $200 is applicable for expenses incurred within 6 months of each surgical procedure. **Eyeglasses (including sunglasses and safety glasses) and contact lenses are not subject to the deductible and are reimbursed at 100%.**

(1) Eligible maximum:

The amount payable with respect to a claim will be the amount equal to the Eligible Maximum shown for the covered expense less any amount which is due to the application of the deductible and percentage of reimbursement, if applicable.

(2) A maximum of $700 per calendar year is applicable for all practitioners combined.

(3) A maximum of $500 per calendar year is applicable for all practitioners combined.

(4) For Ontario residents, paramedical fees for a podiatrist are payable from the first visit.

SUPPLEMENTAL HEALTH INSURANCE

Classes 570, 650

MEDICAL EXPENSES INCURRED IN CANADA – DRUGS

Drugs only

Deductible:	$50 per insured person, maximum of $100 per family
Reimbursement	
– Individual protection:	75% of the first $2,600 of eligible expenses per insured person, per calendar year, and 100% of the excess. This amount includes all eligible drugs under the present plan.
– Family protection:	75% of the first $5,200 of eligible expenses per family, per calendar year, and 100% of the excess. This amount includes all eligible drugs under the present plan.
Maximum	
– Obesity treatment drugs:	$1,800 per calendar year
– Preventive immunization vaccines:	Unlimited
– Antismoking aids:	$500 per calendar year
– Drugs:	Unlimited
– Other expenses:	These expenses are not covered.

Termination:

This benefit terminates on the participant's date of retirement.

DENTAL CARE INSURANCE

Classes 580, 590, 660, 670 only

Deductible:	$25 per insured person Maximum of $50 per family
Reimbursement	
– Preventive treatments:	100%
– Basic treatments:	100%
(endodontics, periodontics and surgical treatments:	90%)
– Major treatments:	60%
Maximum per insured person	
– Preventive, Basic, Endodontics, Periodontics and Surgical treatments:	Unlimited
– Major treatments:	$1,500 per calendar year

Expenses are reimbursed according to the Dental Surgeons Association's Fee Guide for the previous year or, if applicable, the Dental Hygienists Association's Fee Guide for the previous year, subject to any limits which are stated under the Dental Care Insurance benefit.

For expenses incurred in Alberta, the prevailing fee guide is the 1997 Alberta Fee Guide plus any annual inflationary adjustment determined by the insurer.

Termination:

This benefit terminates on the participant's date of retirement.

DEFINITIONS

Accident: A sudden, violent and unforeseeable occurrence which is external to the person.

Actively at work: If it is a scheduled work day, the participant will be considered actively at work if he reports for work at his usual place of employment or at some other location where his employer's business requires him to be and when he so reports he is able to perform all of the usual and customary duties of his occupation on a regular and full-time basis.

If the participant is not at work due to it being a non-scheduled work day, holiday or vacation day, the participant will be considered to be actively at work if on such date he is neither (i) hospital confined nor (ii) disabled to a degree that he could not then have reported to his usual place of employment or some other location where his employer's business requires him to be and performed all of the usual and customary duties of his occupation on a regular, full-time basis.

Annual salary:

- Employees paid on a regular basis:
  The remuneration received from the employer, excluding bonuses, gratuities and any other form of remuneration.
- Hourly-paid employees on a regular schedule:
  The remuneration received from the employer, based on the hourly rate multiplied by 40 hours and by 52 weeks.
- Hourly-paid employees on a flexible schedule:
  The remuneration received from the employer, based on the weekly average regular hours worked over a period of 6 months multiplied by the hourly rate and by 52 weeks.

  The weekly average is adjusted and calculated as follows:

  January 1st: The salary is based on the average regular hours worked from June 1st to November 30th of the previous year.

July 1st: The salary is based on the average regular hours worked from December 1st of the previous year to May 31st of the current year.

Approval of evidence of insurability: The date of approval of any evidence of insurability shall mean the date the insurer receives the last document which allows it to accept the risk on the person.

Assignee: A person who is entitled to an insurance settlement.

Calendar year: The period from any January 1st to the next December 31st, both inclusive.

Day: A calendar day, except if otherwise defined in the group policy.

Dependent: The participant's spouse or a child of the participant or of the spouse. If dependents are insured under the group policy, "spouse" and "child" shall have the following meanings:

a) Spouse

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.

However, for a de facto spouse, a separation of more than 3 months will result in the person no longer qualifying as the participant's spouse for the purposes of the group policy.

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

b) Child

An unmarried child of the participant or of his spouse who wholly 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 26 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).

Eligibility period: The period, as specified in the Summary of Benefits, during which an employee must be actively at work before being eligible for coverage under the group policy.

Employee: A person who is employed by his employer on a temporary, full-time or part-time basis.

Full-time resident of Canada: Has a permanent residence in Canada and resides in Canada for at least 182 days a year.

Illness: Any deterioration in health requiring regular, continuous and curative care actively provided by a physician.

Insured person: A participant or a dependent of a participant who is insured under the group policy.

Monthly salary: The participant's annual salary divided by 12.

However, for calculating benefits for regular temporary employees, the monthly salary is calculated by using the average regular hours worked in a period of 6 months preceding the disability multiplied by the hourly rate on the date of the disability.

Normal retirement age: The age indicated in the Summary of Benefits.

Participant: An employee who is insured under the group policy.

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

Regular unionized temporary employee: A person hired as an employee on call, as required by the employer, who is affiliated with the Communications, Energy and Paperworkers Union of Canada and who has at least one year of service.

Regular non-unionized temporary employee: A person hired as an employee on call, as required by the employer, who is not affiliated with any union and who has at least one year of service.

Specialist: A physician licensed by the appropriate provincial licensing authority to practice medicine with a specialization.

Temporary employee: A person hired as an employee on call, as required by the employer.

Weekly salary: The participant's annual salary divided by 52.

However, for calculating benefits for regular temporary employees, the weekly salary is calculated by using the average regular hours worked in a period of 6 months preceding the disability multiplied by the hourly rate on the date of the disability.

CHANGES IN GOVERNMENT PLANS

The benefits provided under the group policy are complementary to the benefits provided by government plans. Any modifications to these 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 and the policyholder.

Notwithstanding the preceding paragraph, this plan 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 provide 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 or a benefit for a participant or a dependent; or

b) an increase, addition or change in the insurance or benefit 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 or benefit for which the evidence was provided; or

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

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

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 or benefit, the insurer's right to void the insurance or benefit 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 coverage under the group policy for such insurance.

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.

ELIGIBILITY

Employee

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 employee in the group policy.

b) He is a full-time resident of Canada.

c) He is covered under the provincial health plan of his province of residence.

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 Income Insurance benefit if he will attain age 65 before the end of the elimination period specified for the benefit under the Summary of Benefits.

Dependents

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 the following conditions:

a) He satisfies the definition of dependent in the group policy.

b) He is a full-time resident of Canada.

c) He is covered under the provincial health plan of his province of residence.

d) The employee of whom he is a dependent has become eligible to be insured under the group policy.

APPLICATION FOR GROUP INSURANCE

An employee who is eligible to become insured under the group policy 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 employee'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.

However, if the application for group insurance is not received within 31 days of the eligibility date for the dependents of a participant, the insurance will not take effect until the date on which the insurer receives and approves the person's evidence of insurability. The evidence of insurability will be provided at no expense to the insurer.

However, if

a) 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; or

b) 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 the insurer receives and approves the employee's evidence of insurability. If the participant's evidence of insurability should not be approved by the insurer, 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 it is approved by the insurer.

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;

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

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

d) The date the participant is no longer a full-time resident of Canada;

e) The date the participant is no longer covered by his provincial health plan;

f) The date of the participant's death;

g) The later of the following dates:

   i) the date indicated on a written notice received from the policy-holder;

   ii) the date this notice was received by the insurer;

h) The date the participant is incarcerated after committing a criminal offence for which he was found guilty;

i) The date the participant ceases to qualify as an employee 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 terminates on the earliest of the following dates:

a) The date the participant of whom he is a dependent ceases to be covered under the group policy;

b) The date the dependent ceases to be a dependent as defined in the group policy;

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

d) The date the dependent is no longer a full-time resident of Canada;

e) The date the dependent is no longer covered by the provincial health plan;

f) The later of the following dates:

   i) the date indicated on a written notice received from the policy-holder;

   ii) the date this notice was received by the insurer.

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

CLAIMS

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

  The insurer must receive notice of any claim for a Supplemental Health Insurance benefit or Dental Care Insurance benefit within 18 months of the date of the event which gives entitlement to the benefit.

  However, if the group policy terminates, notice of claim for a Supplemental Health Insurance benefit or Dental Care Insurance benefit must be submitted to the insurer within 90 days following termination of the group policy.

- **Life Insurance:**

  The insurer must receive notice of any claim for a Life Insurance benefit as soon as possible after the date of the event which gives entitlement to the benefit, but in any event within 6 years of the event.

- **Short-Term Disability Income Insurance:**

  The insurer must receive notice of any claim for a Short-Term Disability Income Insurance benefit within 3 months of the date of the commencement of the participant's disability.

- **Long-Term Disability Income Insurance:**

  The insurer must receive notice of any claim for a Long-Term Disability Income Insurance benefit within 3 months of the end of the participant's elimination period.

  If notice of a claim for a Long-Term Disability Income Insurance benefit is received more than 3 months after the end of the participant's elimination period, the insurer reserves the right to limit the participant's monthly indemnity benefit to the 3 months preceding the date the claim was received from the participant.

All notices of claims must be submitted to the insurer on the forms provided for that purpose by the insurer and must include all information that the insurer deems necessary for the assessment of the claim. If all information that is required by the insurer is not received, the insurer will have the right to deny the claim.

The insurer reserves the right to require additional proof or information regarding a claim whenever it deems necessary.

If notice of claim is not received by the insurer within the periods set out above or additional proof or information requested by the insurer is not provided, the insurer will have the right to deny the claim.

At the time of claim for a benefit which is based on the participant's salary, the amount of salary that will be used to determine the benefit will be the lesser of

a) the salary that the policyholder had last reported to the insurer and which has been used in the calculation of the premium payable; and

b) the participant's actual salary at the time of the event for which a claim is being made, as determined in accordance with the definition of salary included in the group policy.

However, for regular temporary employees, the amount of salary that will be used to determine the benefit is equivalent to the average regular hours worked in a period of 6 months preceding the disability multiplied by the hourly rate on the date of the disability.

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 has intentionally submitted a 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, the insurer will have the right to terminate the participant's entire coverage under this policy including any coverage for the participant's dependents, and will have the right to undertake the prosecution of the participant in accordance with provincial and/or federal law.

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 this 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.

This 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 OF A CLAIMANT

The insurer, at its own expense, shall have the right and opportunity, whenever it deems necessary, to require a medical examination, by a physician designated by it, of any person for whom a claim is submitted and to make an autopsy in case of death, where it is not forbidden by law. In addition, the insurer reserves the right to obtain the report of any medical practitioner who has examined the person for whom a claim was submitted.

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

SUBROGATION

(This provision is not applicable to the Life Insurance and Accidental Death and Dismemberment benefits, if applicable.)

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 (i) past, present or future loss of income, loss of wages, or loss of earnings, and (ii) 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 or settlement recovered. 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 or otherwise allocated.

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 the dependent. The insurer's recovery in this regard shall not exceed the participant or dependent's gross damages or settlement

recovered. The insurer shall also have the right to seek recovery directly from the participant or dependent 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 the 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/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 or dependent in accordance with its rights under the group policy.

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 the terms and conditions of this policy.

Every action or proceeding against an insurer for the recovery of insurance money payable under this contract 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 [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 the terms and conditions of this benefit and the group policy.

DEFINITION

As used in this benefit:

Disability and Disabled: A state of total and continuous incapacity, resulting from illness or accidental injury, which wholly prevents the participant from performing:

a) all of the essential duties of his regular employment during the first 26 weeks of disability and during the 24 months immediately following this period, regardless of the availability of such occupation; and

b) afterwards, any remunerated function or work for which he is reasonably qualified by training, education or experience, regardless of the availability of such occupation.

However, if the participant should be covered by a Long-Term Disability Income Insurance benefit under the group policy, the definitions of “disability” and “disabled” shall be as defined under such benefit.

CONVERSION PRIVILEGE

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

a) his employment;

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;

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 policy will include all amounts of life insurance that the participant was covered 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;

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

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;

d) $200,000.

The individual 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 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 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 insurance, the insurer shall pay an amount equal to that which he could have converted whether or not he made application for the individual policy.

WAIVER OF PREMIUM

a) A participant who becomes 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 Income Insurance benefit, if included in the group policy.

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

i) the participant was less than 65 years of age at the onset of disability;

ii) the participant became disabled as defined under this benefit, while insured under this benefit and before any termination of employment;

iii) the participant has been disabled for at least 6 continuous months;

iv) proof of disability, satisfactory to the insurer, was submitted to the insurer within 12 months of the onset of the disability. The evidence will be submitted at no expense to the insurer.

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 disability, and will be subject to any reductions and termination indicated in the Summary of Benefits 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 Income Insurance benefit, if applicable;

ii) the day following a continuous period of disability of 26 weeks.

d) The participant whose premiums are waived under this section must provide the insurer with proof of disability, as often as the insurer may reasonably require. Such proof will be provided at no expense to the insurer.

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

i) the date on which the participant ceases to be disabled;

ii) the date on which the participant fails to submit to an examination by the physician designated by the insurer;

iii) the date on which the participant retires or reaches the normal retirement age under the employer's pension plan, but never beyond the normal retirement age indicated in the Summary of Benefits of the group policy;

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;

v) the date on which the participant fails to provide any proof of disability required by the insurer;

vi) the date on which the participant is incarcerated after committing a criminal offence for which he was found guilty.

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

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.

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 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.

EXCLUSION

If a participant commits suicide, while sane or insane, less than 12 months after the date his coverage 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 12 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.

DEPENDENTS' LIFE INSURANCE

Upon the death of a dependent while insured under this benefit, the insurer undertakes to pay to the participant the sum insured, as indicated in the Summary of Benefits, subject to 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 life insurance is cancelled on or prior to the earlier of (i) his 65th birthday and (ii) his spouse's 65th birthday, due to the termination of

a) his employment;

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 is cancelled on or prior to the earlier of (i) his 65th birthday and (ii) 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;

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 policy will include all amounts of life insurance that the spouse is covered for under the group policy, 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 the spouse, if applicable;

b) the amount for which the spouse was insured immediately prior to the termination of his insurance; and

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; and

d) $200,000.

The individual policy shall not include a disability benefit nor an accidental death and dismemberment benefit and the premiums shall 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 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 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 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 policy.

SURVIVOR BENEFIT

At the participant's death, insurance under this benefit shall continue for his dependents who were covered under this benefit at the time of his death, without premium payment, until the earliest of

a) 12 months after the participant's death;

b) The date on which the dependents' insurance would have terminated had the participant then been living;

c) The termination date of this benefit.

SPOUSE'S OPTIONAL LIFE INSURANCE

A participant may obtain an amount of optional life insurance on his spouse if he so requests it in writing to the insurer and furnishes evidence of insurability satisfactory to the insurer.

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

Upon the death of the spouse while insured under this benefit the insurer undertakes to pay to the participant the sum insured at the time of death, subject to 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 life insurance is cancelled on or prior to the earlier of (i) his 65th birthday and (ii) his spouse's 65th birthday, due to the termination of

a) his employment;

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 is cancelled on or prior to the earlier of (i) his 65th birthday and (ii) 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.

SPOUSE'S OPTIONAL LIFE INSURANCE

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

a) permanent;

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 policy will include all amounts of life insurance that the spouse is covered for under the group policy, 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 the spouse, if applicable;

b) the amount for which the spouse was insured immediately prior to the termination of his insurance; and

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; and

d) $200,000.

The individual policy shall not include a disability benefit nor an accidental death and dismemberment benefit and the premiums shall 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 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 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 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 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 person insured for optional life insurance commits suicide, while sane or insane, less than 12 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 12 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.

SPOUSE'S OPTIONAL LIFE INSURANCE

SURVIVOR BENEFIT

At the participant's death, insurance under this benefit shall continue for his spouse who was covered under this benefit at the time of his death, without premium payment, until the earliest of

a) 12 months after the participant's death;

b) The date on which the spouse's insurance would have terminated had the participant then been living;

c) The termination date of this benefit.

SHORT-TERM DISABILITY INCOME INSURANCE

If a participant becomes disabled while insured under this benefit and while he is actively at work, the insurer will undertake to pay the participant the amount of weekly indemnity benefit specified herein for each week or part of a week during which such disability lasts, subject to the terms and conditions of this benefit and the group policy.

DEFINITIONS

As used in this benefit:

Hospitalization: Occupancy of a hospital room as an admitted bedridden patient, where a room and board charge has been made in connection with the confinement, or admittance as an out-patient for a surgical procedure.

Disability and Disabled: The participant is not able to perform substantially all of the essential duties of his own occupation, as determined by the insurer, due to an illness or injury. However, a participant who engages in any occupation or employment, except as specifically provided in this benefit, will be deemed to no longer be disabled.

Pre-disability gross weekly salary: The weekly salary applicable to the participant immediately prior to the date his disability commenced and prior to the deductions for income tax, contributions to the Canada or Quebec Pension Plan, Employment Insurance and the Quebec Parental Insurance Plan.

Pre-disability net weekly salary: The weekly salary applicable to the participant immediately prior to the date his disability commenced, less the deductions for Income Tax, Canada or Quebec Pension Plan, Employment Insurance and the Quebec Parental Insurance Plan.

Elimination period: The period specified in the Summary of Benefits during which the participant must be absent from work due to a disability before he can begin to receive weekly indemnity benefit payments.

PARTICULARS

Beginning of Benefit Payments

Payment of the weekly indemnity benefit begins following completion of the elimination period specified in the Summary of Benefits.

Amount of Benefit Payments

The amount of the weekly indemnity benefit payable is determined according to the formula set forth in the Summary of Benefits and will not exceed the weekly maximum amount specified.

Reduction of Benefit Payments

The weekly indemnity benefit payments will be reduced by:

a) Any benefits which are payable or which would have been payable due to his disability had a satisfactory application been made under

   i) a workers' compensation act;

   ii) a provincial automobile insurance law if the reduction is acceptable under the Employment Insurance Regulations;

   iii) the Quebec or Canada Pension Plan;

   iv) any similar law, act or plan to those listed in (i), (ii) and (iii);

   v) a provincial crime victims compensation act, except for the period during which employment insurance benefits would or could have been payable;

b) Any pension benefits that the participant receives from the Quebec or Canada Pension Plan;

c) Any payment received according to the employer's policy regarding continuation of salary, statutory holidays or sick leave;

d) Any damages for loss of income received from a third party which arise out of the same circumstances that caused the participant’s disability.

Termination of Benefit Payments

The weekly indemnity benefit payments cease 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 disabled participant reaches the age of termination, if any, indicated in the Summary of Benefits provided the participant has received at least 15 weeks of benefit payments; otherwise, on the date on which he has received 15 weeks of benefit payments;

d) The date on which the participant retires;

e) The date of the participant's death;

f) The date on which the participant fails to submit to an examination by the physician designated by the insurer;

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

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

i) The date on which the participant refuses to participate in good faith in a trial work, part-time work or modified work program or a rehabilitation program which the insurer has recommended;

j) The date the participant is capable of earning at least 80% of his pre-disability gross weekly salary, if he is involved in a trial work, part-time work or modified work program or a rehabilitation program as provided under the Work Re-Entry provision.

SUCCESSIVE PERIODS OF DISABILITY

If a participant who had been disabled returns to full-time active work and again becomes disabled while this benefit is in force, such disability will be considered a continuation of the previous disability provided he has been back at full-time active work for less than 15 consecutive days and the disability results from the same or related cause or causes as the previous disability.

However, if the successive period of disability is due to a cause or causes unrelated to the cause or causes of the previous period of disability, it will be considered to be a new disability and a new elimination period will apply.

EXCLUSIONS AND LIMITATIONS

a) The weekly indemnity benefit will not be payable for a disability resulting from one of the following causes:

   i) Civil unrest, insurrection or war, whether war be declared or not, or participation in a riot;

   ii) Voluntarily self-inflicted injury, while sane or insane;

   iii) Care which is not medically required or which is given for cosmetic purposes, unless such care is for an illness or an accidental injury.

b) The weekly indemnity benefit will not be payable:

   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 was kept in force during the leave, the elimination period will begin on the date the participant would have returned to work if not for his disability.

c) The weekly indemnity benefit will not be payable for any period the participant is not under the regular care and attendance of a physician, other than himself, who is a registered specialist in the field of medicine which is applicable to his disability, or is not undergoing a course of medical treatment or participating in a program of rehabilitation which, in the opinion of the insurer, is medically required.

d) The weekly indemnity benefit will not be payable to a participant who is out of Canada and the United States for a period of 90 consecutive days or more. The participant’s entitlement to the weekly indemnity benefit will be restored only upon the participant's return to Canada or the United States, subject to all other provisions of this benefit.

e) The weekly indemnity benefit will not be payable for a disability which occurs during a strike, lock-out or temporary lay-off, if the participant's benefit was not kept in force during the strike, lock-out or temporary lay-off.

However, if the participant's benefit was kept in force during the strike, lock-out or temporary lay-off, the elimination period will begin on the date the participant would have returned to work if not for his disability, provided that on the date the disability occurred he would have satisfied the definition of being actively at work during a non-scheduled work day.

f) The weekly indemnity benefit will not be payable to a participant who refuses to enter a trial work, part-time work or modified work program or a rehabilitation program which has been recommended by the insurer.

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 waiver of premiums for this benefit, under the same conditions.

However, the waiver of premiums will cease on the termination date of this benefit or the group policy.

WORK RE-ENTRY

If a disabled participant, after completion of his elimination period, participates in

a) a trial work, part-time work or modified work program, which has been approved by the insurer, or

b) a rehabilitation program, which has been approved by the insurer,

with the intent of returning to his own or any other occupation, and at such time he is incapable of earning at least 80% of his pre-disability gross weekly salary due to the illness or injury which caused his disability, he will still be considered by the insurer to be disabled and will continue to receive a weekly indemnity benefit.

The insurer reserves the right to require that a disabled participant engage in a rehabilitation program or a trial work, part-time work or modified work program which has been recommended by the insurer to assist him in returning to gainful

employment, if the insurer determines that the program is appropriate to the participant based on his disability, and his level of education, training or experience. If the participant does not co-operate or participate in the program, the participant will no longer be eligible to receive a weekly indemnity benefit.

If the disabled participant receives an income as a result of his participation in the rehabilitation program, trial work, part-time work or modified work program, the amount of the weekly indemnity benefit payable to him under the terms of this benefit will not be reduced unless the total of the weekly indemnity benefit he is receiving under this benefit, the income received from his participation in the program and the sources listed in the Reduction of Benefit Payments provision exceeds

a) 100% of his pre-disability gross weekly salary, if the weekly indemnity benefit is taxable to him, or

b) 100% of his pre-disability net weekly salary, if the weekly indemnity benefit is non-taxable to him. (For the purposes of this calculation, the income for the program shall be net.)

If the total of the weekly income he is receiving exceeds 100% of the salary, the amount of weekly indemnity benefit payable to him under the terms of this benefit will be reduced so that his total weekly income does not exceed 100% of such salary.

The insurer will pay the expenses incurred by the participant, other than usual employment expenses, which are associated with the approved trial work, part-time work or modified work program or rehabilitation program, provided the expenses were approved, in writing, by the insurer prior to being incurred.

If a participant becomes disabled while insured under this benefit and while he is actively at work, the insurer will undertake to pay the participant the amount of the monthly indemnity benefit specified herein for each month or part of a month during which such disability lasts, subject to the terms and conditions of this benefit and the group policy.

DEFINITIONS

As used in this benefit:

Disability and Disabled: During the participant's elimination period and the first 24 months following the elimination period, the participant is not able to perform substantially all of the essential duties of his own occupation and earn at least 80% of his indexed pre-disability gross monthly salary due to an illness or injury, as determined by the insurer.

Thereafter, the participant is not able to perform substantially all of the essential duties of his own or any other occupation for which he is reasonably qualified by training, education or experience and earn at least 70% of his indexed pre-disability gross monthly salary due to the illness or injury, as determined by the insurer.

However, a participant who engages in any occupation or employment, except as specifically provided in this benefit, will be deemed to no longer be disabled.

Indexed pre-disability gross monthly salary: The monthly salary applicable to the participant immediately prior to the date his disability commenced, increased each March 1st coincident with or next following the anniversary of the date on which the participant became entitled to a monthly indemnity benefit by the Consumer Price Index (as published by the Government of Canada) during the immediately preceding calendar year.

Pre-disability gross monthly salary: The monthly salary applicable to the participant immediately prior to the date his disability commenced and prior to the deductions for income tax, contributions to the Canada or Quebec Pension Plan, Employment Insurance and the Quebec Parental Insurance Plan.

Pre-disability net monthly salary: The monthly salary applicable to the participant immediately prior to the date his disability commenced, less the deductions for Income Tax, Canada or Quebec Pension Plan, Employment Insurance and the Quebec Parental Insurance Plan.

Elimination period: The period specified in the Summary of Benefits during which the employee must be disabled before he can begin to receive monthly indemnity benefit payments.

PARTICULARS

Beginning of Benefit Payments

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

Amount of Benefit Payments

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

Reduction of Benefit Payments

The monthly indemnity benefit will be reduced, after the application of the monthly maximum amount, 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 workers' compensation act;

c) a provincial automobile insurance law;

d) a provincial crime victims compensation act.

Moreover, the amount of the monthly indemnity income benefit payable by the insurer will be 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) his employer, (c) any government body, (d) a franchise or association insurance plan, (e) any group insurance or pension plan to which the policyholder or employer contributes, and (f) a third party in the form of damages for loss of income, will not exceed the overall maximum, as specified in the Summary of Benefits.

After the first reductions made for each of the sources listed in this provision, future cost of living adjustments made to amounts received from such sources will not bring about further reductions.

Termination of Benefit Payments

The monthly indemnity benefit payments cease 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 on which the participant retires or reaches the normal retirement age under the employer's pension plan, but never beyond the normal retirement age indicated in the Summary of Benefits of the group policy;

e) The date of the participant's death;

f) The date on which the participant fails to submit to an examination by the physician designated by the insurer;

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

h) The date on which the participant refuses to participate in good faith in a trial work, part-time work or modified work program or a rehabilitation program which the insurer has recommended;

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

SUCCESSIVE PERIODS OF DISABILITY

If the participant who had been disabled returns to full-time active work and again becomes disabled while this benefit is in force, such disability will be considered a continuation of the previous disability, provided

a) it is due to the same cause or causes as the previous disability;

b) during the elimination period, he has been back at full-time active work for less than 15 consecutive days; and

c) after the elimination period has been completed, he has been back at full-time active work for less than 6 months.

However, if the successive period of disability is due to a cause or causes unrelated to the cause or causes of the previous period of disability, it will be considered to be a new disability and a new elimination period will apply.

EXCLUSIONS AND LIMITATIONS

a) The monthly indemnity benefit will not be payable for a disability resulting from one of the following causes:

   i) Civil unrest, insurrection or war, whether war be declared or not, or participation in a riot;

   ii) Voluntarily self-inflicted injury, while sane or insane;

   iii) Care which is not medically required or which is given for cosmetic purposes, unless such care is for an illness or an accidental injury.

b) The monthly indemnity benefit will not be payable:

   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 was kept in force during the leave, the elimination period will begin on the date the participant would have returned to work if not for his disability.

c) The monthly indemnity benefit will not be payable for any period the participant is not under the regular care and attendance of a physician, other than himself, who is a registered specialist in the field of medicine which is applicable to his disability, or is not undergoing a course of medical treatment or participating in a program of rehabilitation which, in the opinion of the insurer, is medically required.

d) The monthly indemnity benefit will not be payable to a participant who is out of Canada and the United States for a period of 90 consecutive days or more. The participant's entitlement to the monthly indemnity benefit will be restored only upon the participant's return to Canada or the United States, subject to all other provisions of this benefit.

e) The monthly indemnity benefit will not be payable for a disability which occurs during a strike, lock-out or temporary lay-off, if the participant's benefit was not kept in force during the strike, lock-out or temporary lay-off.

However, if the participant's benefit was kept in force during the strike, lock-out or temporary lay-off, the elimination period of the monthly indemnity benefit will begin on the date the participant would have returned to work if not for his disability, provided that on the date the disability occurred he would have satisfied the definition of being actively at work during a non-scheduled work day.

f) The monthly indemnity benefit will not be payable to a participant who refuses to enter a trial work, part-time work or modified work program or a rehabilitation program which has been recommended by the insurer.

PRE-EXISTING CONDITION EXCLUSION

As used in this provision, "pre-existing condition" means an illness or injury

a) which was sustained or contracted, or

b) for the symptoms of which the participant was under treatment by a physician, or

c) for the symptoms of which a physician had undertaken an investigation or review of, or

d) for which the participant was taking medication as prescribed by a physician,

during the 12 months prior to the date on which the participant became covered under this benefit.

No monthly indemnity benefit will be payable for a disability

a) that resulted either directly or indirectly from, or was in any manner or degree associated with or occasioned by a pre-existing condition; and

b) which begins in the first 12 months after the participant became covered under this benefit.

This exclusion does not apply to a participant who has been working actively, with no absence related to the pre-existing condition, for 3 consecutive months after becoming insured.

However, if the group policy is a replacement policy, a monthly indemnity benefit will be payable for a disability due to a pre-existing condition, provided the participant

a) was covered under the previous policy on the date it was terminated; and

b) became covered under this benefit on the effective date of the group policy; and

c) was actively at work on the effective date of the group policy; and

d) was insured with similar coverage under a previous policy and provided the present provision was replaced within 31 days after the termination of that policy.

The monthly indemnity benefit payable to the participant will be determined in accordance with this benefit, but in no case will it exceed the previous policy's maximum monthly indemnity benefit.

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 waiver of premiums for this benefit, under the same conditions.

WORK RE-ENTRY

If a disabled participant participates in

a) a trial work, part-time work or modified work program, which has been approved by the insurer, or

b) a rehabilitation program, which has been approved by the insurer,

with the intent of returning to his own or any other occupation, and at such time he is incapable of earning at least 80% of his indexed pre-disability gross monthly salary due to the illness or injury which caused his disability, he will still be considered by the insurer to be disabled.

The insurer reserves the right to require that a disabled participant engage in a rehabilitation program or a trial work, part-time work or modified work program which has been recommended by the insurer to assist him in returning to gainful employment, if the insurer determines that the program is appropriate to the participant based on his disability, and his level of education, training or experience. If the participant does not co-operate or participate in the program, the participant will no longer be eligible to receive a monthly indemnity benefit.

If the disabled participant receives an income as a result of his participation in the rehabilitation program, trial work, part-time work or modified work program, the amount of the monthly indemnity benefit payable to him under the terms of this benefit will not be reduced unless the total of the monthly indemnity benefit he is receiving under this benefit, the income received from his participation in the program and the sources listed in the Reduction of Benefit Payments provision exceeds

a) 100% of his pre-disability gross monthly salary, if the monthly indemnity benefit is taxable to him, or

b) 100% of his pre-disability net monthly salary, if the monthly indemnity benefit is non-taxable to him. (For the purposes of this calculation, the income for the program shall be net.)

If the total of the monthly income he is receiving exceeds 100% of the salary, the amount of monthly indemnity benefit payable to him under the terms of this benefit will be reduced so that his total monthly income does not exceed 100% of such salary.

The insurer will pay the expenses incurred by the participant, other than usual employment expenses, which are associated with the approved trial work, part-

time work or modified work program or rehabilitation program, provided the expenses were approved, in writing, by the insurer prior to being incurred.

SURVIVOR BENEFIT

If a participant should die while he is receiving a monthly indemnity benefit or he was entitled to receive a monthly indemnity benefit under this benefit, the insurer will pay a benefit to his eligible survivor(s). If there is no eligible survivor on the date of his death, no benefit will be payable.

The amount of the benefit to be paid to the eligible survivor(s) will be equal to 3 times the net monthly indemnity benefit payment which was made or would have been made to the participant by the insurer immediately prior to his death.

If the benefit becomes payable to the children of a participant, the insurer will make the payment to the children or to the individual legally entitled to receive payment on behalf of the children. If two or more children are entitled to a benefit, they shall share the benefit equally.

As used above:

- **Eligible survivor:** The participant's spouse, children, or assignee thereof, if the participant has no spouse or children at the time of death.
- **Assignee:** Will be as defined under the definition of Assignee of the Definitions provision.
- **Spouse:** Will be as defined under the definition of Dependent of the Definitions provision.
- **Children:** Will be as defined under the definition of Dependent of the Definitions provision.

SUPPLEMENTAL HEALTH INSURANCE

The insurer undertakes to reimburse the medical expenses defined herein which are due to an injury, illness or pregnancy and which are incurred after the insured person became covered under this benefit, subject to the terms and conditions of this benefit and the group policy.

DEFINITIONS

As used in this benefit:

Disability and Disabled (classes 570 and 650 only): A state of total and continuous incapacity, resulting from illness or accidental injury, which wholly prevents the participant from performing:

a) all of the essential duties of his regular employment during the first 26 weeks of disability and during the 24 months immediately following this period, regardless of the availability of such occupation; and

b) afterwards, any remunerated function or work for which he is reasonably qualified by training, education or experience, regardless of the availability of such occupation.

Hospital: An institution which

a) is legally licensed by the appropriate government body;

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

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

Also included are legally licensed hospitals which provide specialized treatments for psychological disorders, drug and alcohol abuse, cancer, arthritis, and where convalescent or chronic care patients are cared for. However, nursing homes, homes for the aged, rest homes and other establishments providing similar care are excluded.

Convalescent home: An institution or health unit which

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

b) is intended for the care of bedridden patients.

Nursing homes, homes for the aged, rest homes, residential and long-term care centres and drug and alcohol treatment centres are excluded.

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

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 in the marketplace. The *generic* drug refers to any reproduction of the original drug.

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

Convention: Drugs which by law do not require a prescription, but which would not ethically be dispensed by a pharmacist without one.

Medically required: Certified by a physician as required to treat a condition which is detrimental to the patient's health.

HOSPITALIZATION IN THE PROVINCE OF RESIDENCE

Room and board charges made by a hospital in the insured person's province of residence which are in excess of the amount reimbursed by the government health plan, up to the daily maximum specified in the Summary of Benefits, provided:

a) the insured person is confined to the hospital on an in-patient basis;

b) the level of accommodation was specifically requested by the insured person; and

c) the insured person was hospitalized for acute care and not chronic or convalescent care.

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 medical emergency occurs during the first 180 days of the insured person's absence from his province of residence, or if 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;

b) the insured person's absence was due to business, a vacation or full-time attendance at an accredited educational institution; and

c) the provision of the services and supplies could not have been delayed until the insured person had returned to his province of residence without endangering his health.

If the insured person should become hospitalized outside Canada 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 the 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 condition, where the insured person was aware of the condition and the fact that it was not stable and under control at the time the absence from his province of residence began.

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 specified for the Hospitalization in the Province of Residence benefit;

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

d) Diagnostic, x-rays and laboratory services;

e) Paramedical services provided during a hospital confinement;

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.

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.

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

The following medical expenses are covered, up to the maximums specified in the Summary of Benefits:

a) Services rendered at the insured person's home by a registered nurse, registered nursing assistant, certified nursing assistant or licensed nurse, provided:

   i) the services were prescribed by a physician and pre-approved by the insurer;

   ii) the services are medically necessary;

   iii) the services fall within the scope of services provided by a registered nurse, registered nursing assistant, certified nursing assistant or licensed nurse; and

   iv) the registered nurse, registered nursing assistant, certified nursing assistant or licensed nurse is unrelated to the insured person and does not normally reside with him.

b) Licensed ambulance service in a medical emergency for 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.

c) Drugs (including preventive immunization vaccines, the vaginal ring Nuvaring and antismoking aids) which are dispensed by a pharmacist or a physician and which can only be obtained with a written prescription of a healthcare provider who is legally licensed to prescribe drugs, other than those drugs that are excluded under the Exclusions and Reductions provision of this benefit.

Drugs which by convention require a prescription such as, but not limited to, maintenance drugs that are used daily to treat an ongoing medical condition for an extended period of time, such as anti-anginal drugs, parasympathomimetics, anticholinergics, anti-arrhythmics, enzymatic debridements, cardiotropics, anti-coagulants and oral fibrinolytic agents, and drugs for the treatment of asthma, diabetes, cholesterol, hyperthyroidism, tuberculosis, glaucoma, potassium replacements or parkinsons, provided they are prescribed by a healthcare provider who is legally licensed to prescribe such drugs and dispensed by a pharmacist or a physician.

Insulin supplies, such as needles, syringes, lancets and diagnostic testing materials.

Injectable drugs.

Compounded prescriptions containing one eligible ingredient.

Obesity treatment drugs, if an exception form completed by a physician is provided and pre-approval from the insurer has been obtained.

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 34 day period, except in the case of drugs for long-term therapy (maintenance drugs) for which up to a 100 day supply is allowable.

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 this policy or a material change in risk for the insurer in general.

If the drug is a brand name product which has a generic equivalent, the amount payable will be based on the lowest priced interchangeable product.

d) Room and board charges made by a convalescent home, while the insured person is under the supervision of a physician or registered nurse, provided the confinement was recommended by a physician.

e) Charges for diagnostic laboratory tests (including prenatal tests), ultrasounds and x-rays, other than x-rays by a chiropractor, an osteopath, a podiatrist or a chiropodist, provided

   i) coverage for these expenses is not prohibited by provincial legislation;

   ii) the tests and x-rays are performed in a facility licensed to perform such tests and services; and

   iii) the tests and x-rays are required for the diagnosis of an illness or injury or to determine the effectiveness of the treatment being prescribed or received.

f) Fees for the care provided by one of the paramedical practitioners listed in the Summary of Benefits provided the practitioner is licensed by the appropriate provincial or federal organization to practice his profession in accordance with the rules of his profession.

   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.

g) Charges for x-rays by a chiropractor, an osteopath, a podiatrist and a chiropodist.

h) Charges for the rental of, or at the insurer's option, the purchase of the following medical appliances and supplies provided they are prescribed by a physician:

i) artificial eyes, including repairs and replacements;

ii) artificial prostheses, including repairs and replacements;

iii) glucometers and other diabetic monitoring and administration equipment other than the insulin supplies such as needles, syringes, lancets and diagnostic testing materials;

iv) transcutaneous nerve stimulator;

v) intermittent positive pressure breathing machine;

vi) breast prostheses;

vii) medical elastic stockings prescribed for the treatment of varicose veins or required as a result of severe burns or surgery;

viii) regular orthopedic shoes or orthopedic shoes (including alterations) which have been custom made, customized or custom molded for the insured person, provided they are prescribed by a physician, a podiatrist, a chiropodist or a chiropractor. *Athletic* orthopedic shoes or alterations to *athletic* shoes are excluded;

ix) foot orthoses which have been specifically designed and constructed for the insured person, provided they are prescribed by a physician, a podiatrist, a chiropodist or a chiropractor;

x) intrauterine devices;

xi) splints, other than dental splints, and casts (plaster of Paris or fiberglass casts);

xii) canes, crutches and walkers;

xiii) hernia belts;

xiv) braces, provided they are not solely for athletic use;

xv) wigs required as a result of chemotherapy or radiotherapy;

xvi) catheters;

xvii) therapeutic equipment and supplies, such as:

- oxygen tents and supplies for its administration;
- mist tents, nebulizers for cystic fibrosis, acute emphysema, chronic obstructive bronchitis or chronic asthma;
- manually operated wheelchairs, or electric wheelchairs (including repairs) when the insured person is incapable of operating a manual wheelchair due to a medical condition;
- manually operated hospital beds or electrically operated hospital beds when the insured person is incapable of operating a manually operated hospital bed due to a medical condition, including bed rails and trapeze bars;
- apnea monitors for respiratory disrhythmias;
- braces with rigid support; back supports; shoulder harnesses; head halters, cervical collars and traction kits;
- colostomy and ileostomy apparatus and supplies;

xviii) blood pressure monitor and sphygmomanometer.

i) Charges made by a substance abuse treatment facility (including cost of room and board and nursing care) provided

i) care is prescribed by a physician;

ii) the insured person is involved in a substance abuse treatment program at the facility;

iii) the facility is a legally licensed facility providing care and treatment on a regular basis to individuals who are involved with substance abuse and is operating in accordance with the laws of the jurisdiction in which it is located, and

iv) the insurer has approved the facility prior to the charges being incurred.

j) Dental care given out of hospital by a dentist which is required as a result of accidental injury to whole, healthy, natural teeth, provided

i) the accidental injury occurs while the insured person is covered under this benefit;

ii) the care is the least expensive that will provide a professionally adequate treatment;

iii) the charges do not exceed the amount shown for the treatment in the current provincial fee schedule for general practitioners in the insured person's province of residence; and

iv) the care is received within 12 months of the date of the accidental injury.

Any charges for dental care which is not related to the accidental injury will not be covered.

k) Charges for hearing aids or any related devices (including repairs and replacements but not batteries), and the professional services given by a hearing aid acoustician following the purchase of the hearing aid or related device provided they have been prescribed by a physician, audiologist or speech therapist.

l) Fees for cosmetic surgery needed following an accident which occurred while the person was insured, provided treatments begin within 12 months of the date of the accident and end within 36 months of that date.

m) Charges for eye examinations when performed by an ophthalmologist or an optometrist.

n) Charges for eyeglasses (including repairs, sunglasses and safety glasses) or contact lenses, when prescribed by an ophthalmologist or an optometrist.

Eyeglasses and contact lenses are considered medically necessary when prescribed by an ophthalmologist following a surgical procedure (including cataracts) or for the treatment of keratoconus.

EXCLUSIONS AND REDUCTIONS

This benefit does not cover any expense

a) Payable or reimbursable under a workers' compensation act or would have been payable if the claim had been submitted;

b) For an illness or injury which was voluntarily self-inflicted, while sane or insane;

c) For an illness or injury resulting from civil unrest, insurrection or war, whether war be declared or not, or participation in a riot;

d) For treatment or appliances to correct vertical dimension or any temporomandibular joint dysfunction;

e) For care or treatment which is not medically required, which is given for cosmetic purposes or for any reason other than curative, which exceeds the normal care or treatment given in accordance with current therapeutic practice, or is of an experimental nature;

f) For 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;

g) For care or treatment of an illness or injury that is not recognized as normal, customary and common practice for such illness or injury;

h) For any portion of a charge for care or treatment which is in excess of the reasonable and customary charge normally incurred for an illness or injury of the same nature and severity in the locality where the service is provided;

i) For any care or treatment rendered free of charge or which would have been free of charge were it not for insurance coverage or which is not chargeable to the insured person;

j) For care or follow-up treatment given at home by a medical auxiliary;

k) For rest cures or travel for reasons of health;

l) For eye examinations, except if specifically mentioned as being covered under this benefit;

m) For eyeglasses and contact lenses, except if specifically mentioned as being covered under this benefit;

n) For care or treatment related to fertility or infertility;

o) For the purchase or rental of any comfort or massage apparatus, and of domestic accessories that are not exclusively required for medical purposes;

p) For any services or supplies which are for the sole purpose of facilitating the insured person's participation in sports or recreational activities and not for daily living activities;

q) For care or treatment of (including breaking the addiction to) such conditions as, but not limited to, obesity, smoking, drug addiction and alcoholism, except if specifically mentioned as being covered under this benefit;

r) For preventive immunization vaccines or the administration of serums, vaccines and injectable medications, except if specifically mentioned as being covered under this benefit;

s) For contraceptives (other than oral or the vaginal ring Nuvaring), except if mention is made that these expenses are covered under this benefit;

t) For the following products unless such products can only be obtained with a written prescription of a healthcare provider who is legally licensed to prescribe them and they are required to be dispensed by a pharmacist or a physician:

- 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, vitamin supplements or multivitamins;
- minerals;
- homeopathic products, except if specifically mentioned as being covered under this benefit;
- anabolic steroids;

u) For any drugs which are considered lifestyle drugs such as, but not limited to, drugs for the treatment of infertility, erectile dysfunction, loss of hair or lack of growth;

v) For any drugs which are excluded from coverage by the insurer under the Dispensing Limitations provision of this benefit;

w) For any prescriptions which are dispensed by a clinic or by any non-accredited hospital pharmacy or for treatment as an out-patient in a hospital, including emergency status and investigational status drugs;

x) For any care or treatment received outside of Canada due to a medical emergency which is related to (i) a pregnancy, if the medical emergency

occurs after the 32nd week of gestation or (ii) the deliberate inducement of a miscarriage;

y) For any 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 and, in the reasonable opinion of the insurer, does not meet the industry standards relevant to his profession.

The amount of benefit payable will be reduced by any benefit that is payable or reimbursable (i) under a government plan, a group plan or an individual plan, or that would have been payable had the person submitted a claim under such plan or (ii) by a third party as a result of a legal action or settlement.

CALCULATION OF REIMBURSEMENT

Deductible

The deductible, if any, must be paid by the insured person during the calendar year before any benefits are payable under this benefit. The deductible is specified in the Summary of Benefits.

Reimbursement

The insurer will reimburse the percentage of covered expenses incurred, as specified in the Summary of Benefits, once the deductible has been satisfied.

Maximum Benefit Per Insured Person

The maximum amount that will be reimbursed by the insurer under this 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.

SURVIVOR BENEFIT

If the participant dies while covered under this benefit and prior to any extension of coverage as provided for under the Extension of Benefits provision, insurance under this benefit shall continue for his dependents who were covered under this benefit at the time of his death, without premium payment, until the earliest of

a) 12 months after the participant's death;

b) The date on which the dependents' insurance would have terminated had the participant then been living;

c) The termination date of this benefit.

EXTENSION OF BENEFITS

If on the date an insured person's coverage under this benefit is discontinued, the insured person is disabled, a benefit will be payable for covered health care expenses directly related to the disability provided:

a) the expenses are incurred within 90 days of the date the coverage was discontinued; and

b) this benefit is in force when the expenses are incurred.

As used in this provision, "disabled" and "disability" mean

a) with respect to a participant, his complete incapacity due to an illness or injury to perform his own occupation; and

b) with respect to a dependent, that the dependent, due to a medically determinable physical or mental impairment, is confined to a hospital or is receiving treatment by a physician.

WAIVER OF PREMIUMS

Classes 580, 590, 660 and 670:

A participant whose premiums are waived under the article Waiver of Premiums of his life insurance benefit is also entitled to waiver of premiums for the present benefit, under the same terms and conditions.

However, waiver of premiums ceases on the termination date of the benefit or the group policy.

Classes 570 and 650:

a) A participant who becomes disabled will be eligible to have his premiums waived for this benefit provided:

   i) the participant was less than 65 years of age at the onset of disability;

   ii) the participant became disabled as defined under this benefit, while insured under this benefit and before any termination of employment;

   iii) the participant has been disabled for at least 6 continuous months;

iv) proof of disability, satisfactory to the insurer, was submitted to the insurer within 12 months of the onset of the disability. The evidence will be submitted at no expense to the insurer.

b) The participant's premiums will begin to be waived on the day following a continuous period of disability of 26 weeks.

c) The participant whose premiums are waived under this section must provide the insurer with proof of disability, as often as the insurer may reasonably require. Such proof will be provided at no expense to the insurer.

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

i) the date on which the participant ceases to be disabled;

ii) the date on which the participant fails to submit to an examination by the physician designated by the insurer;

iii) the date on which the participant retires or reaches the normal retirement age under the employer's pension plan, but never beyond the normal retirement age indicated in the Summary of Benefits of the group policy;

iv) the date on which the participant fails to provide any proof of disability required by the insurer;

v) the date on which the participant is incarcerated after committing a criminal offence for which he was found guilty;

vi) the date on which the benefit is terminated;

vii) the date on which the group policy is terminated.

CONVERSION PRIVILEGE

A participant whose coverage under this 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 premium for the individual insurance contract within 60 days of the termination date of his insurance under the policy. 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.

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 covered by the Supplemental Health Insurance benefit at the time of the emergency;

b) the emergency occurs during the first 180 days of the insured person's absence from his province of residence, or if the absence is due to his attendance at an accredited educational institution on a full-time basis, the emergency occurs during the school year for which he is enrolled at the institution;

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

d) 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 benefit.

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.

DEFINITION

As used in this benefit:

Member of the immediate family: The insured person's spouse, father, mother, child, brother or sister.

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 general practitioners or specialists in order to obtain the best medical care available in the area;
- Provide assistance with admittance to a hospital;
- Confirm to doctors and hospitals that the insured person's group policy will cover the insured person's medical expenses.

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 benefit;

- 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.

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, up to a maximum of $3,000. Funeral expenses will not be covered.

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 Insured Person's Immediate Family

- The Medical Assistance Service provider will organize the return of the insured person and/or a member of the insured person's 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 imme-

diate 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 $1,500.

  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 they are covered under the Supplemental Health Insurance benefit.

SUPPLEMENTAL HEALTH INSURANCE – EMERGENCY OUT OF PROVINCE ASSISTANCE

PERSONAL EMERGENCY TRAVEL ASSISTANCE SERVICES

The following services will be provided during a personal emergency:

a) Telephone Interpretation Service

- In case of emergency, the Medical Assistance Service provider will provide the insured person with telephone interpretation services in most foreign languages.

b) Messages

- In case of emergency, the Medical Assistance Service provider will relay a message, upon request, from the insured person at 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

- In case of emergency, 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

The medical emergency assistance services provided under this benefit will be subject to the exclusions that are applicable to the Emergency Medical Expenses Incurred Outside the Province of Residence section of the Supplemental Health Insurance benefit.

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 doctors, 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 doctors, 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 to cover a charge that had been made or a charge was paid, and the participant submits to the insurer such charge as a covered expense under the Supplemental Health Insurance benefit at a later date, the insurer will only reimburse the participant an amount, less that which was previously advanced or paid for such expense, subject to the deductible and reimbursement level that is 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

SUPPLEMENTAL HEALTH INSURANCE – EMERGENCY OUT OF PROVINCE ASSISTANCE

Medical Expenses Incurred Outside the Province of Residence section of the Supplemental Health Insurance benefit 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.

DENTAL CARE INSURANCE

The insurer undertakes to reimburse the insured person's dental care expenses which are incurred after the insured person became covered under this benefit, subject to the terms and conditions of this benefit and the group policy.

DEFINITIONS

As used in this benefit:

General practitioner: A licensed dentist who practices dentistry without specialization.

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

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

Expenses incurred: Any fee corresponding to a professional procedure which has been 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 the dentures are installed.

Time units: A unit of time is equivalent to 15 minutes.

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.

DENTAL EXPENSES

Only those items included below which are specified in the Summary of Benefits will be considered "eligible expenses" provided they were rendered by a general practitioner, a specialist on the recommendation of a general practitioner or by a dental hygienist.

Preventive and Basic Treatments

a) Examinations and Diagnoses
   - i) complete oral examination: once every 36 months
   - ii) recall oral examination: once every 6 months
   - iii) emergency oral examination: twice every 12 months
   - iv) specific oral examination
   - v) house call, hospital call or office visit

b) Tests and Laboratory Examinations
   - i) microbiologic culture
   - ii) biopsy of tissues
   - iii) cytologic smear
   - iv) diagnostic casts

c) X-rays
   - i) periapical films
   - ii) occlusal films
   - iii) interproximal films
   - iv) extra-oral films
   - v) sialographies
   - vi) radiopaque dyes to demonstrate lesions
   - vii) temporomandibular joint films
   - viii) panoramic films: once every 36 months
   - ix) cephalometric films

x) interpretation of x-rays from another source

xi) duplicates

d) Preventive Services

i) polishing of coronal portion of teeth: once every 6 months

ii) scaling of coronal portion of teeth and root planing: 8 units of time per calendar year for insured persons residing outside Quebec

iii) topical application of fluoride: once every 6 months for children aged 14 and under

iv) initial oral hygiene instruction: once per lifetime

v) nutritional counselling: once per lifetime

vi) finishing restorations

vii) plaque control program: 5 visits per calendar year

viii) pit and fissure sealants (for children aged 14 and under)

ix) caries control

x) interproximal discings (for children aged 14 and under)

xi) enameloplasty

xii) space maintainers (for children aged 14 and under)

e) Restorative

i) amalgam

ii) bonded amalgam

iii) acrylic or composite: the equivalent of an amalgam restoration is reimbursed when composite restoration on a molar is claimed

f) Anesthesia

Endodontics, Periodontics and Surgical Care

a) Endodontics

i) pulpotomy

ii) root canal therapy

iii) retreatment of root canal
iv) periapical treatments
v) emergency treatments
vi) other endodontics care

b) Periodontics
i) non-surgical services
ii) surgical services
iii) post-surgical treatments
iv) occlusal equilibration
v) additional care

c) Surgical care
i) surgical removal (uncomplicated)
ii) surgical removal
iii) surgical exposure
iv) alveoloplasty
v) surgical movement of tooth
vi) incision
vii) fractures
viii) frenectomy
ix) miscellaneous surgical services

Major Treatments

a) Crowns, inlays and onlays
i) prefabricated post (pivot)
ii) gold foil restorations
iii) inlays

iv) onlays

v) crowns

vi) other restorative services

b) Fixed bridges

i) pontics

ii) abutments

iii) repairs

iv) butterfly bridge (Rochette) or Maryland

v) other services

c) Complete and partial dentures - removable

i) complete dentures

ii) partial dentures

d) Repairs and adjustments

i) remake

ii) adjustments

iii) bridge repairs

iv) other curative services

v) relining and rebasing

Expenses for the replacement of an existing removable denture, bridge, crown or inlay are eligible if the removable denture, bridge, crown or inlay has been in place for at least 5 years. These expenses are limited to the cost and quality of the original removable denture, bridge, crown or inlay.

EXCLUSIONS AND REDUCTIONS

This benefit does not cover any expenses:

a) Related directly or indirectly to a full mouth reconstruction, to correct vertical dimension or any temporomandibular joint dysfunction;

b) Related to any appliance which is to be worn by the insured person during his participation in sports or recreational activities;

c) Which are payable or reimbursable under a workers' compensation act, or would have been payable if the claim had been submitted;

d) For services and supplies resulting from voluntarily self-inflicted injury, while sane or insane;

e) For services and supplies resulting from civil unrest, insurrection or war, whether war be declared or not, or participation in a riot;

f) For services and supplies which are not medically required, which are given for cosmetic purposes or for any reason other than curative, or which exceed the normal services and supplies given in accordance with current therapeutic practice;

g) For services and supplies rendered free of charge or which would be free of charge were it not for insurance coverage or which are not chargeable to the insured person;

h) For implants and services related to implants such as, but not limited to, surgical services, except if specifically mentioned as being covered under this benefit.

The amount of benefit payable will be reduced by any benefit that is payable or reimbursable (i) under a government plan, a group plan or an individual plan, or that would have been payable had the person submitted a claim under such plan, or (ii) by a third party as a result of a legal action of settlement.

TREATMENT PLAN

If the total cost of a course of treatment is expected to exceed $500, a treatment plan should be submitted to the insurer who will determine, before commencement of the treatment, the amount of eligible expenses.

"Treatment plan" means a written description of the course of 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 the treatment.

PAYMENT OF BENEFITS

Fees

Eligible expenses will be reimbursed according to the appropriate Fee Guide of the year specified in the Summary of Benefits, subject to any limits stated in the benefit.

Expenses incurred in Canada, other than expenses related to services provided by a denturist, will be limited to the normal rate suggested for general practitioners in the province where the expenses were incurred.

Expenses incurred for services provided by a denturist are limited to the normal suggested fee for denturists of the province where the expenses were incurred.

Expenses incurred outside Canada are limited to the normal rate suggested for general practitioners in the insured person's province of residence.

Proof

Before paying benefits, the insurer may require, 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 it deems necessary, require laboratory or hospital reports, x-rays, casts, molds or models used for examination purposes, or any other similar evidence.

Alternative Treatment Plan

If more than one type of treatment exists for the dental condition of the insured person, the insurer will limit reimbursement to the least expensive treatment that will produce a professionally adequate result with respect to the insured person's condition.

CALCULATION OF REIMBURSEMENT

Deductible

The deductible, if any, must be paid by the insured person during the calendar year before any benefits are payable under this benefit. The deductible is specified in the Summary of Benefits.

Reimbursement

The insurer will reimburse the percentage of eligible expenses incurred as specified in the Summary of Benefits, once the deductible has been satisfied.

Maximum Benefit Per Insured Person

The maximum amount that will be reimbursed by the insurer is specified in the Summary of Benefits.

In the case of any dependent becoming insured more than 31 days following his eligibility date, the reimbursement for dental expenses during the first 12 months of coverage will be limited to $250.

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.

SURVIVOR BENEFIT

If the participant dies while covered under this benefit and prior to any continuation of coverage as provided under the Extension of Benefits provision, insurance under this benefit shall continue for his dependents who were covered under this benefit at the time of his death, without payment of premium, until the earlier of:

a) 12 months after the participant’s death;

b) The date on which the dependent’s insurance would have terminated had the participant then been living;

c) The termination date of this benefit.

EXTENSION OF BENEFITS

If insurance under this benefit is terminated, covered expenses incurred after the termination date are not payable, regardless of the fact that a Treatment Plan may have been filed and benefits approved by the insurer, unless the dental treatment is provided within 31 days following the termination date and, as of the date of termination,

a) the impression had been taken for full or partial dentures but the dentures have not yet been installed; or

b) the tooth had been prepared for fixed bridges, crowns, onlays, inlays or gold restorations; or

c) the pulp chamber had been opened for root canal therapy.

WAIVER OF PREMIUMS

A participant whose premiums are waived under the article Waiver of Premiums of his life insurance benefit is also entitled to waiver of premiums for the present benefit, under the same terms and conditions.

However, waiver of premiums ceases on the termination date of the benefit or the group policy.

CONVERSION PRIVILEGE

A participant whose coverage under this 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 premium for the individual insurance contract within 60 days of the termination date of his insurance under the policy. 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 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.

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.

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 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

ANNEX – BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Classes 580, 590, 660, 670 only

Policy No. 100007510 issued by Special Markets Solutions, a division of Industrial Alliance Insurance and Financial Services Inc.

You are covered for a principal sum amount equal to the amount of your basic group life insurance, if an injury is sustained as the result of any accident anywhere in the world - 24 hours per day - on or off the job. Benefits shall be reduced by 50% upon attainment of age 65.

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.

	% of Principal Sum
Life	100%
Both Hands or Both Feet	100%
Entire Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and Entire Sight of One Eye or 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 or Speech or Hearing in both Ears	75%
Thumb and Index Finger of Either Hand or Four Fingers of Either Hand	40%
Hearing in One Ear	40%
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%

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.

Identification Benefit ($10,000)

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.

Spousal Retraining Benefit ($15,000)

If injury results in the 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.

Education Benefit ($10,000)

If injury results in loss of life, the Company will pay 5% of the principal sum 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, there are no dependent children eligible for the Education Benefit, the Company shall pay an additional amount of $2,500.00 to the designated beneficiary.

Day Care Benefit ($5,000)

If injury results in the 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 the accident, or within the 12 months following.

Seat Belt Benefit

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.

Hospital Indemnity Expense ($2,500)

A daily benefit, 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.

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 150 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.

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, provided such injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity.

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.

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.

Waiver of Premium

In the event of total disability and waiver of premium has been approved and accepted by the group long term disability 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.

Continuation of Coverage

Coverage can be continued while the insured is on an approved leave of absence, maternity/parental leave, temporary lay-off or disability. This continuation is subject to continued payment of premiums and is granted for a maximum of 12 months (or to age 65 if on disability leave) or on the date the insured returns to work, whichever is earlier.

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 31 days. Premiums become payable annually in advance.

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 or 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 or being struck by or making a forced landing with or from any aircraft owned, operated or leased by the policyholder.

Termination of Insurance of an Insured

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".

When Does This Insurance Not Apply?

- declared or undeclared war or any act thereof;
- 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 the part titled "Limited Air Travel Coverage".

ANNEX – BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Beneficiary

Indemnity payable in the event of the loss of life of an insured is payable in accordance with the beneficiary designation in effect under the Policyholder's current Basic Group Life Insurance policy. Unless otherwise indicated and if there is no such designation, the indemnity is payable to the estate of the insured. All other indemnities are payable to the insured, with the exception of indemnities payable under the following parts:

Day Care Benefit	Identification Benefit
Education Benefit	Repatriation Benefit
Family Transportation Benefit	Spousal Retraining Benefit

Workplace Modification and Accommodation Benefit

In the situation where this 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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