SYNDICAT DES MÉTALLOS,
TC SECTION LOCALE 1976
(SCREENING OFFICERS)

Class 2
Part-time Employees of
Montreal-Trudeau Airport

GROUP INSURANCE PLAN

Policyholder: **SYNDICAT DES MÉTALLOS, TC SECTION LOCALE 1976**
(SCREENING OFFICERS)

Policy No.: ***28580***

Policy Effective Date: ***September 1, 2016***

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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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 class:

Class

2 – Part-time Employees of Montreal-Trudeau airport

GENERAL PROVISIONS

ELIGIBILITY DATE

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

a) The Effective Date of the policy, if, at that date, the Employee has completed the Eligibility Period;

or

b) On the date the Employee has completed the Eligibility Period.

ELIGIBILITY PERIOD

The first Day of the month coincident with or next following a continuous period of 3 months ending on or after the Effective Date of the group policy, during which the Employee must be Actively at Work.

Moreover, once the eligibility period has been satisfied, the Employee will be considered as having been covered retroactively to the later of the following dates: the Effective Date of the group policy or his date of employment. The participant will then be able to claim benefits retroactively to such date.

PARTICIPANT'S LIFE INSURANCE

Sum Insured

$10,000

Reductions, Exclusions and Limitations:

The sum insured is reduced by 50% on the Participant's 65th birthday.

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

Termination:

The insurance under this benefit terminates on the earliest of: the Participant's 80th birthday; or his date of retirement; or such other earlier date indicated in this benefit or in the General Provisions of the group policy.

LIVING BENEFIT

Sum Insured

Equal to the lesser of

50% of the Participant's amount of life insurance,

and

$5,000

Reductions, Exclusions and Limitations:

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

Termination:

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

QUEBEC PRESCRIPTION DRUG INSURANCE

(Addendum to Supplemental Health Insurance Applicable to Quebec Residents Only)

(eligible drugs as per the list of the *Régie de l'assurance-maladie du Québec)*

Maximum Contribution for the Participant during the Calendar Year:

As stated under the *Act respecting prescription drug insurance* (R.S.Q., chapter A-29.01).

Notwithstanding what is indicated in the group policy, the Participant's Maximum Contribution will include any amounts paid as a Deductible and/or coinsurance for a Spouse and a Dependent Child, if applicable.

Deductible:

As stated under the Supplemental Health Insurance benefit, subject to any maximum stated under the *Act respecting prescription drug insurance.*

Reimbursement by the insurer:

As stated under the Supplemental Health Insurance benefit. However, if the level of Reimbursement is less than that provided by the *Act respecting prescription drug insurance*, the Reimbursement level will be as per the minimum Reimbursement level allowed.

Once the Maximum Contribution has been satisfied by the Participant (including a Spouse and Dependent Children) during the Calendar Year, the level of Reimbursement will be 100% for the rest of the Calendar Year.

QUEBEC PRESCRIPTION DRUG INSURANCE (cont'd)

Reductions, Exclusions and Limitations:

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

Termination:

The insurance under this benefit terminates on the earliest of: the Participant's 65th birthday; or his date of retirement; or such other earlier date indicated in this benefit or in the General Provisions of the group policy, subject to the Special Provision For Insured Persons Age 65 and Over provision under this benefit.

SUPPLEMENTAL HEALTH INSURANCE

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 [1] – Drugs:	$50 per Insured Person Maximum of $50 per family
– Other expenses:	$50 per Insured Person Maximum of $50 per family
Reimbursement [2]:	80%
Maximum:	Unlimited

(1) *The Deductible will only be applicable as of January 1, 2017.*

(2) *For drugs, the level of reimbursement is 80% up to an amount equivalent to the maximum contribution, per family, per calendar year, as stated under the Act respecting prescription drug insurance. When this amount has been satisfied during the calendar year, the level of reimbursement by the insurer will be 100% for the rest of the calendar year. The calculation of the maximum contribution, per family, per calendar year, includes all eligible drugs under the group policy.*

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

Applicable to Quebec residents only:

FOR PERSONS AGE 65 AND OVER covered with the *Régie de l'assurance maladie du Québec* for drugs which are listed under the Basic Prescription Drug Insurance Plan of Quebec, this benefit includes:

- the cost of drugs not covered by RAMQ; and
- expenses for any contribution (coinsurance and deductible) to the cost of drugs and pharmaceutical services which must be paid by the insured person under the Basic Prescription Drug Insurance Plan of Quebec.

Reductions, Exclusions and Limitations:

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

Termination:

The insurance under the Supplemental Health Insurance benefit terminates on the earliest of: the Participant's 80th birthday; or his date of retirement; or such other earlier date indicated in this benefit or in the General Provisions of the group policy.

However, the Emergency Medical Expenses Incurred Outside the Province of Residence and Emergency Out of Province Assistance terminates on the earliest of: the Participant's 70th birthday; or his date of retirement; or such other earlier date indicated in this benefit or in the General Provisions of the group policy.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

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.
Preventive immunization vaccines	$100 per Calendar Year. **These expenses are subject to the deductible and reimbursement percentage for drugs.**
Anaesthetic products	$20 per visit. **These expenses are subject to the deductible and reimbursement percentage for drugs.**
Fees for nursing care	$5,000 per Calendar Year.
Breast prostheses	$200 per period of 24 consecutive months.
Medical elastic stockings	4 pairs per Calendar Year.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

Medical Expenses

Covered Expenses	Maximums Per Insured Person
Room and board in a facility licensed to provide rehabilitative or convalescent care	Semi-private room rate, up to $40 per Day; combined maximum of 90 Days per Calendar Year for all periods of confinement due to the same cause. **These expenses are not subject to the deductible and are reimbursed at 100%.**
Laboratory fees, magnetic resonance imaging and prenatal tests	Combined maximum of $500 per Calendar Year.
Aerosol equipment, mist tents and nebulizers for cystic fibrosis, acute emphysema, chronic obstructive bronchitis or chronic asthma, diabetic administration equipment and intermittent positive pressure breathing machine	$10,000 per Calendar Year.
Diabetic monitoring equipment	$300 per period of 60 consecutive months.
Orthopedic shoes and deep shoes	Combined maximum of $200 per Calendar Year.
Foot orthoses and arch supports	Combined maximum of $200 per Calendar Year.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

Medical Expenses

Covered Expenses	Maximums Per Insured Person
Intrauterine devices	One device per Calendar Year.
Intraocular lenses following cataract surgery	$200 per lifetime. **These expenses are not subject to the deductible and are reimbursed at 100%.**
Wigs	$300 per lifetime.
Sclerosing injections	$15 per visit.
Fees for the following paramedical practitioners: physiotherapists, physiatrists and physical rehabilitation therapists	Combined maximum of $350 per Calendar Year.
Fees for the following paramedical practitioners: acupuncturists, chiropractors, occupational therapists, homeopaths, massage therapists, naturopaths and osteo-paths	Maximum of $350 per Calendar Year for each practitioner.
Fees for the following paramedical practitioners: Audiologists and hearing therapists	Combined maximum of $350 per Calendar Year.
Fees for the following paramedical practitioners: speech therapists and speech and language therapists	Combined maximum of $350 per Calendar Year.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

Medical Expenses

Covered Expenses	Maximums Per Insured Person
Fees for the following paramedical practitioners: psychologists, psychiatrists, psychoanalysts, psychotherapists and social workers	Combined maximum of $500 per Calendar Year.
Fees for the following paramedical practitioners: chiropodists [(1)] and podiatrists	Combined maximum of $350 per Calendar Year.
[(1)] *in Ontario and Saskatchewan only*	
X-rays by a chiropractor	$50 per Calendar Year.
Hearing aids	$500 per period of 48 consecutive months.
Substance abuse treatment	$80 per Day; lifetime maximum of $2,500 and one treatment.
Eye examinations	$50 per period of 24 consecutive months. **Eye examinations are not subject to the deductible and are reimbursed at 100 %.**

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

Medical Expenses

Covered Expenses	Maximums Per Insured Person
Eyeglasses (including sunglasses and safety glasses), contact lenses or corrective laser surgery	Eyeglasses (including sunglasses and safety glasses), contact lenses or corrective laser surgery up to a maximum of $150 per Calendar Year. **These expenses are not subject to the deductible and are reimbursed at 100%.**

DENTAL CARE INSURANCE

Deductible [(1)]:	$50 per Insured Person Maximum of $50 per family
Reimbursement	
– Preventive treatments:	80%
– Endodontic and Periodontal treatments:	80%
– Basic treatments:	80%
Maximum per Insured Person	
– Preventive, Endodontic, Periodontal and Basic treatments:	$750 per Calendar Year

[(1)] The Deductible will only be applicable as of January 1, 2017.

Expenses are reimbursed according to the Dental Surgeons Association's Fee Guide for the current year or, if applicable, the Dental Hygienists Association's Fee Guide for the current year, subject to any limits which are stated under the Dental Care Insurance. If the dental expenses are incurred in Alberta, the fee guide that will be used to determine the level of dental expenses to be reimbursed will be the 1997 Alberta Dental Association Fee Guide for General Practitioners, plus an inflationary adjustment as determined by the insurer.

Reductions, Exclusions and Limitations:

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

Termination:

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

DEFINITIONS

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

Actively at Work means:

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

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

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

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

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

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

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

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

Dependent means:

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

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.

A de facto 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).

Earnings means:

Annual Earnings means the Participant's annual remuneration as reported by the Policyholder to the insurer.

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

Weekly Earnings means the Participant's Annual Earnings divided by 52.

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

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

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

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

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

Amount of Earnings to Be Used

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

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

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

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

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

Employee means:

Part-time Employee means a person who is actively employed by the Employer on a part-time basis and for less than 24 hours per week.

Employer means any entities who give a regular salary to the Employee.

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

Hospital: An institution which:

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

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

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

Hospitalization or Hospitalized means the occupancy of a Hospital room as an admitted bedridden patient where a room and board charge has been charged in connection with the confinement. Day Surgery is considered to be a period of Hospitalization.

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

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

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

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

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

Participant means an Employee who is insured under the group policy.

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

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

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

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

CHANGES IN GOVERNMENT PLANS

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

Notwithstanding the preceding paragraph, 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 under the group policy or insurance under a benefit for a Participant or a Dependent; or

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

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

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

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

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

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

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

LAWFUL CURRENCY

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

COVERAGE ELSEWHERE

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

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

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

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

AGENTS

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

ERRORS

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

a) Continue insurance otherwise validly terminated.

b) Increase any existing insurance.

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

d) Otherwise prejudice the insurer in any other way.

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

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

b) Terminate or rescind any such associated insurance.

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

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

ELIGIBILITY

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 all of the following conditions:

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

b) He is a Full-Time Resident of Canada; and

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

d) He has satisfied the Eligibility Period specified in 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 all of the following conditions:

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

b) He is a Full-Time Resident of Canada; and

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

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

APPLICATION FOR GROUP INSURANCE

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

EFFECTIVE DATE OF INSURANCE

Whether membership under the group policy is compulsory or voluntary, the 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 on or prior to such date, or within 8 months after such date.

If the application for group insurance is not received within 8 months of the eligibility date, the insurance will not take effect until the date on which the insurer receives evidence of insurability and provides Approval of Evidence of Insurability.

However:

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

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

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

TERMINATION OF INSURANCE

Participant

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

a) The date the group policy is terminated; or

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

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

d) The date the Participant is no longer a Full-time Resident of Canada; or

e) The date the Participant loses his Legal Capacity to Work in Canada; or

f) The date the Participant is no longer covered by his provincial health plan; or

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

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

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

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

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

Dependents

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

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

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

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

d) The date the Dependent is no longer a Full-Time Resident of Canada; or

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

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

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

NOTICE AND PROOF OF CLAIM

Notice and proof of any claim must be submitted to the insurer in the format required by the insurer. The proof of claim must include all information that the insurer requires and deems necessary as to the circumstances and extent of

the loss, or which the insurer otherwise requests in order to complete its assessment of a claim. The insurer will not be liable for any claim that is not submitted in accordance with all of the terms and conditions and time limits prescribed under the group policy.

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

  Notice and proof of any claim must be submitted to the insurer within 12 months of the date of the event which gives entitlement to the benefit.

- **Life Insurance:**

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

NOTICE AND PROOF OF CLAIM IN CASE OF TERMINATION

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

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

FRAUDULENT CLAIMS

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

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

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

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

APPEAL PROCESS

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

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

EXPENSES

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

BENEFICIARY

The Participant’s beneficiary shall be the person or persons designated by the Participant, in writing, to receive the death benefit payable under the Participant's Life Insurance benefit, and if applicable, the Participant's Accidental Death and Dismemberment Insurance benefit, Participant's Optional Life Insurance benefit and Participant's Optional Accidental Death and Dismemberment Insurance benefit. If the Participant does not designate a

beneficiary, any death benefit payable under such benefits will be payable to the Participant's estate.

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

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

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

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

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

INSURER'S RIGHT TO EXAMINATION, RECORDS AND INVESTIGATION

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

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

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

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

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

SUBROGATION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

OVERPAYMENT

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

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

a) Reduce to zero the Short-Term or Long-Term Disability benefit payments payable to the Participant under the group policy until such time as the overpayment is fully recovered.

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

LIMITATION ON LEGAL ACTIONS

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

Every action or proceeding against an insurer for the recovery of insurance money payable under 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 of Quebec) in the Participant's province.

PARTICIPANT'S LIFE INSURANCE

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

DEFINITION

As used in this benefit:

Total Disability and Totally Disabled means that, due to an Illness or Accident, the Participant is continuously unable to perform all the essential duties of his Own Job, all of which shall be determined by the insurer.

If a Participant engages in any occupation, any employment, or any other activity for compensation or profit, he will be deemed to no longer be Totally Disabled.

The following will not be taken into consideration in determining the Total Disability of the Participant:

a) The availability of his Own Job; and

b) The loss, revocation, withdrawal, or non renewal of a professional or occupational, license, permit or any other certification required to perform his Own Job.

Own Job means the Participant's own job that he was regularly performing for his own Employer immediately before the date of Total Disability.

CONVERSION PRIVILEGE

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

a) his employment; or

b) his group membership; or

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

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

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

a) Permanent; or

b) Term to age 65; or

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

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

a) The amount selected by the Participant; or

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

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

d) $200,000.

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

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

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

WAIVER OF PREMIUM

a) A Participant who becomes Totally 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 Totally Disability; and

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

   iii) The Participant has been Totally Disabled for at least 12 continuous months; and

   iv) Proof of Totally Disability, satisfactory to the insurer, was submitted to the insurer within 12 months of the onset of the Totally Disability.

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

c) The Participant's premiums will begin to be waived on the Day following a continuous period of Total Disability of 12 months.

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

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

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

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

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

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

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

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

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

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

REDUCTIONS

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

TERMINATION

The insurance under this benefit terminates on the date the Participant attains the age limit indicated in the Summary of Benefits, or the date of his retirement if earlier, or such other earlier date indicated in this benefit or in the General Provisions of the group policy.

LIVING BENEFIT

INSURING AGREEMENT

Upon request by the Participant for the benefit and upon receipt by the insurer of due proof that the Participant has incurred a terminal condition, the insurer will pay a Living Benefit to the Participant provided the conditions set out below are satisfied. The amount of the Living Benefit will be as determined in accordance with the Summary of Benefits.

As used in this benefit, “Terminal Condition” shall mean an injury or Illness that is expected to result in death within 24 months and from which there is no reasonable prospect of recovery as determined by the insurer.

CONDITIONS

The Living Benefit will be subject to the following conditions, unless otherwise agreed to by the insurer and the Policyholder.

a) The Participant must provide all medical information requested by the insurer so as to allow the insurer to determine whether or not the Participant is suffering a Terminal Condition as defined in this benefit.

b) The Participant will be required to sign a "Living Benefit Agreement" prior to a Living Benefit being payable.

c) The Participant’s amount of life insurance under the group policy will be reduced by the amount paid under this benefit and any interest on such amount which may be charged by the insurer.

EXCLUSION

No amount will be payable under this benefit if all or a portion of the Participant’s life insurance under the group policy is to be paid to his former Spouse as part of a divorce or separation agreement.

REDUCTIONS

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

TERMINATION

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

QUEBEC PRESCRIPTION DRUGS INSURANCE

Addendum to Supplemental Health Insurance
Applicable to Quebec Residents Only

The insurer undertakes to reimburse the expense of prescription drugs which are listed under the Basic Prescription Drug Insurance Plan of Quebec, for each Insured Person who is a resident of Quebec and who is registered with the *Régie de l'assurance-maladie du Québec* (hereafter referred to as the "Board"), regardless of the Insured Person's state of health.

Insurance under this benefit is mandatory for all Participants and their Dependents who are eligible to be insured under the group policy, subject to the provisions of the Act respecting prescription drug insurance.

The insurance provided under this benefit is in accordance with the relevant provisions of the Act respecting prescription drug insurance and the Summary of Benefits.

Any modification to the Act respecting prescription drug insurance which relates to the Basic Prescription Drug Insurance Plan of Quebec will automatically result in the modification of the relevant provisions of this addendum and policy.

If a provision of the Supplemental Health Insurance is, in full or in part, contrary to the Act respecting prescription drug insurance, that provision, or the part that is deemed to be contrary will be presumed to be amended to comply with the minimum requirements of the Act respecting prescription drug insurance.

DEFINITIONS

As used in this addendum:

Deductible: The Deductible is the portion of the cost of the covered expenses which must be paid by the Insured Person. The Deductible, if applicable, is specified in the Summary of Benefits.

Reimbursement: The Reimbursement is the percentage of the covered expenses incurred that is reimbursed by the insurer after the Deductible has been satisfied. The percentage is specified in the Summary of Benefits.

Coinsurance Payment: The Coinsurance Payment is the portion of the cost of the covered expenses that must be paid by the Insured Person until the Maximum Contribution is reached.

Maximum Contribution: The Maximum Contribution is the total amount paid by the Insured Person beyond which the cost of the covered expenses which are eligible as per the list under the Basic Prescription Drug Insurance Plan of Quebec is covered 100% by the insurer.

SPECIAL PROVISION FOR INSURED PERSONS AGE 65 AND OVER

The Insured Person's choice to be covered by the Board for the Basic Prescription Drug Insurance Plan of Quebec is irrevocable.

For the purpose of the group policy, Insured Persons who are age 65 and over will be presumed to be covered with the Board for the Basic Prescription Drug Insurance Plan of Quebec. In addition, Dependents of a Participant who is 65 years of age or over will be presumed to be covered with the Board for the Basic Prescription Drug Insurance Plan of Quebec, regardless of age. However, dependents age 65 and over of a participant less than age 65 remain covered with the insurer under the present benefit.

The insurer reserves the right to modify the rates applicable to this benefit for any Insured Person age 65 and over, who is eligible for insurance under the group policy and who has chosen to be insured under this benefit.

Notwithstanding any stipulation to the contrary in the group policy, this benefit does not provide any termination with regard to the Participant's age.

COVERED EXPENSES

The following expenses are covered, provided they are incurred in Quebec after the Insured Person became insured under this benefit:

a) The services of a pharmacist to fill or renew a prescription for a drug which is included on the list of the Board or specified by government regulation;

b) Drugs which are included on the list of the Board and which are provided by a pharmacist on a prescription of a healthcare provider who is legally licensed to prescribe drugs;

c) Any drug specified by government regulation, when prescribed for the conditions and the therapeutic indications as set out in the regulation.

This benefit does not include the cost of pharmaceutical services and drugs that an Insured Person may obtain or to which the person is otherwise entitled, pursuant to any government plan or act, other than the *Act respecting prescription drug insurance* in Quebec.

Dispensing Quantity 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.

REDUCTIONS

The expenses covered under the present benefit are limited to the reasonable and customary charges normally incurred in Quebec for the same expenses. These reasonable and customary charges are established by the insurer and can be revised as needed.

EXCLUSIONS

None, except if provided by the *Act respecting prescription drug insurance* or one of its regulations.

CO-ORDINATION OF BENEFITS

The Co-ordination of benefits will be as provided for under the Co-ordination of Benefits provision of the Supplemental Health Insurance.

TERMINATION

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

SUPPLEMENTAL HEALTH INSURANCE

Includes Prescription Drugs for Residents of Provinces Outside Quebec

INSURING AGREEMENT

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

DEFINITIONS

As used in this benefit:

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

Deductible: The Deductible is the portion of the cost of the covered expenses which must be paid by the Insured Person. The Deductible, if applicable, is specified in the Summary of Benefits.

General Dental Practitioner: A licensed dentist who practices dentistry without specialization.

Hospitalization and Hospitalized: Occupancy of a Hospital room as an admitted bedridden patient where a room and board charge has been made in connection with the confinement. Day Surgery will be considered to be a period of Hospitalization.

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

Medically Required means broadly accepted and recognized by the Canadian medical profession, and where applicable the Canadian dental profession as effective, appropriate and essential in the treatment of an Illness or injuries,

including injuries due to an Accident, in accordance with Canadian medical standards, or where applicable Canadian dental standards.

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.

Reimbursement: The Reimbursement is the percentage of the covered expenses incurred that is reimbursed by the insurer after the Deductible has been satisfied. The percentage is specified in the Summary of Benefits.

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; and

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

b) The Medical Emergency occurs during the first 180 Days of the Insured Person's absence from his province of residence.

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

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

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

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

a) Services of a Physician;

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

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

d) Diagnostic, medical imaging and laboratory services;

e) Paramedical services provided during a Hospitalization;

f) Hospital out-patient services and supplies;

g) Drugs;

h) Medical appliances and supplies provided out of Hospital;

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

For paramedical services, drugs and medical appliances, only those drugs, appliances and services which would have been covered in the Insured Person's province of residence will be covered when they are received outside of his province of residence in a Medical Emergency.

Limitations for emergency medical expenses incurred outside the province of residence

If the Insured Person should become Hospitalized outside 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 Emergency if:

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

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

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

a) Medical status;

b) Medical treatment, examination, consultation or Hospitalization;

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

d) Change in medical treatment or in medication;

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

within a period of 90 Days prior to that absence.

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 or certified nursing assistant provided:

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

   ii) The services are Medically Required; and

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

   iv) The registered nurse or certified nursing assistant 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 and anaesthetic products) which are dispensed by a pharmacist 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 law 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 medication to treat asthma, diabetes, high cholesterol or high blood pressure, provided they are prescribed by a healthcare provider who is legally licensed to prescribe such drugs and dispensed by a pharmacist.

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

   For Quebec residents, this medical expense is supplementary to the Quebec Prescription Drug Insurance benefit.

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

d) Room and board charges made in a facility licensed to provide rehabilitative or convalescent care provided:

i) The Insured Person is under the regular supervision of a Physician or registered nurse; and

ii) The confinement was recommended by a Physician; and

iii) The confinement takes place within 14 Days of a period of Hospitalization; and

iv) The confinement is for rehabilitative or convalescent care.

However, there will be no coverage if the rehabilitative or convalescent care is for drug or alcohol abuse or addiction.

e) Charges for diagnostic laboratory tests (including prenatal tests), magnetic resonance imaging and other medical imaging services, other than x-rays by a paramedical practitioner, provided:

   i) Coverage for the tests and services is not prohibited by provincial legislation; and

   ii) The tests and services are performed in a facility licensed to perform such tests and services; and

   iii) The tests and services 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 paramedical practitioner, if specifically mentioned as being covered under the Summary of Benefits.

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) Oxygen tent and oxygen supplies;

   ii) Aerosol equipment, mist tents and nebulizers for cystic fibrosis, acute emphysema, chronic obstructive bronchitis or chronic asthma;

   iii) Artificial eyes, including repairs and replacements;

   iv) Artificial prostheses, including repairs and replacements, but excluding myoelectric and electric prostheses;

   v) Manual wheelchairs or electric wheelchairs when the Insured Person is incapable of operating a manual wheelchair due to a medical condition;

vi) 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;

vii) Apnea monitors for respiratory disrhythmias;

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

ix) Percutaneous or transcutaneous nerve stimulator;

x) Intermittent positive pressure breathing machine;

xi) Breast prostheses;

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

xiii) Orthopedic shoes which are Medically Required by a health practitioner operating within the scope of his license and which have been custom made, custom modified or custom molded for the Insured Person by a certified specialist in orthopedic footwear. Off the shelf orthopedic shoes which have not been custom made, modified or molded for the Insured Person will not be eligible for coverage;

xiv) Foot orthoses which are Medically Required by a health practitioner operating within the scope of his license and which have been specifically designed and constructed for the Insured Person by a certified specialist in foot orthoses. Off the shelf foot orthoses which have not been specifically designed and constructed for the Insured Person will not be eligible for coverage;

xv) Prefabricated deep shoes, specifically designed to insert a foot and one orthesis;

xvi) Arch supports;

xvii) Intrauterine devices;

xviii) Intraocular lenses following cataract surgery;

xix) Braces with rigid support; back supports; shoulder harnesses; head halters and cervical collars;

xx) Splints, other than dental splints, and casts;

xxi) Canes, crutches and walkers;

xxii) Hernia belts;

xxiii) Wigs required as a result of chemotherapy;

xxiv) Sclerosing injections;

xxv) Colostomy and ileostomy apparatus and supplies;

xxvi) Catheters;

xxvii) Thoracic drainage pumps;

xxviii) Tube feeding supplies;

xxix) Glasses for psoriasis;

xxx) Burn garments;

xxxi) Medicated dressings;

xxxii) Paraplegic, tetraplegic or quadriplegic supplies.

i) Dental care given out of Hospital by a General Dental Practitioner which is required as a result of an Accident to whole, healthy, natural teeth, provided:

i) The Accident occurs while the Insured Person is insured under this benefit; and

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

iii) The charges do not exceed the amount shown for the treatment in the current provincial fee schedule for General Dental Practitioners in the Insured Person's province of residence; and

iv) The care is received within 12 months of the date of the Accident.

Any charges for dental care which is not directly related to the Accident will not be covered.

j) 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.

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

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

   ii) 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

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

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

m) Charges for eyeglasses (including sunglasses and safety glasses), or contact lenses or corrective laser surgery, when prescribed by an ophthalmologist or an optometrist.

EXCLUSIONS AND REDUCTIONS

This benefit does not cover any of the following expenses:

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 or any expenses resulting, directly or indirectly, from attempted suicide or which was voluntarily self-inflicted, while sane or insane.

c) For an Illness or injury or any expenses resulting, directly or indirectly, from civil unrest, insurrection or war, whether war be declared or not, or a riot.

d) For an Illness or injury or any expenses resulting, directly or indirectly, from the commission of an offence under any criminal code or similar law in any jurisdiction, if the Insured Person has been charged or convicted.

e) For treatment or appliances to correct vertical dimension or any temporomandibular joint dysfunction.

f) For care or treatment which is not Medically Required, or which is given for cosmetic purposes, or for any reason other than curative, or which exceeds the normal care or treatment given in accordance with current therapeutic practice, or is of an experimental nature.

g) 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.

h) For care or treatment of an Illness or injury that is not recognized as normal, customary and common practice for such Illness or injury.

i) 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.

j) 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.

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, except if specifically mentioned as being covered under the Summary of Benefits.

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 for fitness and training

(except if specifically mentioned as being covered under this benefit), 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 the Summary of Benefits.

r) For preventive immunization vaccines or the administration of serums, vaccines and injectable medications, except if specifically mentioned as being covered under the Summary of Benefits.

s) For contraceptives (other than oral), 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:

- 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;
- 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, except if specifically mentioned as being covered under the Summary of Benefits.

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, false labour, delivery or resulting complications, 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; or

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

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

   – any business, group or association who is the subject of any of the matters set out in subparagraphs (i) to (v) above; or

   – any entity that is affiliated with or related to such business, group or association.

The amount of 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 Insured 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.

Carry-over Provision

If the Deductible for a Calendar Year is satisfied in whole or in part by the payment of covered expenses incurred during the last 3 months of the Calendar Year, the amount of covered expenses incurred in such 3 month period and which were applied toward satisfaction of the Deductible for that Calendar Year, shall be carried over and applied toward satisfaction of the Deductible for the next Calendar Year.

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 insured under this benefit and prior to any extension of insurance as provided for under the Extension of Benefits provision, insurance under this benefit shall continue for his Dependents who were insured

under this benefit at the time of his death, without premium payment, until the earliest of:

a) 24 months after the Participant's death; or

b) The date on which the Dependents' insurance would have terminated had the Participant then been living; or

c) The termination date of this benefit.

EXTENSION OF BENEFITS

If on the date an Insured Person's insurance 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 insurance 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 any work for which he is reasonably qualified by education, training or experience; 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.

CONVERSION PRIVILEGE

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

a) his employment; or

b) his group membership,

will be able to convert his Supplemental Health Insurance to an individual insurance contract without having to submit evidence of insurability to the insurer.

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

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

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 terminate on the earliest of the following dates:

a) the date on which ceases the waiver of premiums under the Participant's Life Insurance benefit;

b) the date on which the participant ceases to be employed by the employer according to the date indicated on the employment record; or

c) the date on which this benefit or policy terminates.

TERMINATION

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

SUPPLEMENTAL HEALTH INSURANCE – EMERGENCY OUT OF PROVINCE ASSISTANCE

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

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

b) The Medical Emergency or personal emergency occurs during the first 180 Days of the Insured Person's absence from his province of residence.

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

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

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

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

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

DEFINITION

As used in this benefit:

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

Hospitalization and Hospitalized: Occupancy of a Hospital room as an admitted bedridden patient where a room and board charge has been made in

connection with the confinement. Day Surgery will be considered to be a period of Hospitalization.

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 Physicians or Specialists in order to obtain the best medical care available in the area;
- Provide assistance with admittance to a Hospital;
- Confirm to Physicians and Hospitals the medical expenses that are covered under the Insured Person's group policy.

c) Medical Transportation

The medical assistance service provider will:

- Arrange and pay for the transportation or transfer of the Insured Person by appropriate means to a Hospital as recommended by the attending Physician, and which the medical assistance service provider agrees to;

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

d) Payment of Medical Expenses and Cash Advance

- The medical assistance service provider will make the necessary arrangements to pay medical expenses which are covered under the Emergency Medical Expenses Incurred Outside of Province section of the Supplemental Health Insurance;
- When necessary in order for the Insured Person to obtain needed medical treatment, the medical assistance service provider will advance up to $10,000 (Canadian), after consultation with the insurer.

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 Immediate Family

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

h) Visit from a Member of the Immediate Family

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

i) Expenses for Commercial Accommodation and Meals

- When a return is delayed due to the Hospitalization of an Insured Person for a period of more than 24 hours or because of an Insured Person’s death, the expenses for commercial accommodation and meals incurred due to the delay by the Insured Person, by a member of the Immediate Family accompanying the Insured Person or visiting the Insured Person in accordance with h) will be reimbursed, subject to a daily maximum of $150 per person, and an overall maximum of $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 the drugs are covered under the Supplemental Health Insurance.

PERSONAL EMERGENCY TRAVEL ASSISTANCE SERVICES

The following services will be provided during a personal emergency:

a) Telephone Interpretation Service

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

b) Messages

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

c) Legal Assistance

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

d) Travel Information

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

e) Lost Baggage or Travel Documents

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

EXCLUSIONS AND REDUCTIONS

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

LIABILITY

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

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

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

SUPPLEMENTAL HEALTH INSURANCE – EMERGENCY OUT OF PROVINCE ASSISTANCE

REIMBURSEMENT

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

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

DENTAL CARE INSURANCE

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

DEFINITIONS

As used in this benefit:

General Dental Practitioner: A licensed dentist who practices dentistry without specialization.

Dental Specialist: A General Dental Practitioner 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.

Deductible: The Deductible is the portion of the cost of the covered expenses which must be paid by the Insured Person. The Deductible, if applicable, is specified in the Summary of Benefits.

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.

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.

Medically Required means broadly accepted and recognized by the Canadian medical profession, and where applicable the Canadian dental profession, as effective and appropriate and essential in the treatment of an Illness or injuries,

including injuries due to an Accident, in accordance with Canadian medical standards, or where applicable Canadian dental standards.

Reimbursement: The Reimbursement is the percentage of the covered Expenses Incurred that is reimbursed by the insurer after the Deductible has been satisfied. The percentage is specified in the Summary of Benefits.

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 Dental Practitioner, a Dental Specialist on the recommendation of a General Dental Practitioner or by a Dental Hygienist.

Preventive Treatments (any expenses related to implants will only be covered under Implants of the Major Treatments section, if included)

a) Examinations and Diagnoses
   - i) Complete oral examination: once every 2 years
   - ii) Recall examination: once every 9 months
   - iii) Emergency oral examination
   - iv) Specific oral examination

b) X-rays
   - i) Intra-oral - periapical: one complete series every 2 years
   - ii) Intra-oral - occlusal
   - iii) Intra-oral - interproximal
   - iv) Extra-oral
   - v) Sialography
   - vi) Panoramic: once every 2 years
   - vii) Radiopaque dyes

c) Tests and Laboratory Examinations
   - i) Microbiologic culture

ii) Biopsy of oral tissue - soft

iii) Biopsy of oral tissue - hard

iv) Cytologic smear

v) Pulp vitality tests

vi) Caries susceptibility tests

d) Preventive Services

For Insured Persons who reside in Quebec

i) Polishing of coronal portion of teeth (prophylaxis): Once every 9 months

ii) Topical application of fluoride

iii) Initial oral hygiene instruction

For Insured Persons who reside in provinces outside Quebec

i) Polishing of coronal portion of teeth (prophylaxis): One unit every 9 months

ii) Scaling of coronal portion of teeth: One unit every 9 months

If Periodontic services are provided under this benefit, any additional scaling will be combined with root planing under the Periodontics section.

iii) Topical application of fluoride

iv) Initial oral hygiene instruction

e) Space maintainers, other than stainless steel crown types, for persons under age 18: maintenance of a maintainer will be limited to twice every 12 months.

Basic Treatments (any expenses related to implants will only be covered under Implants of the Major Treatments section, if included)

a) Basic Services

i) Finishing restorations

ii) Pit and fissure sealant

iii) Caries control

iv) Interproximal discing

v) Prophylactic odontomy

b) Restorative

i) Amalgam restorations

ii) Composite restorations

c) Endodontics

i) Pulp capping

ii) Pulpotomy (excluding final restoration)

iii) Emergency pulpotomy

iv) Endodontic trauma

v) Root canal therapy

vi) Endodontic surgery

vii) Apexification

d) Periodontics

i) Surgical services

ii) Provisional matching

iii) Adjunctive periodontal procedures

For Insured Persons who reside in Quebec

Root planing and curettage are covered up to a maximum of 14 teeth in any 12 months. These procedures are only covered if testing of periodontal pockets indicates 4 mm or more.

Scaling is covered up to a maximum of 12 units in any Calendar Year.

For Insured Persons who reside in provinces outside Quebec

Root planing is covered up to a maximum of 12 units in any Calendar Year. Coverage will be combined with any units of scaling which are in excess of the limit stated under the Preventive Services section.

e) Dentures - removable
   - i) Adjustments
   - ii) Repairs
   - iii) Rebasing and relining
   - iv) Prophylaxis and polishing

f) Oral Surgery
   - i) Removal of erupted tooth (uncomplicated)
   - ii) Surgical removals (complicated)
   - iii) Surgical exposure and movement of tooth
     - transplantation: maximum of $150
     - surgical repositioning: maximum of $150
   - iv) Enucleation of tooth
   - v) Remodelling and recontouring of oral tissues
     - alveoloplasty
     - gingivoplasty and/or stomatoplasty
     - vestibuloplasty
     - remodelling of floor mouth
     - extension of mucous folds
   - vi) Surgical excision and incision
     - excision of tumors and cysts
     - enucleation of cysts/granulomas
     - cheiloplasty (lip shave)
     - graft of bone to jaw
     - marsupialization
     - incision and drainage and/or exploration
     - incision for removal of foreign bodies: maximum of $150

vii) Treatment of fractures

- mandibular or maxillary (including wiring): open reductions limited to a maximum of $750
- alveolar fractures
  - debridement, teeth removed
  - replantation of avulsed tooth (includes splinting)
  - repositioning of traumatically displaced tooth
  - repairs and lacerations: if over 6 cm, limited to a maximum of $750

viii) Frenectomy/frenoplasty

ix) Antral surgery

g) Adjunctive General Services

i) Anaesthesia (in relation to surgery)

EXCLUSIONS AND REDUCTIONS

In addition to the exclusions and reductions outlined in the Exclusions and Reductions provision of the Supplemental Health Insurance, if such a benefit is included in the group policy, the Dental Care Insurance 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, directly or indirectly, from attempted suicide or voluntarily self-inflicted injury, while sane or insane;

e) For services and supplies resulting, directly or indirectly, from civil unrest, insurrection or war, whether war be declared or not, or 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;

i) For services and supplies or any expenses resulting, directly or indirectly, from the commission of an offence under any criminal code or similar law in any jurisdiction, if the Insured Person has been charged or convicted.

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 General Dental Practitioner, 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 Dental Practitioners in the Insured Person's province of residence.

Expenses Incurred for services provided by a Denturist are limited to the normal suggested fee for Denturists in the Insured Person's province of residence.

Expenses Incurred outside Canada are limited to the normal rate suggested for General Dental 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.

Carry-over Provision

If the Deductible for a Calendar Year is satisfied in whole or in part by the payment of covered Expenses Incurred during the last 3 months of the Calendar Year, the amount of covered Expenses Incurred in such 3 month period and which were applied toward satisfaction of the Deductible for that Calendar Year,

shall be carried over and applied toward satisfaction of the Deductible for the next Calendar Year.

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 Insured Person 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 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; and

ii) Any government-sponsored plan; and

iii) Any non-insured employee benefit plan.

SURVIVOR BENEFIT

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

a) 24 months after the Participant's death; or

b) The date on which the Dependent's insurance would have terminated had the Participant then been living; or

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.

CONVERSION PRIVILEGE

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

a) his employment; or

b) his group membership,

will be able to convert his Dental Care Insurance to an individual insurance contract without having to submit evidence of insurability to the insurer, provided he is also converting his Supplemental Health Insurance. Failure to convert his Supplemental Health Insurance will prevent the Participant from converting his Dental Care Insurance.

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

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

TERMINATION

The insurance under this benefit terminates as indicated in this benefit or in the General Provisions of the group policy.

COPY OF CONTRACT AND ENROLLMENT MATERIAL

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

SUBMITTING CLAIMS

Health and Dental Claims

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

For Participants residing in Quebec

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

For Participants residing outside Quebec

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

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

IMPORTANT NOTICE
For Persons Hospitalized Outside their Province of Residence

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

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

PROTECTING PERSONAL INFORMATION

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

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

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

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

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

Participant's Right to Access His or Her Personal Information

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

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

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

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

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