COSTI IMMIGRANT SERVICES

(CLASS B)

COSTI IMMIGRANT SERVICES

Class B - All Union Employees

This Booklet provides you with a brief outline of the benefits for which you and, if applicable, your dependents are eligible. This booklet does not confer or create any contractual or other rights.

The exact terms of the benefits are described in the Group Policy G23294 issued by Industrial Alliance Insurance and Financial Services Inc. All rights with respect to the benefits will be governed solely by the Group Policy and in the event of a discrepancy between the Booklet and the Group Policy, the terms of the Group Policy will apply.

The policyholder reserves the right to amend or suspend any coverages, that are provided under the group policy as well as terminate the group policy in its entirety at any time with respect to active employees (including those that may be absent due to a disability).

In addition, the policyholder reserves the right to change the contribution requirements for the coverages, provided under the group policy at any time with respect to active employees (including those that may be absent due to a disability).

All matters and questions which you may have regarding your benefits should be handled by your employer or, if applicable, the plan administrator who has been appointed by your employer.

GROUP INSURANCE PROGRAM

ARRANGED BY:

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SUMMARY OF BENEFITS

This section provides a summary of the benefits for which you and, if applicable, your dependents, are eligible to be covered for. A more detailed description of the benefits follows this section.

LIFE INSURANCE BENEFIT

Basic Life Insurance For Employees

Classification	Amount of Basic Life Insurance
All Employees	Equal to 3 times annual earnings, rounded to the next higher multiple of $1,000, if not already such multiple, to a maximum of $300,000.

Reductions and Termination

Your Basic Life Insurance will reduce to 50% at age 65 and terminate at age 70.

SUMMARY OF BENEFITS

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT

Basic Accidental Death and Dismemberment Insurance

Classification	Amount of Basic Principal Sum
All Employees	An amount equal to the employee's Basic Life Insurance.

Reductions and Termination

Your Basic Principal Sum will terminate at age 70.

SUMMARY OF BENEFITS

LONG TERM DISABILITY INSURANCE BENEFIT FOR EMPLOYEES

Classification	**Amount of Monthly Income Benefit**
All Employees	Equal to 66.7% of monthly earnings, rounded to the next higher multiple of $1.00, if not already such multiple, to a maximum of $3,500.

Reductions

Your Monthly Income Benefit is subject to the reductions described in the Long Term Disability Insurance Benefit.

Qualifying Disability Period

Your qualifying disability period shall be 120 days.

Maximum Benefit Period

To age 65.

Termination

Your coverage under the Long Term Disability Insurance Benefit will terminate on your 65th birthday.

SUMMARY OF BENEFITS

SUPPLEMENTARY HEALTH INSURANCE BENEFIT FOR EMPLOYEES AND DEPENDENTS

Covered Expenses

- Hospital Care
- Nursing Care
- Convalescent Home Care
- Ambulance, Laboratory and Out-Patient Charges
- Prescription Drugs (Drug Card Plan)
- Paramedical Care
- Appliances
- Physician's Services
- Out of Canada Emergency Coverage
- Accidental Dental Care

Cash Deductible

- Hospital Care	Not subject to the Cash Deductible
- Out of Canada Emergency Coverage	Not subject to the Cash Deductible
- Chiropractic Services (applicable only to an insured person who resides in Ontario)	$10 per visit for the first 15 visits in a calendar year and Nil thereafter during such calendar year.
- All Other Covered Expenses	
- single	$25
- family	$50

The Cash Deductible which is shown for "all other Covered Expenses" is the amount that an insured person must pay in a calendar year before any amount is paid by the Insurer for those expenses.

Benefit Percentage

- All Covered Expenses	100%

SUMMARY OF BENEFITS

The Benefit Percentage means that part of the Covered Expense that the Insurer pays after the Cash Deductible has been satisfied.

Covered Expense Maximums

- Hospital Care	Semi-private room rate.
- Nursing Care	$10,000 in any continuous period of 12 months.
- Convalescent Home Care	Semi-private room rate.
- Prescription Drugs	$8.00 maximum for the dispensing fee of each prescription or refill of a prescription item.
- Paramedical Care	Chiropractors*, Osteopaths*, Naturopaths*, Podiatrists*, Speech Therapists, Masseurs and Psychologists: $40 per visit (waived if visit is for surgical procedure), subject to a maximum of $400 in any calendar year. The maximum is applied separately to each practitioner. (If the services of the practitioner are covered under the Provincial Medicare Act, no benefit is payable until the annual maximum under the Act is satisfied. *For these practitioners, if the visit is for diagnostic purposes, the maximum per visit will be $50. Physiotherapists: $60 per visit subject to a maximum of $720 in any calendar year.

- Accidental Dental Care $3,000 per lifetime.

Additional maximums are applicable to the Covered Expenses provided under this Benefit. You should refer to the Benefit description for these maximums.

Lifetime Maximum Benefit

$5,000,000 in respect of each insured person.

Termination

This Benefit will terminate on attainment of age 70 by the insured person.

SUMMARY OF BENEFITS

DENTAL EXPENSE BENEFIT FOR EMPLOYEES AND DEPENDENTS

Covered Expenses

Part A Services

- Diagnostic
- Preventive
- Restorative
- Minor Surgical
- Other (includes denture rebasing and relining)

Part B Services

- Endodontic Services
- Periodontic Services
- Oral Surgery

Cash Deductible

- All Covered Expenses	Not subject to a Cash Deductible

Benefit Percentage

Part A Services	100%
Part B Services	100%

The Benefit Percentage means that part of the Covered Expense that the Insurer pays after the Cash Deductible has been satisfied.

Schedule of Fees

Current Provincial Fee Schedule for General Dental Practitioners less two years.

Covered Expense Maximums

Part A and Part B Services (combined)	$1,500 in any calendar year.

SUMMARY OF BENEFITS

Benefits for some dental procedures are limited. You should refer to the Benefit description for these limits.

Termination

This Benefit will terminate on attainment of age 70 by the insured person.

LIFE INSURANCE BENEFIT FOR EMPLOYEES

Benefit

In the event of your death FROM ANY CAUSE, the amount of Life Insurance for which you are eligible will be paid to your beneficiary.

You name your own beneficiary and should you desire to change beneficiaries at any time you may do so (subject to any applicable law) by completing the necessary form which may be obtained from your employer.

Waiver of Premium Benefit

If you become disabled prior to age 65 and your disability lasts for a continuous period of 6 months , your Life Insurance will be continued without payment of further premiums while you remain disabled. The coverage being continued will terminate on your 65th birthday.

The amount of Life Insurance for which premium payments are being waived will be the amount of Life Insurance you were insured for on the date your total disability commenced.

This Benefit will be subject to proof of initial and continuing disability as set out in the Group Policy.

As used in this Benefit, “totally disabled” means your complete incapacity due to a medically determinable mental or physical impairment to perform substantially all of the essential duties of any occupation or employment for which you are reasonably qualified by education, training or experience.

Conversion Privilege

If your Life Insurance should terminate on or prior to your 65th birthday, you will, in specific circumstances, have a conversion privilege with respect to such insurance. The conversion privilege, if any, will be as set out in the Group Policy.

NOTE: The total amount of Life Insurance that you can convert during the lifetime of the Group Policy will be $200,000.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT FOR EMPLOYEES

Definitions

As used throughout this Benefit:

"Principal Sum" shall mean the amount of Basic Principal Sum which applies to you on the date of the accident.

"Loss" shall mean:

(1) with regard to the hand or foot, complete severance through or above the wrist or ankle joint, but below the elbow or knee joint;
(2) with regard to an arm or a leg, complete severance through or above the elbow or knee joint;
(3) with regard to the thumb, complete loss of one entire phalanx of the thumb;
(4) with regard to a finger, complete loss of two entire phalanges of the finger;
(5) with regard to a toe, the complete loss of one entire phalanx of the big toe and all phalanges of the other toes;
(6) with regard to an eye, the irrecoverable loss of the entire sight thereof;
(7) with regard to speech, the complete and irrecoverable loss of the ability to utter intelligible sounds; and
(8) with regard to hearing, the complete and irrecoverable loss of hearing.

"Loss of Use" shall mean the total and irrecoverable loss of use provided the loss is continuous for 12 consecutive months and such loss of use is determined to be permanent at the end of such period.

Benefit

If you suffer any of the losses listed in the Schedule of Amounts of Insurance (see below) as a direct result of an accident which occurred while you were covered under this Benefit, the Insurer will pay the amount of insurance specified for the loss in the Schedule provided the loss occurred within 365 days after the date on which the accident occurred. The amount payable will be subject to any limitations and exclusions included in this Benefit.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT FOR EMPLOYEES

Schedule of Amounts of Insurance

Principal Sum for "Loss" of: Life; Both hands; Both feet; Sight of both eyes; One hand and one foot; One hand and sight of one eye; One foot and sight of one eye; Speech and hearing in both ears.

Two times the Principal Sum for: Quadriplegia (total paralysis of both upper and both lower limbs), paraplegia (total paralysis of both lower limbs), hemiplegia (total paralysis of both the upper and lower limbs of one side of the body).

Principal Sum for "Loss of Use" of: Both hands; Both feet.

Three-quarters of the Principal Sum for "Loss" of: One arm; One leg.

Three-quarters of the Principal Sum for "Loss of Use" of: One arm; One leg.

Two-thirds of the Principal Sum for "Loss" of: One hand; One foot; Sight of one eye; Speech; Hearing in both ears.

Two-thirds of the Principal Sum for "Loss of Use" of: One hand; One foot.

One-third of the Principal Sum for "Loss" of: Thumb and index finger of one hand; Four fingers on one hand; All toes on one foot.

One-quarter of the Principal Sum for "Loss" of: Hearing in one ear.

Exposure and Disappearance

If due to an accident you are unavoidably exposed to the elements and as a result of such exposure suffer a loss for which a benefit is otherwise payable hereunder, such loss will be covered under the terms of this provision.

If your body is not found within one year of an accident which results in the disappearance, sinking or wrecking of the conveyance in which you were riding at the time of the accident and such accident occurs under circumstances as would otherwise be covered hereunder, it will be presumed that you suffered an

accidental loss of life at the time of such disappearance, sinking or wrecking, unless there is evidence to the contrary.

Rehabilitation

If you should sustain a loss for which a benefit is payable under this provision, and such loss requires you to undergo a rehabilitation program in order to be qualified to engage in a special occupation for which you would not have engaged except for such loss the Insurer will pay the reasonable and necessary expenses incurred for such program, provided the Insurer has approved the rehabilitation program in advance. Payment by the Insurer for the total of all expenses incurred shall not exceed $10,000, nor shall payment be made for any expenses incurred more than 3 years after the date of the accident or for any expenses for room, board, or other ordinary living, travelling or clothing expenses. If a rehabilitation benefit is provided under any other provision included in the Group Policy, it will only be payable under one of the provisions.

Occupational Training

If you suffer an accidental loss of life for which a benefit is payable under this provision, the Insurer will pay the reasonable and necessary expenses incurred by your spouse if he or she engages in an occupational training program in order to become specifically qualified for active employment in an occupation for which he or she would not otherwise have sufficient qualifications provided the Insurer approves such program in advance. Payment by the Insurer for the total of all expenses incurred shall not exceed $10,000 nor shall payment be made for any expenses incurred more than 3 years after the date of the accident or for any expenses for room, board or other ordinary living, travelling or clothing expenses. If the spouse should receive a benefit hereunder, he or she will not be eligible to receive a benefit under the Education benefit.

Education

If you suffer an accidental loss of life for which a benefit is payable under this provision, the Insurer will pay the reasonable and necessary expenses incurred as a result of your dependent's continuation of their education as a full-time student at an educational institute which is beyond the high school level provided that the dependent was enrolled as a full-time student at such institute at the time of

your death or if the dependent is in high school at the time of your death, he or she enrolls as a full-time student at an educational institute which is beyond the high school level within 365 days of the date of your death. Payments will be made by the Insurer each year, for up to 4 successive years, that the dependent provides proof that he or she is a full-time student at an educational institute which is beyond the high school level. The amount of each payment shall not exceed $5,000. If the spouse should receive a benefit hereunder, he or she will not be eligible to receive a benefit under the Occupational Training benefit.

Family Transportation and Accommodation

Should you be hospitalized more than 150 kilometers from your normal place of residence due to a loss for which a benefit is payable under this provision and you are under the regular care and attendance of a physician, the Insurer may pay the expenses for accommodation and transportation incurred by your immediate family members in visiting you. The expenses will only be reimbursed if (i) the Insurer deems the expenses to be reasonable and necessary, (ii) the expenses are a direct result of the visit, (iii) the transportation was by the most direct route to the hospital and (iv) the visit itself was deemed by the attending physician to be beneficial to your health. Payment by the Insurer for the total of all expenses incurred shall not exceed $2,000.

If transportation is provided by a vehicle other than one operated under a license for the conveyance of passengers for hire, the reimbursement of transportation expenses will be limited to a maximum of $0.20 per kilometer.

As used above, “immediate family” shall mean a person who is at least 18 years of age and who is your spouse, son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law.

If a family transportation and accommodation benefit is provided under any other provision included in the Group Policy, it will only be payable under one of the provisions.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT FOR EMPLOYEES

Repatriation

Should you accidentally die while outside of your province of residence and a benefit is payable for such loss under this provision, the Insurer will reimburse the actual expenses, up to a maximum of $10,000, which are incurred for the preparation of your body for transportation and the actual transportation of the body to its first resting place (e.g. funeral home) in proximity to your normal place of residence. The reimbursement of the expenses will be made to the individual who incurred the expenses.

If a repatriation benefit is provided under any other provision included in the Group Policy, it will only be payable under one of the provisions.

Home Alteration and Vehicle Modification

If you should suffer a loss for which a benefit is payable under this provision and such loss results in you requiring a wheelchair to be ambulatory, the Insurer will pay the one time costs associated with

(1) alterations to your principal residence, which have been recommended, in writing, by a recognized organization providing support to wheelchair users and which have been made by an individual experienced in such alterations, so as to make the residence wheelchair accessible and habitable, and

(2) modifications to a motor vehicle used by you which have been made by an individual experienced in such modifications and which have been approved by the appropriate Provincial licensing authorities, so as to make the vehicle accessible and/or drivable by you.

Payment by the Insurer for the costs associated with the home alterations and vehicle modifications shall not exceed $10,000 in total, nor shall payment be made for any expenses which are deemed by the Insurer to be unreasonable or unnecessary or which are incurred more than 365 days after the date of the accident which caused your loss.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT FOR EMPLOYEES

Seat Belt

If you should sustain a loss for which a benefit is payable under this provision and such loss occurred while you were driving or riding in a motor vehicle and while you were wearing a seat belt the Insurer will pay an additional benefit equal to 10% of your Principal Sum provided

(1) the motor vehicle was being used in a prudent manner at the time of the accident,

(2) the operator of the motor vehicle had a valid driver's license for the type of motor vehicle being used, and

(3) proof, satisfactory to the Insurer, that you were wearing a seat belt at the time of the accident is submitted to the Insurer at time of claim.

As used above, “motor vehicle” means a private passenger motor vehicle.

Day Care

If you should suffer an accidental loss of life for which a benefit is payable under this provision, the Insurer will pay the reasonable and necessary expenses incurred as a result of your dependent child's enrollment in a legally licensed Day Care Centre, provided the child was enrolled in the Day Care Centre at the time of your death or is enrolled in the Day Care Centre within 365 days of your death. Payments will be made by the Insurer each year that the child is enrolled in a legally licensed Day Care Centre, for up to four successive years or until the dependent child's twelfth birthday, if earlier. Proof that the dependent child is enrolled in the legally licensed Day Care Centre will be required by the Insurer before payments will be made. The amount of each payment shall not exceed $5,000.

Limitations

(1) The total amount payable for all losses resulting from any one accident shall not exceed your Principal Sum, except with respect to hemiplegia, quadriplegia and paraplegia.

(2) If as a result of any one accident, you should suffer more than one of the losses shown in the Schedule of Amounts of Insurance with respect to any one limb, payment will be made only for the one loss for which the largest amount is applicable.

Aggregate Limit of Indemnity

The Insurer's aggregate limit of indemnity for all losses resulting from any one aircraft accident for which coverage under this provision is provided is $5,000,000. In the event this limit is insufficient to pay the full amount of indemnity for each individual involved in the accident, the amount payable for each individual shall be in the proportion that the limit of indemnity for any one such accident bears to the total amount of benefit that would have been payable except for such limit of indemnity.

Exclusions

No benefit will be payable for any loss that resulted either directly or indirectly from, or was in any manner or degree associated with, or occasioned by, any one or more of:

(1) Suicide, while sane or insane, or intentionally self-inflicted injury.

(2) War or any act of war, whether declared or undeclared.

(3) Participation in any riot or civil strife.

(4) Committing or attempting to commit a criminal offense or provoking an assault.

(5) Travel or flight in any vehicle or device for aerial navigation except:

(a) riding as a passenger and not as a pilot, operator or member of the crew, in or on any aircraft having a current and valid certificate of air worthiness and piloted by a person who holds a current and valid pilot's license of a rating authorizing such person to pilot the aircraft, or

(b) riding as a passenger and not as a pilot, operator or member of the crew, in or on any aircraft operated by the Canadian Armed Forces or by a similar military service of any duly constituted governmental authority of any other recognized country.

Boarding or alighting from the aircraft will be deemed to be part of the flight. However, this provision will not cover any loss sustained while and in consequence of riding as a passenger, pilot, operator or member of the crew in or on any aircraft owned, operated, chartered or leased by the Policyholder and/or your employer.

LONG TERM DISABILITY INSURANCE BENEFIT

Definitions

As used throughout this Benefit:

"Total disability" and "totally disabled" shall mean:

(1) During your qualifying disability period and the first 24 months thereafter during a continuous period of disability, that the Insurer has determined that you are unable to

(a) perform substantially all of the essential duties of your own occupation, and

(b) earn more than 80% of your indexed pre-disability monthly earnings,

due to a medically determinable physical or mental impairment.

(2) After the 24 months specified above, that the Insurer has determined that you are unable to earn more than 75% of your indexed pre-disability monthly earnings due to the medically determinable physical or mental impairment.

However, if you engage in any occupation or business except as specifically provided in this Benefit, you will be deemed to no longer be totally disabled.

"Qualifying disability period" shall mean the period for which you have actually been totally disabled during a continuous period of disability before you may receive a monthly income benefit. It will not include any period for which you are not

(a) under the regular care and attendance of a legally licensed physician, other than yourself, who is a registered specialist in the field of medicine which is applicable to your disability, or

(b) undergoing a course of medical treatment or participating in a program of rehabilitation which, in the opinion of the Insurer, is medically required.

LONG TERM DISABILITY INSURANCE BENEFIT

The qualifying disability period that will be applicable to you will be as stated under the Summary of Benefits.

"Continuous period of disability" shall include all periods of total disability that meet all of the following conditions:

(a) they commence while you are insured under this Benefit,

(b) they are due to the same or related cause or causes,

(c) during your qualifying disability period, they are not separated by a period of more than fourteen days during which you are not totally disabled, and

(d) after you have completed your qualifying disability period, they are not separated by a period of more than six months during which you were not totally disabled.

"Indexed pre-disability monthly earnings" shall mean your average monthly earnings for the 12 month period immediately prior to the date your disability commenced, increased each March 1st coincident with or next following the anniversary of the date on which you became entitled to a monthly income benefit by the change in the Consumer Price Index (as published by the Government of Canada) during the immediately preceding calendar year.

Benefit

If the Insurer receives proof that you became totally disabled while insured under this Benefit, the Insurer will pay a monthly income benefit to you upon completion of your qualifying disability period provided you are then totally disabled. The amount of the monthly income benefit payments will be the amount for which you were insured on the date you became totally disabled.

Your monthly income benefit payments will cease on the earlier of :

(1) The end of the maximum benefit period as stated under the Summary of Benefits.

(2) The date you are no longer totally disabled.

(3) The date you refuse to participate in a rehabilitation program which has been recommended by the Insurer.

(4) The date you refuse to participate in a trial-work, part-time work or modified work program which has been recommended by the Insurer.

Recurrent Total Disability

If, within six months of your monthly income benefit ceasing due to your returning to full-time work, you are again totally disabled, such disability will be considered a continuation of the previous disability provided it is due to the same cause or causes related to the previous disability. If the subsequent period of disability is due to a different and unrelated cause or causes it will be considered a new disability.

Notwithstanding the above, no monthly income benefit is payable if your total disability re-occurs after the Long Term Disability Insurance Benefit has terminated and a period of 90 days has elapsed during which you were not so disabled.

Waiver of Premium

Premiums will be waived for any period during which you are receiving benefit payments under this Benefit.

Work Re-Entry

If, while totally disabled, you engage in

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

(2) a rehabilitation program which has been approved by the Insurer,

with the intent of returning to full-time employment, you will not be considered by the Insurer to have ceased to be totally disabled.

LONG TERM DISABILITY INSURANCE BENEFIT

During your participation in the program, your monthly income benefit will continue, but it will be reduced so that the total of the monthly income you are receiving under this Benefit, the income received from participation in the program and the sources described in the Benefit Reduction section does not exceed 100% of your indexed pre-disability monthly earnings (after tax earnings if the monthly income benefit is non-taxable).

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

The Insurer reserves the right to require that you engage in a reasonable part-time work, trial-work, modified work or rehabilitation program, which has been recommended by the Insurer to assist you in returning to gainful employment. If you do not co-operate or participate in the program you will no longer be eligible to receive a monthly income benefit under this Benefit.

Survivor Benefit

Should you die during a continuous period of disability in which you have been receiving or were entitled to receive a monthly income benefit, your spouse (or dependent children, if you have no spouse) will be eligible to receive a benefit equal to three times the net monthly benefit payment you received or which you were entitled to receive from the Insurer immediately prior to your death. The benefit will be payable upon receipt by the Insurer of proof of your death.

Benefit Reduction

The purpose of this Benefit is to extend to you a reasonable level of income when you are totally disabled. It is not designed to give you an income which would exceed or even equal your normal take-home pay when you are working. For this reason, your monthly income benefit will be reduced by any benefits you are entitled to receive from any of the following:

(1) Workers' Compensation or similar legislation.

(2) Canada or Quebec Pension Plan or U.S. Social Security Act. (Will not include any benefits which apply to your spouse and child(ren) as a result of your disability.)

(3) Any government legislated no-fault automobile insurance plan.

If, after taking the above reductions into consideration, the total amount of your monthly income from this Benefit and all sources listed below, still exceeds 85% of your indexed pre-disability monthly earnings (after-tax earnings if the benefit is non-taxable) then your monthly income benefit will be further reduced until it does not exceed such level.

(1) Workers' Compensation or similar legislation.

(2) Canada or Quebec Pension Plan or U.S. Social Security Act. (Will include both benefits which apply to you and your spouse and child(ren) as a result of your disability.)

(3) Any government legislated no-fault automobile insurance plan.

(4) Any other government plan.

(5) Any benefit plan, or retirement or pension plan which is provided by or through or administered by your employer or a related employer.

(6) Any group, association, or franchise insurance plan.

(7) Any plan or arrangement for which you receive a salary, wage, or other payment from any employer during your total disability. (Will not include any payments which are received by you from an employer due to your participation in an approved trial-work, modified work, part-time work or rehabilitation program.)

(8) Damages for loss of income received from a third party and arising out of the same circumstances that caused the total disability.

LONG TERM DISABILITY INSURANCE BENEFIT

Limitations and Exclusions

No monthly income benefit is payable with respect to a total disability during any of the following periods:

(1) Any period during which you are not under the regular care and attendance of a legally licensed physician, other than yourself, who is a registered specialist in the field of medicine which is applicable to your disability, or you are not undergoing a course of medical treatment or participating in a program of rehabilitation which, in the opinion of the Insurer, is medically required.

(2) For any period you are on a pregnancy leave of absence.

(3) For any period you are on a parental leave of absence.

(4) For any period during which you are in receipt of pregnancy benefits, parental leave benefits, pregnancy-related sickness benefits or any combination of such benefits under the Employment Insurance Act.

(5) For any period during which you are either permanently or temporarily outside of Canada. If you become disabled while outside of Canada, the disability will be deemed not to have commenced until the date of your return to Canada. However, if you are outside of Canada when the disability commences and you cannot return to Canada due to a medical reason, as verified by a legally licensed physician who is satisfactory to the Insurer, your disability will be deemed to have commenced on the date it commenced and not on the date that you return to Canada and, if applicable, a benefit will be payable while you are outside of Canada.

(6) For any period you receive a severance allowance as a result of your employment being terminated, if your benefits are being extended after your termination due to the applicable laws of the province where you reside.

No monthly income benefit will be payable if your total disability resulted either directly or indirectly from, or was in any manner or degree associated with, or occasioned by, any one or more of:

(1) War or any act of war, whether declared or undeclared.

(2) Participating in any riot or civil commotion.

(3) Intentional self-inflicted injury, while sane or insane, or intentional self destruction while sane or insane.

(4) The commission of or an attempt to commit a criminal offense or provoking an assault.

(5) While on active duty (including active duty for training purposes) in the armed forces of any nation, international organization or combination of nations or in any civilian non-combatant unit which serves with such forces in combat.

Pre-Existing Condition Exclusion

No monthly income benefit will be payable for your total disability if it:

(1) is caused by, contributed to by, or resulted from a mental or physical impairment (i) which was sustained or contracted, or (ii) for the symptoms of which you were treated by a legally licensed physician, or (iii) for which you were taking medication as prescribed by a legally licensed physician, during the 12 months prior to the date on which your insurance commenced under this Benefit, and

(2) begins in the first 12 months after the date you became insured under this Benefit.

Plan Termination

Termination of the Group Policy will not affect any claims incurred prior to termination and benefits will continue for such claims as though the policy was still in force.

SUPPLEMENTARY HEALTH INSURANCE BENEFIT FOR EMPLOYEES AND DEPENDENTS

Benefit

The Insurer will reimburse you for all covered expenses which are incurred by you or your insured dependents in an amount equal to the Benefit Percentage as outlined under the Summary of Benefits. Such amount will be subject to the Cash Deductible, any dollar maximums shown in the Summary of Benefits, and the limitations and exclusions included in this Benefit. The covered expenses apply separately to each insured person.

Covered Expenses

A charge made for any of the following services and supplies shall be considered to be a covered expense provided:

(1) The charge is deemed to be reasonable and customary by the Insurer. If the charge is in excess of what is deemed reasonable and customary, it will only be covered up to the level which has been deemed reasonable and customary.

(2) The charge is incurred after the person became insured under this Benefit.

(3) The services or supplies are deemed by the Insurer to be medically necessary.

(4) Coverage of the services or supplies is not prohibited under the Provincial Hospital or Provincial Medicare Act of your province of residence.

Out-of-province including out-of-country expenses are payable in excess of the benefits provided by the Provincial Hospital and/or Provincial Medicare Act of your province of residence, where not prohibited by government legislation or regulation.

Hospital Care

(1) Room and board charges made by a hospital, as shown in the Summary of Benefits.

(2) Hospital services and supplies furnished during a hospital confinement (not including special nursing services).

Nursing Care

Private duty nursing when (i) certified in writing by the attending physician as medically necessary and (ii) performed in the patient's home by a registered graduate nurse or registered nursing assistant, provided the nurse is not a relative of yours and does not have the same legal residence as you. All private duty nursing care must be pre-approved by the Insurer.

Convalescent Home Care

Room and board charges made by a convalescent home which is licensed by the appropriate licensing authority, to the extent that the charges are not covered by any other plans and do not include any part of a charge exceeding the limit stated under the Summary of Benefits, for a maximum of 120 days during any one continuous period of confinement provided the confinement:

(1) occurs within 48 hours following a hospital stay of at least 3 consecutive days,

(2) is for the same cause or causes as the preceding hospital stay,

(3) has been recommended and approved, in writing, by a legally licensed physician, and

(4) is primarily for rehabilitation or convalescent care and not primarily for custodial care.

"Continuous period of confinement" as used above, shall include all periods of confinement in a convalescent home which are due to the same or related cause or causes except periods of confinement separated by more than (i) 30 consecutive days, with respect to you and (ii) 180 consecutive days with respect to your dependent, during which you or your dependent was not so confined.

SUPPLEMENTARY HEALTH INSURANCE BENEFIT FOR EMPLOYEES AND DEPENDENTS

Ambulance, Laboratory and Out-Patient Charges

(1) Use of professional ambulance service (including, where necessary, use of air ambulance and scheduled common carrier), to transport the insured person in a medical emergency to the nearest hospital equipped to provide the required treatment.

(2) X-ray examinations and other diagnostic laboratory services.

(3) Out-patient charges.

Prescription Drugs (Drug Card Plan)

(1) The following items are covered when prescribed by a legally licensed physician, surgeon or dentist:

(a) Prescribed drugs which bear a valid Drug Identification Number (DIN) and are listed as prescription-requiring in the federal or provincial drug schedule.

Fertility drugs limited to a lifetime maximum of $1,000 per insured person.

(b) Prescribed drugs which bear a valid Drug Identification Number (DIN) and which by convention require a prescription.
(c) Extemporaneous preparations or compounds provided one of the ingredients is eligible for coverage.
(d) Insulin supplies, such as needles, syringes, lancets and diagnostic testing materials.

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.

If the drug you or your insured dependent require is a brand name product which has a generic equivalent, the level of payment will be based on the lowest priced interchangeable product. However, if the physician has included the notation "Do not product select", or "No Sub." or "No Substitution", the amount payable will be based on the cost of the eligible product prescribed.

(3) Items not covered, whether prescribed or not, include:

(a) Over-The-Counter (OTC) drugs.
(b) Alcohol, alcohol swabs, disinfectants, cotton or bandages.
(c) Vitamins, other than injectable vitamins, minerals, dietary supplements, infant formulas or injectable Total Parenteral Nutrition (TPN) solutions.
(d) Diaphragms, condoms, contraceptive jellies/sponges/foams/suppositories, Intrauterine Devices (IUDs), contraceptive implants or appliances normally used for contraception.
(e) Proprietary drugs bearing a General Product (G.P.) number.
(f) Homeopathic preparations.
(g) Prescriptions dispensed by a physician, dentist, clinic or by any non-accredited hospital pharmacy or for treatment as an outpatient in a hospital, including emergency status and investigational status drugs.
(h) Preventative immunization vaccines and toxoids.
(i) All allergy extracts, compounded by a lab, which do not bear a Drug Identification Number (DIN).
(j) Habit breaking drugs for, but not limited to, smoking, obesity, drugs and alcohol.
(k) Drugs considered lifestyle drugs such as, but not limited to, drugs for the treatment of erectile dysfunction, but not including drugs for the treatment of infertility.

SUPPLEMENTARY HEALTH INSURANCE BENEFIT FOR EMPLOYEES AND DEPENDENTS

Paramedical Care

Services performed by a licensed Chiropodist[(1)] or Podiatrist, Chiropractor, Masseur, Naturopath, Osteopath, Speech Therapist, Physiotherapist*, or Psychologist, excluding any charges in excess of the limits stated in the Summary of Benefits.

([(1)] in Ontario and Saskatchewan only

*Physiotherapist's services must be recommended and approved, in writing, by a legally licensed physician.

Appliances

The Insurer will rent or purchase at its option the following:

splints excluding dental splints,
apnea monitors for respiratory disrhythmias,
canes and walkers,
crutches,
casts,
burn garments,
sleeves for lymphoedema following mastectomy,
support hose (calendar year maximum of $100 per insured person),
braces with rigid support,
orthopedic shoes which have been custom made, customized or custom molded for the Insured and which were recommended, in writing, by a legally licensed physician, up to a calendar year maximum of $300 per insured person,
artificial eyes (repairs and replacements covered up to a calendar year maximum of $1,000 per insured person),
artificial limbs and prostheses other than myoelectric and electric prostheses (repairs and replacements covered up to a calendar year maximum of $2,000 per insured person),
wigs required as a result of chemotherapy or bodily injury (lifetime maximum of $500 per insured person),
back supports,
stump socks,
shoulder harnesses,

head halter,
traction apparatus,
cervical collar,
colostomy and ileostomy apparatus and supplies,
catheters,
external breast prosthesis (two per insured person in any calendar year),
surgical bras (two per insured person in any calendar year),
diabetic monitoring and administration equipment (lifetime maximum of $1,000 per insured person),
non-electric wheelchairs (lifetime maximum of $2,000 per insured person) or electric wheelchairs where medically necessary (lifetime maximum of $4,000 per insured person).
hospital beds,
bed rail,
trapeze bar,
transcutaneous nerve stimulator (lifetime maximum of $2,000 per insured person),
intermittent positive pressure breathing machine,
aerosol equipment, mist tents and nebulizers for cystic fibrosis, acute emphysema, chronic obstructive bronchitis or chronic asthma,
oxygen tent and oxygen supplies,
sphygmomanometers (lifetime maximum of $200 per insured person).
Foot orthoses which have been specifically designed and constructed for the Insured and which were recommended, in writing, by a physician or legally licensed surgeon, up to a calendar year maximum of $300 per insured person.
Hearing aids obtained on a written prescription of a physician licensed as a otolaryngologist (excluding charges for batteries) up to $400 per insured person in any 5 consecutive calendar years.

Physician's Services

(1) Charges made by a legally licensed physician or surgeon in your province of residence, in excess of the current tariff of the relevant Medical Association, where not prohibited by any government legislation or regulations.

(2) Charges made by a legally licensed physician or surgeon in respect of services performed outside of your province of residence but excluding

any benefit payable under the provincial government plan and where not prohibited by any government legislation or regulations.

Out of Canada Emergency Coverage

Charges made for services performed outside of Canada provided that:

(1) The services are required for emergency treatment of an injury, disease or pregnancy while travelling.

(2) The emergency occurs within the first 90 days of the insured person's absence from Canada.

(3) The services are defined under this Benefit , except that any charges for hospital room and board will be limited to ward level.

(4) The services would have been covered if they had been performed in Canada.

Travel Assist

This coverage is provided by the Insurer through CanAssistance Inc.

To make use of this coverage simply phone the number on your TRAVEL ASSIST card and provide whatever information is requested by the co-ordinator at CanAssistance Inc.

The following charges and services will be supplied with respect to a medical or personal emergency while you and/or your insured dependents are travelling outside of Canada for the purpose of vacation or business provided the medical or personal emergency occurs during the first 90 days after the commencement of the absence from Canada:

(1) Multilingual assistance by telephone or telex, 24 hours a day, 365 days a year. (This includes interpretation services in most major languages.)

(2) Assistance in locating appropriate medical care.

(3) If required to obtain needed emergency medical treatment, an advancement of funds will be provided for such treatment, subject to a maximum of $5,000.

(4) If you or your insured dependent's medical condition requires it, transportation to a medical facility or repatriation to a hospital in Canada, under proper medical supervision, if needed, will be arranged.

(5) If you and/or your insured dependents are travelling together and miss a pre-arranged return flight home due to the hospitalization or death of one member, economy class transportation will be arranged and paid for to the original point of departure in Canada. (If the return tickets have any redeemable value only the additional costs necessary after applying such value to the transportation will be provided.)

(6) If you or your insured spouse is hospitalized and as a result your insured children are left unattended, economy class transportation will be arranged and paid for to their usual home in Canada. If needed an escort will be arranged. (If valid transportation tickets should exist only the additional costs necessary for the return tickets after applying the value of the original tickets will be provided.)

(7) If you or one of your insured dependents are travelling alone and are hospitalized for at least 7 consecutive days, round-trip economy class transportation will be arranged for a spouse, parent, child, brother or sister to visit. (The visit must be considered by the attending physician to be beneficial to the patient.)

(8) If a transportation benefit is provided under 5, 6 or 7 above, charges incurred for commercial accommodation and meals will be reimbursed, up to a maximum of $150 per day for a period of up to 7 days. (For reimbursement retain the receipts and submit them to CanAssistance Inc. upon returning to Canada.)

(9) If you or one of your insured dependents should die while travelling outside of Canada, all necessary authorizations and arrangements will be made to return the remains to their province of usual residence. A

maximum of $3,000 will be provided. (The cost of a burial coffin will be excluded.)

Note: The maximum amount provided under 5, 6, 7, 8 and 9 above, during any one travel emergency will be $10,000.

(10) Assistance in replacing lost or stolen documents or tickets.

(11) Assistance in locating legal assistance and, if needed, arranging cash advances from credit cards, family or friends to pay bail or legal fees.

(12) A message center where messages will be held for and from you or your insured dependent who is travelling, for up to 15 days.

The following limitations will apply to this Covered Expense:

(1) You and/or your insured dependent will be responsible for any services requiring payment of $200 or less. (For these services submit the receipts to the government body administering the Provincial Hospital or Provincial Medicare Act of your province of residence and the Insurer for reimbursement.)

(2) Services will not be provided in (i) Canada, (ii) countries designated from time to time (it is your responsibility to enquire with CanAssistance Inc., whether the services are provided in a particular country prior to your or your insured dependent's departure), and (iii) any countries where the local authorities refuse to permit the providing of the services described above.

Neither the Insurer nor CanAssistance Inc. and its affiliated companies will be responsible for the availability, quantity, quality or results of services requested and received under this Covered Expense or the failure of you and/or your insured dependents to receive medical services for any reason.

SUPPLEMENTARY HEALTH INSURANCE BENEFIT FOR EMPLOYEES AND DEPENDENTS

Accidental Dental Coverage

Charges by a legally licensed dentist for treatment necessitated by a traumatic injury to sound natural teeth or the surrounding tissues provided:

(1) The damage is not due to an object or food placed wittingly or unwittingly in the mouth.

(2) The injury occurs while the insured person is insured under this Benefit.

(3) The charges are incurred within twelve months of the injury. However, if the charges are to be incurred more than 60 days after such injury, a treatment plan must be submitted to the Insurer within 60 days of the injury.

(4) The treatment is the least expensive that will provide a professionally adequate result.

(5) No payment will be made by the Insurer for any part of the charge which exceeds the amount shown for the treatment in the Current Provincial Fee Schedule for general practitioners in your province of residence.

The total amount payable under this covered expense during the lifetime of the insured person (whether or not the insured person is continuously insured) including any amount payable for charges incurred following discontinuance of the insured person's insurance under this Benefit shall not exceed the limit stated in the Summary of Benefits.

Extension of Benefits

If you or your insured dependent is disabled on the date your or their insurance is discontinued under this Benefit, benefits will be available during the continuance of such disability but only while this Benefit remains in force and only with respect to the charges for covered expenses which arise as a result of the disability, provided such charges are incurred within three months of the date of the discontinuance.

SUPPLEMENTARY HEALTH INSURANCE BENEFIT FOR EMPLOYEES AND DEPENDENTS

As used above “disabled” and “disability” mean

(1) with respect to you, a state of incapacity resulting from disease, injury or pregnancy by which you are unable to perform substantially all of the essential duties of any occupation or employment for which you are reasonably qualified by education, training or experience, and

(2) with respect to your dependent, that due to injury, disease or pregnancy your dependent is confined to hospital or is receiving treatment by a legally licensed physician or surgeon.

Survivor Benefit

If you die while insured under this Benefit and prior to any continuance of insurance as provided under the Extension of Benefits section, insurance under this Benefit will be continued with respect to your dependents who were insured under this Benefit on the date of your death, without payment of premiums. The insurance will terminate on the earliest of:

(1) 2 years following the date of your death, and

(2) the date the dependent no longer qualifies as a dependent, and

(3) the date of termination of this Benefit with respect to active employees.

Coordination of Benefits

The Group Policy includes a Coordination of Benefits provision. This provision operates in the event that you and/or your insured dependents are covered under this policy as an employee and as a dependent or as a dependent of more than one employee, or under another Group Plan, or individual insurance plan, or any government legislated automobile insurance plan including the Quebec Automobile Insurance Plan, and ensures that payments made by all plans do not exceed the actual expenses incurred.

SUPPLEMENTARY HEALTH INSURANCE BENEFIT FOR EMPLOYEES AND DEPENDENTS

Exclusions

"Covered Expenses" shall not include any charge:

(1) For any services or benefits which are "insured services or benefits" under any government legislation or regulation and to the extent that insurance for such service is prohibited by law.

(2) For or in connection with general health examinations.

(3) For or in connection with the treatment of pre-existing dental disease or orthodontic malocclusion in order to facilitate treatment for a traumatic injury to sound natural teeth or the surrounding tissues.

(4) For or in connection with a surgical procedure or treatment performed for primarily cosmetic reasons, or for hospital confinement for such procedure or treatment.

(5) For or in connection with any services or supplies which are for the sole purpose of facilitating the insured person's participation in sports or recreational activities and not for other daily living activities.

(6) For services or treatments due to insurrection or war, declared or undeclared, whether or not the insured person is actually participating in such insurrection or war.

(7) Which occurs as a result of participation in a riot or civil commotion.

(8) Which results from the commission of or attempted commission of a criminal offense or the provoking of an assault.

(9) Which results from an intentionally self-inflicted injury while sane or insane.

(10) For services for which the insured person is not required to make payment or where payment is received as a result of legal action or settlement.

(11) For any drugs, medicines, medical testing, surgical procedures and appliances considered by the Insurer to be experimental and not recognized by the Canadian Medical Association as an established standard treatment for the condition.

(12) For private duty nursing where:

(a) services are performed by a registered graduate nurse unless such qualified individual is required to administer intravenous medication or narcotics and to continuously monitor the vital signs of the patient;

(b) services are performed by a registered nursing assistant when the care could be administered by a less qualified individual;

(c) no record of the nurse's daily duties are submitted as part of the proof of claim.

(13) For any orthotic appliance which was not specifically designed and constructed for the insured person and which was not recommended, in writing, by a legally licensed physician or surgeon.

(14) For any fees charged in respect of services performed by a legally licensed physician or surgeon in your province of residence which are not included in the current tariff of the provincial government plan.

(15) For or in connection with any services received or performed outside of Canada which (i) are due to a pregnancy (includes childbirth, miscarriage or any complications incident to a pregnancy) and which are received or performed after the 32nd week of gestation, or (ii) are due to the deliberate inducement of a miscarriage.

(16) For any emergency services provided outside of Canada if the absence from Canada was for a purpose other than business or vacation travel.

(17) For which the insured person incurs while attending an accredited educational institute, college or university outside of Canada.

(18) For or in connection with any services or supplies received outside of Canada during an emergency if such services or supplies could have been delayed until the insured person returned home without endangering the insured person's health.

(19) For any non-emergency services received or performed outside of Canada.

(20) For which the insured person may apply and receive indemnity or compensation under any Worker's Compensation Act.

(21) For any care or treatment which was provided by a healthcare provider who, or a service provider that:

(a) has been charged with professional misconduct or improper practices; or

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

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

(d) is a member of a profession that is not regulated by an officially recognized federal or provincial regulatory body in the jurisdiction where the services were provided and, in the reasonable opinion of the insurer, does not meet the industry standards relevant to his profession.

Conversion Privilege

If your coverage under the Group Policy is cancelled due to termination of

a) your employment; or

b) your group membership,

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

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

You must make application and pay all required premium for the individual insurance contract within 60 days of the termination date of your insurance under the Group Policy. Failure to submit the application and premium within such 60 days will prevent you 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.

DENTAL EXPENSE BENEFIT FOR EMPLOYEES AND DEPENDENTS

Benefit

The Insurer will reimburse you for all covered expenses which are incurred by you or your insured dependents. Payment will be made up to the amount set for General Practitioners in the Provincial Association Schedule of Fees subject to the Benefit Percentage, Cash Deductible and any dollar maximums shown in the Summary of Benefits and the limitations and exclusions included in this Benefit.

Alternative Courses of Treatment

When there are two or more courses of treatment available with respect to a dental condition, the amount payable under this Benefit will be limited to the least expensive treatment which will produce a professionally adequate result.

Pre-Determination of Benefits

When a course of treatment is expected to exceed $500 or when an alternative course of treatment is available, you may want to submit a treatment plan, prepared by the dentist, for review prior to the treatment commencing. This will enable the Insurer to determine for you what level of coverage will be provided under this Benefit with respect to the proposed treatment, thus avoiding any potential misunderstandings.

Covered Expenses

A charge made for any of the following services shall be considered to be a covered expense provided:

(1) The charge was incurred after the person became insured under this Benefit.

(2) The services for which the charge was incurred are deemed by the Insurer to be necessary.

(3) The services for which the charge was incurred were performed by a legally licensed dentist.

(4) Coverage of the services for which the charge was incurred is not prohibited by law.

PART A SERVICES

(1) Diagnostic

(a) Clinical oral examinations
- complete oral examinations – limited to one in any 3 calendar years
- recall examinations – limited to 2 in any calendar year
- all other limited and specific examinations – limited to 2 in total in any calendar year

(b) X-rays
- complete series – limited to one in any 3 calendar years
- bitewings – limited to 6 films in any calendar year
- panoramic – limited to one in any 3 calendar years

(c) Histological, cytological and pulp vitality tests and analyses

(d) Treatment planning and consultation with the dentist – limited to 2 units in any calendar year

(2) Preventive Services

(a) Polishing of teeth – limited to 2 units in any calendar year

(b) Scaling of teeth – limited to 2 units in any calendar year*
* If Periodontal Services are covered under this Benefit, any additional units of scaling will be combined with root planing.

(c) Topical application of fluoride – limited to twice in any calendar year

(d) Oral hygiene instruction – limited to once per lifetime

(e) Application of fissure sealants for children under 18 years of age

(f) Space maintainers for children under 18 years of age – maintenance limited to twice in any calendar year

(g) Finishing restorations provided the restorations are at least 2 years of age

(h) Interproximal disking of teeth – limited to 2 units in any calendar year

(i) Recontouring of teeth for functional reasons – limited to 2 units in any calendar year

(3) Minor Restorative Services – only covered if necessitated by decay or traumatic injury to the teeth

(a) Caries, trauma and pain control

(b) Amalgam, prefabricated (for children under 18 years of age), tooth coloured composite and gold foil restorations

(c) Retentive pins

(4) Minor Surgical

(a) Removal of teeth and residual roots

(b) Control of hemorrhages

(5) Additional Services

(a) Anesthesia – local, general, deep and conscious sedation

(b) Special professional visits (home, office and institutional visits) – limited to $250 in total during any calendar year

(c) Therapeutic injections

(d) Repairs or additions to dentures – limited to twice in any calendar year

(e) Relining or rebasing of dentures – limited to once in any 2 years

(f) Repairs to porcelain/ceramic inlays, onlays and crowns

(g) Recontouring of existing crowns

PART B SERVICES

(1) **Endodontic Services** (includes pulpotomy/pulpectomy, root canal therapy, apexification and periapical services) – a claim for services on a tooth within 3 months of a previous claim on the same tooth will be reduced by the amount of the previous benefit paid

(2) **Periodontic Services** (includes non-surgical, surgical and adjunctive services)

- occlusal adjustment/equilibration – limited to 2 units in any calendar year
- root planing – limited to 8 units in any calendar year*
  * Will be combined with any units of scaling which are in excess of the limit stated under the Preventive Section.
- periodontal appliances (includes impression, insertion and adjustment) – limited to one in any 4 years
- repair, maintenance and adjustments of periodontal appliances – limited to 2 units in any calendar year

(3) **Oral Surgery**

(a) Transplantation or repositioning of tooth – limited to a maximum of $150

(b) Remodelling and recontouring of oral tissues (includes alveoloplasty, gingivoplasty, stomatoplasty and vestibuloplasty)

(c) Surgical excision provided not in conjunction with tooth removal

- excision of benign or malignant tumors – if over 1 cm. in diameter will be limited to a maximum of $150
- enucleation of cysts/granulomas – if over 1cm. in diameter will be limited to a maximum of $150
- marsupialization of cyst – if over 1cm. in diameter will be limited to a maximum of $150
- excision of cyst – if over 1cm. in diameter will be limited to a maximum of $150

(d) Surgical incisions
- removal of foreign bodies – limited to a maximum of $150

(e) Treatment of fractures (includes treatment of mandibular, maxillary and alveolar fractures)
- mandibular or maxillary fractures (includes wiring) – if open reduction will be limited to a maximum of $750

- alveolar fractures - repairs and lacerations - if over 6 cm. will be limited to $750

(f) Frenectomy/ frenoplasty

(g) Antral surgery

Coordination of Benefits

The Group Policy includes a Coordination of Benefits provision. This provision operates in the event that you and/or your insured dependents are covered under the policy as an employee and as a dependent or as a dependent of more than one employee, or under another Group Plan, or individual insurance plan, or any government legislated automobile insurance plan and ensures that payments made by all plans do not exceed the actual expenses incurred.

Survivor Benefit

If you die while insured under this Benefit and prior to any continuation of insurance that may be provided, the insurance under this Benefit will be continued with respect to your dependents who are insured under this Benefit on

the date of your death, without payment of premiums. The insurance will terminate on the earliest of

(1) 2 years following the date of your death, and

(2) the date the dependent no longer qualifies as a dependent, and

(3) the date of termination of this Benefit with respect to active employees.

Limitations

If the date your or your dependent's insurance commenced is more than 31 days after the date you or your dependent became eligible, covered expenses will be limited to $200 for the first 12 months of coverage, during which time full premiums must be paid.

Exclusions

The determination of "Covered Expenses" shall not include any charge:

(1) For services or treatments due to insurrection or war, declared or undeclared, whether or not the insured person is actually participating in such insurrection or war.

(2) For services or treatments due to participation in any riot or civil commotion.

(3) For services or treatments due to the commission of or attempted commission of a criminal offense or provoking an assault.

(4) For services or treatments due to an intentionally self-inflicted injury, while sane or insane

(5) For services or an examination performed by a dentist solely for the use of a third party.

(6) For recent duplication of services by the same or a different dentist.

(7) For a broken appointment.

(8) For services or treatments which the insured person received while attending an accredited educational institute, college or university outside of Canada.

(9) For services or treatments for which an insured person is not required to pay, including any expenses reimbursed, assumed or allowed under any other non-contractual plan, scheme or arrangement.

(10) For services for which the insured person receives payment as a result of legal action or settlement.

(11) For which the insured person may apply for and receive indemnity or compensation under any Workers' Compensation Act.

(12) For services or treatments performed by a specialist and which are only included under a Specialist's Dental Fee Guide.

(13) For services or treatments considered by the Insurer to be experimental and not recognized by the Canadian Dental Association as an established, standard treatment for the condition.

(14) For services or treatments which are due to or related (directly or indirectly) to implants.

(15) For a full mouth reconstruction, for a vertical dimension correction, or for a correction of a temporomandibular joint dysfunction.

(16) For services or treatments performed for primarily cosmetic reasons.

(17) For the placing of crowns to restore occlusal height or as a preventive measure.

(18) For the permanent splinting of teeth.

(19) For services or treatments furnished before the date on which the insured person on whose account the charge was made became insured under this Benefit.

Conversion Privilege

If your coverage under the Group Policy is cancelled due to termination of

(1) your employment; or

(2) your group membership,

you will be able to convert your dental care insurance coverage to an individual insurance contract without having to submit evidence of insurability to the insurer, provided you are also converting your supplementary health insurance. Failure to convert your supplementary health insurance will prevent you from converting your 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.

You must make application and pay all required premium for the individual insurance contract within 60 days of the termination date of your insurance under the Group Policy. Failure to submit the application and premium within such 60 days will prevent you 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.

GENERAL INFORMATION

Your Eligibility

You are eligible, and will continue to be eligible, to be covered for the insurance described in this booklet while you meet all of the following conditions:

(3) You are a full-time employee and are actively working for your employer.

(4) You are a full-time resident of Canada.

(5) You have been continuously employed by your employer for at least as long as the waiting period defined below.

(4) You are under 70 years of age.

(5) You are insured under the Provincial Hospital and/or Provincial Medicare Plan of your province of residence. (This condition only applies to the insurance provided under the Supplementary Health Insurance Benefit.)

Your waiting period: 3 months of continuous employment for your employer.

Date Your Coverage Commences

Your coverage will commence on the latest of:

(1) the date you satisfy the conditions of eligibility,

(2) the date you complete an application for coverage, and

(3) the date of approval by the Insurer of any required evidence of insurability,

provided you are then actively at work. If you are not actively at work on the date your coverage is to commence, your coverage will not commence until you return to work.

GENERAL INFORMATION

If you complete your application for coverage more than 31 days after you have satisfied the conditions of eligibility, you will be required to provide satisfactory evidence of your insurability to the Insurer for all coverages.

Date Changes In Your Coverage Take Effect

An increase in your coverage will take effect on the later of:

(1) the date you become eligible for the change in coverage, and

(2) the date of approval by the Insurer of any required evidence of insurability,

provided you are then actively at work. If you are not actively at work on the date your coverage is to increase, the increase will not take effect until you return to work.

A decrease in your coverage will take effect automatically on the date of the change.

Evidence of insurability will be required as specified in the Summary of Benefits and as detailed in the Group Policy.

Date Coverage On Your Dependents Commences

If you are insured, you may apply to cover your dependents. The coverage on your dependents will commence on the date you apply for it provided you applied within 31 days of first being eligible to do so. If you apply for the coverage more than 31 days after you were first eligible to do so, you will be required to furnish satisfactory evidence of insurability of your dependents to the Insurer, at your expense, before the coverage on your dependents may commence.

If you already have dependents covered, all future dependents will become covered automatically on the date they become dependents.

If on the date a dependent is to become covered, the dependent is confined to a hospital or other treatment facility for the purpose of medical care or treatment, the coverage with respect to the dependent shall not become effective until the

date the dependent is no longer so confined. This paragraph will not result in postponing the effective date of the coverage on a child born while you have other dependents covered.

For the purposes of the Supplementary Health Insurance Benefit a dependent will not become covered unless the dependent is covered under the Provincial Hospital and/or Provincial Medicare Plan of your province of residence.

Conditions Under Which You May Waive Coverage

If your spouse is covered for benefits which are comparable to the benefits under the Supplementary Health Insurance Benefit and/or Dental Expense Benefit you may decline to cover yourself and your dependents or your dependents only, for such benefits under the Group Policy.

If the coverage under your spouse's plan should cease because the plan terminated or eligibility for such coverage ceased, you may make application to cover under the Group Policy those persons who had been covered under your spouse's plan.

Such application must be made within 31 days after the cessation of the coverage under your spouse's plan and the coverage under the Group Policy shall be effective on the day following the date of termination of the coverage under your spouse's plan.

No benefits, other than the Supplementary Health Insurance Benefit and the Dental Expense Benefit may be waived.

GENERAL INFORMATION

Conditions Under Which Your Coverage Terminates

Your coverage under the Group Policy terminates when your employment terminates, unless otherwise provided in the Summary of Benefits.

Information may be obtained from your employer regarding the status of your coverage in the event of layoff, leave of absence, or absence caused by disability.

Submission Of Claim

Written proof stating the occurrence, character and extent of the loss for which a claim is being made must be furnished to the Insurer as follows:

(1) With respect to Life and Accidental Death and Dismemberment Benefits, as soon as possible after the loss, but in any event within one year of the date of the loss.

(2) With respect to the Long Term Disability Benefit, within 90 days of the commencement of the period for which the Insurer is liable.

(3) With respect to the Supplementary Health Insurance Benefit and the Dental Expense Benefit, the claim must be submitted in the calendar year in which the claim was incurred or the calendar year immediately following the calendar year in which the claim was incurred.

However:

(a) If your employment should terminate, proof of loss must be submitted to the Insurer within 90 days of the date of your termination, or if the plan should terminate during the 90 days, proof of loss must be submitted on or prior to the plan's termination date. Any Supplementary Health and Dental Expense claims submitted after the earlier of the 90th day following your termination of employment and the plan's termination date will not be eligible for reimbursement from the Insurer, regardless of whether or not they were incurred prior to the date your employment terminated.

(b) If the plan should terminate, proof of loss must be submitted to the Insurer on or prior to the date of termination. Any Supplementary Health and Dental Expense claims submitted after the date of termination will not be eligible for reimbursement by the Insurer, regardless of whether or not they were incurred on or prior to the plan's termination date.

If proof of loss has not been submitted by the dates specified above, the Insurer will not be responsible for the claim.

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 you have intentionally submitted a claim that contains false or misleading information, the insurer shall have the right, at its sole discretion, to notify the policyholder, decline the claim or require reimbursement if the claim has been paid. In addition, the insurer will have the right to terminate your entire coverage under this policy including any coverage for your dependents.

Discontinuance of the Group Policy

Your employer hopes and expects to continue the plan indefinitely, but the possibility of unforeseen circumstances makes it necessary to reserve the right to amend, suspend or entirely discontinue the plan at any time.

GENERAL INFORMATION

Medical Services and/or Supplies Covered by a Government Sponsored Plan or Program

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

Incontestability

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

a) insurance or a benefit for you or your dependent; or
b) an increase, addition or change in the insurance or benefit for a you or your dependent;

the statements provided by you or your 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 your or your dependent is alive at the time:

a) 2 years from the effective date of the insurance or benefit for which the evidence was provided; or
b) 2 years from the effective date of the increase, addition or change to the insurance or benefit; or
c) 2 years from the effective date of the last reinstatement of the insurance or benefit.

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

GENERAL INFORMATION

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

Beneficiary

Your beneficiary shall be the person or persons designated by you, in writing, to receive the death benefit payable under the Life Insurance Benefit, and if applicable, the Accidental Death and Dismemberment Insurance Benefit, Optional Life Insurance Benefit and Optional Accidental Death and Dismemberment Insurance Benefit. If you do not designate a beneficiary, any death benefit payable under such benefits will be payable to your estate.

All benefits, other than the Life Insurance Benefit, Accidental Death and Dismemberment Insurance Benefit, Optional Life Insurance Benefit and Optional Accidental Death and Dismemberment Benefit, will be payable only to you, or if you are deceased at the time of the payment of the benefit, to your estate.

You 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 you named a beneficiary under the Policyholder's prior group policy, such designation will be applicable to the insurance provided under this policy, unless you have changed the designation in writing with the insurer. You should review the beneficiary designation made under the Policyholder's prior group policy to ensure that it reflects your current intentions in regard to his insurance.

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

GENERAL INFORMATION

Limitation on Legal Actions

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

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

Copy of Contract and Enrolment Material

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

DEFINITIONS

The following terms are used in this Booklet.

"Actively at Work" means that you are:

(1) at work and performing all of the usual and customary duties of your occupation on a full-time basis, if it is a scheduled work day, or

(2) capable of performing all of the usual and customary duties of your occupation on a full-time basis, if you are not at work due to it being a non-scheduled work day, holiday or vacation day. You will not be considered to be actively at work if you are either hospital confined or disabled to a degree that you could not have reported to work.

"Dependent" shall mean:

(1) Your spouse. Spouse shall mean either:

(a) an individual who is married to you by reason of a valid religious or civil marriage ceremony, while not legally separated from you,

or

(b) your common-law spouse.

If you have had more than one spouse, spouse shall mean the individual most recently qualified.

(2) Each unmarried child, step-child, legally adopted child or common-law child of yours provided the child is not employed on a full-time basis, relies fully upon you for support and maintenance and fits one of the following descriptions:

(a) the child is under 21 years of age, or

(b) the child is at least 21 years of age but under 25 years of age and is attending an accredited educational institute, college or university on a full-time basis.

(3) each unmarried child, step-child, legally adopted child or common-law child of yours, regardless of such child's age, if the child, due to a mental or physical handicap, is incapable of earning their own living and relies fully upon you for support and maintenance provided such handicap commenced while the child was a dependent child as defined in clause (2) and that proof of such handicap was received by the Insurer within 31 days of the applicable of the maximum ages stated in clause (2).

However, for the purpose of this plan, anyone who is:

(a) in the armed forces of any country or state or international organization or a civilian force auxiliary to any military force, or

(b) at least 70 years of age,

will be excluded from this definition.

“Common-law spouse” shall mean a person who resides with you and who has resided with you for at least 12 months and whom you publicly represent as your spouse.

“Common-law child” shall mean a child of your common-law spouse from another relationship and who resides with you and is in your and your common-law spouse's care and custody.

“Monthly earnings” shall mean all forms of regular monthly income which have been received by you as employment earnings from your employer and which have been reported to the Insurer. Your monthly earnings will not include any additional forms of income such as, but not limited to, bonuses, commissions, dividends and overtime, which you may have received from your employer.

“Annual earnings” shall mean the total of the monthly earnings you have received from your employer over the immediately preceding 12 months.

“Full-time employee” shall mean a person who customarily works a regularly scheduled work week of at least 21 hours per week with the employer.

“Calendar year” shall mean the period from any January 1st to the next following December 31st, both inclusive.

DEFINITIONS

“Pregnancy” shall include childbirth or a miscarriage and any disease or infirmity from or aggravated by the pregnancy.

“Pregnancy leave of absence” shall mean:

(1) any period of pregnancy taken by you pursuant to Provincial or Federal statute or pursuant to a mutual agreement between you and your employer, or

(2) any pregnancy leave which your employer requires you to take pursuant to Provincial or Federal statute.

However, if you have not taken or been required to take a pregnancy leave of absence, you will be deemed to have commenced a pregnancy leave of absence on the date of your child's birth. Your leave will be deemed to continue until you are again actively at work or if you are unable to return to work as a result of a disability, the end of the period specified by Provincial or Federal statute for a pregnancy leave of absence.

“Parental leave of absence” shall mean:

(1) any period of parental leave taken by you pursuant to Provincial or Federal statute, or

(2) any period of parental leave taken by you pursuant to a mutual agreement between you and your employer.

“Emergency” means a sudden, unexpected occurrence that requires immediate medical attention.

PROTECTING PERSONAL INFORMATION

Industrial Alliance is committed to protecting the privacy of your (including your dependent's) personal information that it collects while providing services under the Group Plan issued to the Policyholder. Industrial Alliance recognizes and respects a person's right to privacy concerning his or her personal information.

When you enroll under the Group Plan, Industrial Alliance will establish a confidential file containing the personal information collected. The file will be kept at Industrial Alliance's offices.

Access to the file will be limited to Industrial Alliance employees, agents and service providers who require access in the performance of their jobs, individuals to whom you have granted access, and persons authorized by law.

At Industrial Alliance 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; and
- Underwriting (includes determining the rates applicable to the Group Plan).

Your Right to Access Your Personal Information

You have the right to access your personal information and to request, in writing, that any inaccurate information be corrected. In addition, you can request that any outdated or unnecessary information be deleted.

If Industrial Alliance has medical information about you which was not obtained directly from you, Industrial Alliance will release the information to you only through your physician.

PROTECTING PERSONAL INFORMATION

To request access to your personal information or to have your name removed from the list to be shared within the Industrial Alliance Group, you 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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