Your group insurance plan

CRYSTAL CONSULTING GROUP OF COMPANIES

ALL EMPLOYEES OF
KANIN CONSTRUCTION MANAGEMENT

Policy No. 667435

Desjardins
Insurance
Life • Health • Retirement

Your Group Insurance

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You may access Claim forms and other information online at:

desjardinslifeinsurance.com

For information, you may contact
our Group Customer Contact Centre

Toll-Free number: 1-800-263-1810

This document is an integral part of the Insurance certificate. It is a summary of your Group Insurance Policy. Only the Group Insurance Policy may be used to settle legal matters.

Use of masculine is intended to include both women and men.

Effective date of the plan: September 1, 2020

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BENEFIT SCHEDULE

GENERAL GUIDELINES

Participation:	Mandatory
Eligibility Requirements	
Number of hours worked per week:	A minimum of 24 hours per week.
Eligibility of Seasonal Employees:	Seasonal Employees are not covered under the policy.
Eligibility Period:	3 months of continuous service for the Employer

BASIC PARTICIPANT LIFE INSURANCE BENEFIT

Amount of Insurance:	* $50,000
Non-Evidence Maximum of Insurability:	$50,000
*** Reduction of Amount:**	On the 65th birthday of the Participant, the amount applicable to the Participant will be reduced by 50%.
Waiver of Premium:	The first day of the month following the date on which Long Term Disability Benefits are expected to commence.

Benefit Termination

Age Limit:	Age 71 of the Participant, or retirement whichever occurs first.

DEPENDENT LIFE INSURANCE BENEFIT

Amount of Insurance:	Spouse: $10,000 Each Child: 50% of the Dependent Life Insurance amount for the Spouse.
Commencement of Newborn Children Insurance:	24 hours after birth

Benefit Termination

Age Limit:	Age 71 of the Participant, or retirement whichever occurs first.

PARTICIPANT ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Amount of Insurance:	Amount is equal to the amount of insurance for which the Participant is eligible under the Participant Basic Life Benefit amount.
*** Reduction of Amount:**	On the 65th birthday of the Participant, the amount applicable to the Participant will be reduced by 50%.

Benefit Termination

Age Limit:	Age 71 of the Participant, or retirement whichever occurs first.

PARTICIPANT LONG TERM DISABILITY BENEFIT

Percentage and Maximum of Benefit:	66 2/3% of gross monthly Earnings, rounded to the next $1, if not already a multiple, up to a maximum of $5,000.
Non-Evidence Maximum of Insurability:	$5,000
Elimination Period:	16 weeks
Maximum Benefit Period:	To age 65
Taxability of Benefits:	Taxable

Benefit Termination

Age Limit:	Age 65 of the Participant, or retirement whichever occurs first.

EMPLOYEE ASSISTANCE PROGRAM 360º

See the EMPLOYEE ASSISTANCE PROGRAM 360º section for details.

Age Limit: Age 71 of the Participant, or retirement whichever occurs first.

EXTENDED HEALTH CARE BENEFIT

Deductible Amount

Drug Co-pay:	Nil
Hospitalization Expenses:	Nil
Travel Insurance:	Nil
Referral Treatment:	Nil
Eyeglasses, Lenses and Eye surgery:	Nil
Dental treatment due to an accident:	Nil
Other Expenses:	Nil
Drug Payment Card:	Direct

Percentage of Reimbursement

Drugs:

1) Generic drugs: 90%* of the lowest priced equivalent drug available on the market

2) Brand name drugs:

   - 90%* of the brand name drug if no equivalent drug is available on the market
   - 90%* of the lowest priced equivalent drug available on the market

* For all employees, if drugs are purchased at a Costco pharmacy, the percentage of reimbursement is increased by 10%.

Hospitalization Expenses: 100%

Dental treatment due to an accident:	100%
Travel Insurance:	100%
Referral Treatment:	80%
Other Expenses:	100%
Eyeglasses, Lenses and Eye surgery	
Eyeglasses, Contact Lenses and Eye surgery:	100%
Contact lenses: (Special conditions)	100%
Limits for Eligible Expenses	
Drugs:	Reasonable and Customary Charges
Hospitalization Expenses:	The cost of a semi-private room for each day of Hospitalization with no limit as to the number of days.
Palliative Care Establishment:	Up to an eligible amount of $40 per day and a lifetime maximum of 60 days.
Convalescent/ Rehabilitation Centre:	Up to an eligible amount of $40 per day and a maximum of 180 days per Period Of Hospitalization.
Travel Insurance:	Up to a payable lifetime maximum of $5,000,000 per Insured Person.
Nursing Care:	Payable amount of $10,000 per Insured Person each Calendar Year.

Paramedical Services:	Payable amount of $500 for each discipline per Insured Person each Calendar Year. For each type of professional, the maximum is limited to one visit per day.
Eyeglasses, Lenses and Eye surgery:	Payable amount of $200 per Insured Person once in any 24 month period for adults and any 12 month period for children under 18.

Benefit Termination

Age Limit:	The date of retirement.

DENTAL CARE BENEFIT

Fee Guide Year:	Current year
Deductible Amount:	Nil
Percentage of Reimbursement	
Preventive Services:	80%
Basic Services, Endodontics and Periodontics:	80%
Major Restorative Services:	50%
Maximum Benefit	
Preventive Services, Basic Services, Endodontics, Periodontics and Major Restorative Services:	Combined maximum of $2,000 per Insured Person each Calendar Year.
Frequency:	For recall oral examination, polishing, light scaling and fluoride treatment: 6 months
Limitations:	Fees for composite restorations performed on either anterior or posterior teeth are eligible.
Payment Card and Electronic Data Interchange (EDI):	Yes
Benefit Termination	
Age Limit:	The date of retirement.

DEFINITIONS

Wherever used in the policy:

Accident means any event due to sudden and unforeseeable external causes that inflicts bodily injuries which are certified by a Physician, directly and independently of any other cause. It does not mean any form of disease, or degenerative process, an inguinal, femoral, umbilical or incisional hernia, or any infection other than an infection of a visible, external cut or wound accidentally sustained.

Actively At Work means, on any day, the performance by the Employee of all the usual and customary duties of his job with the Employer for the scheduled number of hours for that day.

Age means the age of the Insured Person on his last birthday when stated or calculated, or on the day when an event referred to under the policy occurs.

Child means a person who:

1) is under 21 years of Age, and over whom the Participant or the Spouse of the Participant exercises parental authority or exercised parental authority until he reached the Age of majority; or

2) has no spouse, is 25 years old or under and is, or is deemed to be, a full-time student at an accredited educational institution, and over whom the Participant or the Spouse of the Participant would exercise parental authority if he were a minor; or

3) has reached the Age of majority, has no spouse, and is suffering from a "functional impairment" that must have existed when the status of the person fit the definition of either 1) or 2) above. In addition, in order to be considered a "person suffering from a functional impairment," this person must be living with the Participant or the Spouse of the Participant who would exercise parental authority over him as if he were a minor.

   It is understood that a functional impairment will be defined as stipulated under the regulations of any provincial legislation, when covered under such regulations.

Continuing Medical Care means the treatment a Participant receives. It must be accepted by the medical profession as an effective, appropriate and essential treatment in the diagnosis or care of the specific Illness or injury. It must be reasonable, considered as standard practice and provided or prescribed by a Physician or, when the Insurer deems necessary, by a specialist in the appropriate field. Such care is not limited to examination and tests, and must be provided at the frequency required for the specific Illness or injury.

Dependent means a Spouse or Child who is domiciled in Canada. However, if a Dependent is domiciled outside Canada, such Dependent may be deemed to be domiciled in Canada provided such individual is covered under a provincial medical plan and prior written approval is obtained from the Insurer.

Earnings means the regular rate of pay of an Employee paid by the Employer, including dividends, bonuses and overtime pay. This does not include any other form of non-regular remuneration.

Where the Participant Weekly Indemnity Insurance coverage is registered under the premium reduction program of the Employment Insurance Act, any applicable bonuses, overtime pay or any other form of pay included in regular compensation will be considered Earnings. These amounts must be reported by the Policyholder to the Insurer as Earnings of the Employee.

For an Employee whose pay is derived in whole or in part from commissions or dividends, Earnings means the average regular rate of pay of an Employee paid by the Employer including commissions and dividends as shown on the income taxation slips of the Employee for the previous two calendar years. If employed less than two years but more than one, Earnings will be averaged over the length of time employed. If employed less than one year, Earnings will be the regular rate of pay of the Employee as reported by the Employer.

Employee means a person who is domiciled in Canada and who is employed by the Employer on a permanent full-time or part-time basis for not less than the number of hours specified in the Benefit Schedule. However, if an Employee is domiciled outside Canada, such Employee may be deemed to be domiciled in Canada provided prior written approval is obtained from the Insurer.

However, for individuals employed in Saskatchewan, Employee means a person who is domiciled in Canada and who is employed by the Employer

1) on a permanent full-time basis or part-time, for not less than the number of hours specified in the Benefit Schedule, or

2) on a permanent part-time basis provided it is determined that such person

    a) initially, following the completion of 26 weeks of continuous employment as calculated from the date that person was hired, had worked an average of not less than 15 hours per week during that period, and

    b) subsequently, on each December 31st following the completion of one year of continuous employment, has worked an average of not less than 15 hours per week in the preceding 52 consecutive weeks.

Employer means any companies listed on the application of the Policyholder for the policy or specified in the Benefit Schedule.

Family-Related Leave means any leave of absence from work taken by a Participant in accordance with such provincial or federal legislation, or an agreement between the Participant and the Employer.

Hospital means any institution designated as a Hospital by law, recognized by the Insurer and providing 24 hours per day:

1) medical and surgical treatment for sick or injured individuals, and

2) nursing care.

Without limitation, this term does not include a nursing home, home for the aged or chronically ill, a rest home, Convalescent/Rehabilitation Centre or a place for the care and treatment of alcoholism, drug addiction or any other dependency.

Illness means any health deterioration or bodily disorder certified by a Physician. For the purposes of the policy, organ donations and related complications are also considered illnesses.

Immediate Family means a person who is the 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 of the Participant.

Insured Person means the Participant or one of his insured Dependents, as the case may be.

Insurer means Desjardins Financial Security Life Assurance Company.

Maternity Leave means any leave of absence from work due to pregnancy in accordance with any labour standards legislation that is applicable in the Insured Person's province of residence. Maternity Leave consists of a voluntary portion and a "health related portion". The "health related portion" of the Maternity Leave commences on the date of the delivery and lasts for at least 6 weeks (8 weeks for a Caesarean delivery). The person is considered to be on Maternity Leave during the entire period for which she is receiving maternity benefits under any provincial or federal legislation. If she is absent from work due to a Total Disability that commenced before or during pregnancy, she is considered to be on Maternity Leave in accordance with any provincial or federal legislation.

Parental Leave means any leave of absence from work taken by a Participant to take care of his newborn or adopted child, in accordance with such provincial or federal labour standards legislation, or an agreement between the Participant and the Employer.

Participant means an Employee who is insured under the policy.

Physician means a legally qualified medical practitioner lawfully entitled to practice medicine in the place where he provides the medical services.

Policyholder means the company or group indicated on the application and specified on the cover page of the policy.

Seasonal Employment means employment that by its nature is not held throughout the year. To be considered seasonal under the policy, the position must provide employment for the minimum annual period of time specified in the Benefit Schedule.

Spouse means an eligible person who is domiciled in Canada and who at the time of the event giving rise to a claim:

1) is legally married to the Participant; or

2) has been living with the Participant in a conjugal relationship for at least 12 months and has not been separated from the Participant for 90 days or more as a result of a breakdown in the relationship; or

3) is living in a conjugal relationship with the Participant who is the natural parent of the Spouse's Child and has not been separated from the Participant for 90 days or more as a result of a breakdown in the relationship.

However, if two individuals fit the definition of Spouse, the Insurer will recognize only one Spouse for all benefits under the same plan in the following order:

1) the eligible Spouse whom the Participant last designated as such in writing to the Insurer, subject to approval of any evidence of insurability required under the policy; or

2) the Spouse to whom the Participant is legally married.

At any one time, only one person may be insured as a Spouse of the Participant.

ELIGIBILITY

EMPLOYEE ELIGIBILITY

An Employee is eligible for insurance:

1) on the EFFECTIVE DATE, if he meets the Eligibility Requirements specified in the Benefit Schedule; or

2) after the EFFECTIVE DATE, on the date on which he meets the Eligibility Requirements specified in the Benefit Schedule.

A Participant, whose insurance under the policy terminated due to termination of employment and who is re-hired by the Employer within 6 months immediately following the termination of his insurance, will be eligible for the reinstatement of his insurance on the date he resumes employment, provided application for reinstatement is made within 31 days of eligibility.

However, notwithstanding the above, an Employee who is under age 65 and employed by the Employer in Saskatchewan on a permanent part-time basis will be eligible for insurance, excluding the Weekly Indemnity or Long Term Disability Benefits (if included in the policy), on the latest of

1) the EFFECTIVE DATE of the policy,

2) the date on which he meets the Eligibility Requirements specified in the Benefit Schedule provided that during that period such Employee worked an average of not less than 15 hours per week,

3) the date on which he has completed a period of 26 weeks of continuous employment provided that during that period such Employee worked an average of not less than 15 hours per week.

DEPENDENT ELIGIBILITY

A Participant with a Dependent on the date he becomes eligible for insurance under the policy will be eligible for Dependent insurance on such date.

A Participant without Dependents who is insured under the policy will be eligible for Dependent insurance on the date he acquires a Dependent.

INSURANCE APPLICATION

An eligible Participant must complete an application or an application for exemption for himself and for his Dependents, if any, within 31 days of the date on which he becomes eligible.

EXEMPTION PRIVILEGE

A Participant may decline to be insured under the Extended Health Care Benefit or Dental Care Benefit, if included in the policy, if such Participant is insured as a Dependent under another similar group insurance plan. However, if the other plan terminates or the Spouse ceases to be a member of an eligible class, the Participant will be eligible for insurance under the Benefit he previously opted out of as of the date of such termination, provided written application is made within 31 days of such eligibility.

If the written application is received more than 31 days after the eligibility date, the following conditions apply:

1) the Insured Person will have to submit evidence of insurability for the Extended Health Care Benefit and insurance will not take effect until the date on which the insurability of the individuals concerned is approved by the Insurer;

2) the Dental Care Benefit will be effective on the date on which the written application is signed by the Participant and evidence of insurability is replaced by a limitation of payment, as indicated in the RESTRICTIONS, EXCLUSIONS AND LIMITATIONS provision under the Dental Care Benefit.

EVIDENCE OF INSURABILITY

Evidence of insurability means any declaration relating to an individual's physical health or to other factual information that could have a bearing on the acceptance of the risk. Only declarations that are provided on the forms approved by the Insurer will be accepted.

COMMENCEMENT OF INSURANCE

COMMENCEMENT OF PARTICIPANT INSURANCE

The insurance of any Employee will become effective on the latest of the following dates, provided that Employee is Actively At Work on such date:

1) the Effective Date of the policy,

2) the date on which he first becomes eligible, provided his written application, completed using the form required by the Insurer, is received by the Insurer within 180 days of his date of eligibility,

3) the date on which the insurability of the Employee is approved by the Insurer, if the application of the Employee for insurance is received by the Insurer more than 180 days after the date of his eligibility.

If an Employee is not Actively At Work on the date his insurance would have otherwise commenced, such insurance will commence on the first day he is subsequently Actively At Work.

If the Employee is not Actively At Work on the date his insurance would have otherwise commenced, due solely to a paid leave or a statutory holiday, then he will be considered Actively At Work on such date.

If a Participant requests an amount of insurance that exceeds the maximum amount the Insurer will provide without evidence of insurability, as specified in the Benefit Schedule, this excess amount will become effective on the latest of the dates specified in the preceding provision or on the date on which the insurability of the Participant is approved, if later.

With respect to the Dental Care Benefit, if included in the policy, if the Employee applies more than 31 days after the date of his eligibility, evidence that the insurability of an Employee is satisfactory will not be required; however, his dental coverage will be limited as set forth in the RESTRICTIONS, EXCLUSIONS AND LIMITATIONS section of the Dental Care Benefit.

COMMENCEMENT OF DEPENDENT INSURANCE

The insurance for the Dependent of a Participant will become effective on the latest of the following dates:

1) the date on which the insurance of a Participant first becomes effective under the policy,

2) the date on which a Participant insured under the policy first becomes eligible for Dependent insurance, provided written application is made within 31 days of the date of such eligibility,

3) the date on which the insurability of the Dependent is approved by the Insurer, if evidence of insurability is requested of a Participant because his application for insurance is received more than 31 days after the date he became eligible,

4) the date on which the insurability of the Dependent is approved by the Insurer, if the application of the Participant for Dependent insurance is made more than 31 days after the Participant first became eligible for such insurance.

The insurance for any individual becoming an eligible Dependent of a Participant insured with Dependent insurance will become effective on the date on which such individual becomes a Dependent as defined in the policy.

If a Dependent (other than a newborn Child) is confined to a Hospital on the date his insurance would have otherwise become effective, his insurance will commence on the day immediately following his discharge from the Hospital.

TERMINATION OF INSURANCE

TERMINATION OF PARTICIPANT INSURANCE

Except as specifically provided to the contrary elsewhere in the policy, the insurance of the Participant will terminate on the earliest of the following dates:

1) the date on which the Participant no longer qualifies as an Employee, as defined in the policy,

2) the date on which the Participant ceases to belong to a class of Participants eligible for insurance,

3) the date on which the Participant reaches the applicable Age Limit specified in the Benefit Schedule,

4) the end of the period for which required premiums were paid on behalf of the Participant,

5) the date on which the Participant retires,

6) the date on which the Participant ceases to be Actively At Work,

7) the date of termination of the policy.

TERMINATION OF DEPENDENT INSURANCE

Except as specifically provided to the contrary elsewhere in the policy, the Dependent insurance of a Participant will terminate on the earliest of the following dates:

1) the date on which the insurance of the Participant terminates,

2) the date on which the Participant no longer has any Dependents,

3) the end of the period for which required premiums for Dependent insurance were paid on behalf of the Participant,

4) the date on which Dependent insurance under the policy is terminated.

The insurance of any Dependent of a Participant will terminate on the date the Dependent no longer qualifies as a Dependent, as defined in the policy.

CONTINUATION OF INSURANCE

If a Participant ceases to be Actively At Work, the insurance may be continued as specified in the policy.

CLAIMS

NOTICE AND PROOF OF CLAIM

Notice and proof of any claim must be received by the Insurer within the time limit, if any, specified for each Benefit. However, if the policy terminates, no payment will be made unless the notice and proof of a claim is submitted to the Insurer within 120 days of the date of termination of the policy.

Failure to submit notice or proof of claim within the prescribed time limit does not invalidate the claim, provided that the notice and proof of the claim are sent as soon as reasonably possible. However, no payment will be made if the notice and proof of claim are sent more than 12 months after the expenses were incurred.

Every action or proceeding against the Insurer for the recovery of insurance money payable under the policy is absolutely barred unless commenced within the time set out in the insurance act or other legislation of the province of residence of the Participant.

BENEFICIARY

Subject to legal provisions, a Participant may designate or revoke, at any time, one or several beneficiaries of his insurance on written notice to the Head Office of the Insurer. Only the benefits that include a benefit payment in the event of the Participant's death are subject to the designation of beneficiary(ies), and the same designation applies to all these benefits. The rights of a beneficiary who dies before the Participant revert to the latter.

The Insurer assumes no responsibility with respect to the validity of any beneficiary designation or revocation.

The death benefit payable when a Dependent dies is paid to the Participant, if alive. If the Participant is deceased, the death benefit is paid as follows:

1) in the event of the Spouse's death:

   to the Spouse's legal heirs;

2) in the event of the death of the Participant's Dependent Child:

   a) to the Spouse, if alive, or

   b) if the Spouse is deceased, to the legal heirs of the Dependent Child.

CLAIMS

Claims under the policy must be submitted to the Insurer on the appropriate form.

Any living benefits will be paid to the Participant unless otherwise indicated in the policy.

Within 90 days of a death, the beneficiary or the Participant must submit to the Insurer proof of death, including a death certificate, proof of the Age, and Earnings of the Participant or the insured Dependent, as well as any other information deemed useful by the Insurer.

If the designated beneficiary is the estate or personal representative of the deceased, or is a minor, or dies before the Participant, or is not competent to give valid release, the Insurer reserves the right to pay, at its option and at its discretion, a part of the proceeds of the Participant Life Insurance Benefit in an amount not exceeding $5,000 to any person the Insurer deems equitably entitled to such amount to cover the Participant's burial expenses. Such payment will fully discharge the Insurer, and the other insurers, provided this payment is made in good faith.

MEDICAL EXAMINATIONS

From time to time, the Insurer will be entitled to have a claimant examined by a Physician or Physicians of its choice.

CO-ORDINATION OF BENEFITS

If an individual, who is insured for a Benefit that is subject to the CO-ORDINATION OF BENEFITS provision, is also insured under another Plan that provides similar benefits, the amount of benefits payable during any calendar year will be co-ordinated.

Co-ordination of benefits is calculated as specified in the guidelines of the Canadian Life and Health Insurance Association. Total amounts paid under all plans cannot exceed 100% of the individual’s incurred Eligible Expenses.

BASIC PARTICIPANT LIFE INSURANCE BENEFIT

DEFINITIONS

As used in this Benefit

Total Disability or Totally Disabled means

1) during the Elimination Period provided for in the Long Term Disability Benefit and the succeeding 24 months,

   a state of incapacity, resulting from an Illness or Accident, which wholly prevents the Participant from performing each and every essential duty of his regular occupation;

2) after the Elimination Period and the succeeding 24 months have elapsed,

   a state of incapacity, resulting from an Illness or Accident, which wholly prevents the Participant from working in any occupation for which he is suited by education, Training and Experience.

   Whether or not any such gainful occupation is available in the area where the Participant resides does not affect his entitlement to disability benefits.

   A Participant who needs a driver's licence issued by the government to perform the duties of his regular occupation is not considered disabled simply because his licence has been revoked or has not been renewed.

Training and Experience means all of the knowledge and skills the Participant acquired while in school, in the performance of his current or former professional activities or during his non-working hours.

EVIDENCE OF INSURABILITY

Evidence of insurability satisfactory to the Insurer will be required of a Participant applying for any amount of Basic Participant Life Insurance in excess of the amount specified in the Benefit Schedule as the Non-Evidence Maximum of Insurability under the Basic Participant Life Insurance Benefit.

PAYMENT OF BENEFIT

Upon receipt of Proof of Claim satisfactory to the Insurer that a Participant died while insured under this Benefit, the Insurer will pay the amount of Life Insurance applicable to such Participant in accordance with the Benefit Schedule and other applicable policy provisions.

WAIVER OF PREMIUM

If a Participant becomes Totally Disabled while insured under this Benefit but prior to attaining Age 65 and submits Proof of Claim satisfactory to the Insurer, premiums for the amount of Life Insurance applicable to such Participant will be waived after the continuous Total Disability period specified in the Benefit Schedule has elapsed. The amount of Life Insurance will be in accordance with the Benefit Schedule and the other policy provisions that are in effect at the time Total Disability commences.

Premiums will continue to be waived until the earliest of the following dates:

1) the date on which the Participant ceases to be Totally Disabled,

2) the date on which the Participant is unable or unwilling to provide satisfactory proof of Total Disability to the Insurer, if such proof is not provided within 3 months of the request,

3) the date on which the Participant converts his insurance under the CONVERSION PRIVILEGE provision,

4) the date on which the Participant attains Age 65 or retires, if earlier.

A recurrence of Total Disability within 6 months after the termination of a previous period of Total Disability for which premiums have been waived under this Benefit shall be deemed a continuation of the previous period if due to the same or related causes.

If a Totally Disabled Participant dies more than 31 days after his insurance terminates, prior to attaining Age 65, and written notice and proof of Total Disability has not been received by the Insurer, the amount of Life Insurance applicable to such Participant in accordance with the Benefit Schedule that was in effect at the time his insurance terminated will be payable provided that

1) the Participant became Totally Disabled while insured under this Benefit,

2) the Total Disability of the Participant was uninterrupted from the onset of his Total Disability to the date of his death,

3) the Participant dies within 12 months from the onset of his Total Disability,

4) the Participant did not convert any or all of his insurance under the CONVERSION PRIVILEGE provision at the time his insurance terminated, and

5) satisfactory proof of the Total Disability and death of the Participant is received by the Insurer within 90 days of his death.

LIVING BENEFIT

Subject to the approval of the Insurer, any Participant whose life expectancy is less than 24 months may apply for payment of a portion of the amount of Life Insurance applicable to him, subject to the following conditions:

1) A Totally Disabled Participant may be required to be examined by a Physician designated by the Insurer;

2) A Totally Disabled Participant must qualify for approval for the Waiver of Premium under the Basic Participant Life Insurance Benefit of the policy;

3) Any individual having an interest in the insurance money must sign a consent to such payment on a form provided by the Insurer.

The Living Benefit is equal to 50% of the amount of Life Insurance applicable to the Participant in accordance with the Benefit Schedule. In addition, this amount may not be less than $5,000 or more than $100,000.

At the death of the Participant, the Value of the Living Benefit will be deducted from the amount that would otherwise have been payable under the Basic Participant Life Insurance Benefit.

The Policyholder is responsible for the premium payments for any Participant who has received an advance payment, unless a Waiver of Premium has been granted.

Value of the Living Benefit means the aggregate of the payments made under the Living Benefit, plus the reasonable costs of verifying the medical condition of the Totally Disabled Participant, plus the interest thereon from the date of payment until the date of death of the Totally Disabled Participant.

The interest rate is set according to the annual average rate of return on one-year guaranteed investment certificates issued by Canadian trust companies. The rate will be that established immediately after the payment of the Living Benefit, as published in the monthly or weekly issue of the Bank of Canada Statistical Summary.

LIVING BENEFIT EXCLUSION

The Living Benefit will not be payable if there has been any material misrepresentation or non-disclosure in the application, whether within two years or not. If the application or coverage is discovered to be null and void after the Living Benefit is paid, the Value of the Living Benefit will be repaid to the Insurer by the recipient of the Living Benefit.

BENEFIT TERMINATION

This Benefit terminates on the date the Participant attains the Age Limit specified in the Benefit Schedule or on the earliest of the dates indicated in the TERMINATION OF PARTICIPANT INSURANCE provision.

CONVERSION PRIVILEGE

If the Life Insurance of a Participant aged 65 or younger terminates or is reduced, the Participant will be entitled to convert any amount of insurance, up to the terminated amount, to an individual policy without evidence of insurability.

In addition, the amount of insurance that may be converted will be further limited to the lesser of

1) the maximum amount applicable in the province of residence of the Participant; or

2) the difference between the amount of Life Insurance in force on the date of termination of insurance and the amount of insurance for which the Participant is eligible under another group life insurance at the time of exercising his conversion right.

The individual policy selected in accordance with the above will be subject to the following conditions:

1) The Participant must submit written application for conversion to the Insurer and must pay the first premium within 31 days of the termination of his insurance under this Benefit;

2) The individual policy may be insurance for a non-convertible Term to Age 65, insurance for a non-renewable 1-Year Convertible Term or any regular permanent plan issued by the Insurer at the date of conversion, excluding special permanent plans as may be designated by the Insurer from time to time. The individual policy will not include any special benefit provisions for which an extra premium is charged and will not be a plan under which the amount of insurance may or will increase in the future; at least one permanent plan will be available for conversion at all times. A Dividend Option under which dividends are used to obtain additional insurance may be elected at the time of conversion, if permitted by the Insurer;

3) In the event the individual policy selected is insurance for a non-renewable 1-Year Convertible Term, the Participant may elect to pay a single premium or quarterly premiums. The policy can be converted to one of the plans described above, but cannot be converted to insurance for another 1-Year Convertible Term;

4) The individual policy issued will conform to the conditions, terms, and amounts of individual insurance plans regularly used by the Insurer at the date of conversion;

5) The individual policy premium will be based on the rate used by the Insurer on the effective date of that policy and that is applicable to the plan and the amount of the policy issued, the Age of the Participant at nearest birthday and the class of risk to which he belongs;

6) If the amount of Life Insurance that may be converted is less than the minimum amount for which the Insurer will then normally issue the selected plan, the individual policy must be for the full amount that the Participant may convert;

7) The individual policy will not take effect prior to the end of the 31 day period immediately following the date of termination of insurance of the Participant under this Benefit.

The amount of Life Insurance for which a Participant who is insured under this Benefit is eligible in accordance with the Benefit Schedule will be reduced by the amount of any individual Life Insurance in force on the life of the Participant that was issued previously in accordance with the CONVERSION PRIVILEGE of the policy or the corresponding provision of any other group policy issued by the Insurer.

EXTENSION OF BENEFIT AFTER TERMINATION

If a Participant dies within 31 days of termination of insurance under this Benefit, the amount of Life Insurance he was eligible to convert will be payable.

NOTICE AND PROOF OF CLAIM

Before settling any death claim, the Insurer will require satisfactory written proof of the occurrence, cause and circumstances of the death, the eligibility of the deceased at the time of death, the date of birth of the deceased, and the right of the claimant to receive the proceeds.

Any death claim notice must be submitted to the Insurer within 30 days of the death and the written proof of claim must be submitted within 90 days of the death.

Subject to applicable legislation, the Insurer may request an autopsy in order to assess its liability in connection with a claim.

The benefit payable on the death of a Participant will be paid to the beneficiary designated by the Participant within 30 days of receipt of satisfactory proof of claim to the Insurer.

To be eligible for WAIVER OF PREMIUM, the Insurer must receive written notice of Total Disability within 12 months of the date the Participant becomes Totally Disabled, and proof satisfactory to the Insurer of Total Disability within 90 days following the date the Insurer received written notice.

In the event of recurrent Total Disability, the Insurer must receive written notice and proof of claim within 12 months of the date of such recurrence.

DEPENDENT LIFE INSURANCE BENEFIT

PAYMENT OF BENEFIT

Upon receipt of Proof of Claim satisfactory to the Insurer that a Dependent died while insured under this Benefit, the Insurer will pay the amount of Dependent Life Insurance applicable to such individual in accordance with the Benefit Schedule and other applicable policy provisions.

COMMENCEMENT OF NEWBORN CHILDREN INSURANCE

Insurance for a newborn Child of a Participant with insured Dependents will commence in accordance with the terms specified in the Benefit Schedule and the policy provisions, including those that pertain to the COMMENCEMENT OF DEPENDENT INSURANCE.

WAIVER OF PREMIUM

If the premiums for the amount of insurance under the Basic Participant Life Insurance Benefit are waived by the Insurer, the premiums under this Benefit will be similarly waived until the date premiums are no longer waived under the Basic Participant Life Insurance Benefit, but not beyond the date on which this Benefit terminates in accordance with the TERMINATION OF DEPENDENT INSURANCE provision of the policy.

BENEFIT TERMINATION

This Benefit terminates on the date the Participant attains the Age Limit specified in the Benefit Schedule or on the earliest of the dates indicated in the TERMINATION OF DEPENDENT INSURANCE provision.

SPOUSE CONVERSION PRIVILEGE

If the Dependent Life Insurance of a Spouse aged 65 or younger, insured for a minimum amount of $5,000, terminates for any reason other than policy termination, the Participant or the Spouse, in the event of the death of such Participant, may convert the Dependent Life Insurance on the Spouse to an individual policy, without evidence of insurability, subject to the following conditions:

1) The written application for conversion must be submitted to the Insurer and the first premium paid within 31 days of the date of termination of the insurance of the Spouse under this Benefit;

2) The individual policy may be any regular permanent plan issued by the Insurer at the date of conversion, excluding special permanent plans as may be designated by the Insurer from time to time. The individual policy will not include any special benefit provisions for which an extra premium is charged and will not be a plan under which the amount of insurance may or will increase in the future; at least one permanent plan will be available for conversion at all times;

3) The individual policy issued will conform to the conditions, terms and amounts of individual insurance plans regularly used by the Insurer at the date of conversion;

4) The individual policy premium will be based on the rate used by the Insurer on the effective date of that policy and that is applicable to the plan and the amount of the policy issued, the Spouse's Age at nearest birthday and the class of risk to which the Spouse belongs;

5) If the amount of Dependent Life Insurance that may be converted is less than the minimum amount for which the Insurer will normally issue the selected plan, the individual policy must be for the full amount that the Spouse may convert;

6) The individual policy will not take effect prior to the end of the 31 day period immediately following the date of termination of insurance on the Spouse under this Benefit.

EXTENSION OF BENEFIT AFTER TERMINATION

If a Spouse dies within 31 days of the termination of his insurance under this Benefit, the amount of Dependent Life Insurance payable will be the amount that the Participant or the Spouse, in the event of the death of such Participant, was eligible to convert.

NOTICE AND PROOF OF CLAIM

Before settling any death claim, the Insurer will require satisfactory written proof of the occurrence, cause and circumstances of the death, the eligibility of the deceased at the time of death, the date of birth of the deceased, and the right of the claimant to receive the proceeds.

Subject to applicable legislation, the Insurer may request an autopsy in order to assess its liability in connection with a claim.

PARTICIPANT ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

DEFINITIONS

As used in this Benefit

Elements means a natural disaster such as an earthquake, storm, flooding, landslide or any other disaster of the same nature.

Hemiplegia means the total, irrecoverable and permanent paralysis of upper and lower limbs on the same side of the body.

Loss of Arm means the complete severance through or above the elbow.

Loss of Finger means the complete severance of two entire phalanges of one finger.

Loss of Foot means the complete severance through or above the ankle joint but below the knee joint.

Loss of Hand means the complete severance through or above the wrist but below the elbow joint.

Loss of Hearing, Sight or Speech means the total and irrecoverable loss of hearing, sight or speech that is certified by a licensed Physician of recognized standing and certified by the Royal College of Physicians and Surgeons of Canada or the Professional Corporation of Physicians of Quebec.

Loss of Leg means the complete severance through or above the knee joint.

Loss of Thumb means the complete severance of one entire phalanx of the thumb.

Loss of Toe means the complete severance of one entire phalanx of the big toe, and all phalanges of the other toes.

Loss of Use means the total and irrecoverable loss of use of a limb following a continuous period of complete disablement of such limb of not less than 12 months.

Motor Vehicle means a passenger car, station wagon, minivan or multipurpose vehicle similar to a jeep or a pickup truck.

Paraplegia means the total, irrecoverable and permanent paralysis of both lower limbs.

Quadriplegia means the total, irrecoverable and permanent paralysis of both upper and lower limbs.

PAYMENT OF BENEFIT

Upon receipt of Proof of Claim satisfactory to the Insurer that

1) a Participant suffered one of the specified losses below within 365 days of an Accident causing bodily injuries; and

2) the loss was the direct result of the Accident, independent of any other cause; and

3) the Accident occurred while the Participant was insured under this Benefit;

the Insurer will pay the amount applicable to any such loss in accordance with the following Schedule of Losses and other applicable policy provisions.

SCHEDULE OF LOSSES

The amount payable shown below is a percentage of the amount specified in the Benefit Schedule.

Loss of	Amount Payable
Life	100%
Hearing in Both Ears and Speech	100%
Sight of Both Eyes	100%
Both Hands or Both Feet	100%
Both Arms or Both Legs	100%
One Hand and Sight of One Eye	100%
One Foot and Sight of One Eye	100%
One Hand and One Foot	100%
One Arm or One Leg	75%
Hearing in Both Ears or Speech	67%
Sight of One Eye	67%
One Hand or One Foot	67%
Thumb and Index Finger of the Same Hand	33%
At least Four Fingers of the Same Hand	33%
Hearing in One Ear	25%
All Toes of One Foot	25%

Loss of Use of	Amount Payable
Both Arms or Both Hands	100%
Both Legs or Both Feet	100%
One Hand and One Foot	100%
One Arm or One Leg	75%
One Hand or One Foot	67%
Thumb and Index Finger of the Same Hand	33%
Hemiplegia, Paraplegia, Quadriplegia	200%

WAIVER OF PREMIUM

If the premiums for the amount of insurance under the Basic Participant Life Insurance Benefit are waived by the Insurer, the premiums under this Benefit will be similarly waived until the earliest of:

1) the date on which the Participant's premiums are no longer waived under the Basic Participant Life Insurance Benefit;

2) the date on which the Participant attains age 65 or retires, if earlier;

3) the date on which the insurance of the Participant terminates in accordance with the TERMINATION OF PARTICIPANT INSURANCE provision; or

4) the date on which this Benefit terminates.

DISAPPEARANCE

If a Participant, while insured under this Benefit, disappears as a result of an Accident involving the sinking or disappearance of a conveyance in which he was riding and if his body is not found within 365 days of such Accident, it will be presumed, unless there is evidence to the contrary, that the Participant suffered a loss of life as a result of a bodily injury caused by the Accident.

EXPOSURE

If a Participant, while insured under this Benefit, suffers a loss due to unavoidable exposure to the Elements, the loss will be deemed to result from an Accident.

REHABILITATION

If a Participant, while insured under this Benefit, suffers a loss, other than a loss of life, for which an amount is payable under this Benefit, the Insurer will pay the reasonable and necessary training expenses actually incurred, up to a maximum of $10,000, provided that:

1) the Participant requires such training because of the loss, in order to qualify for employment in an occupation in which he would not have been engaged except for such loss; and

2) such expenses are incurred within 2 years of the date of the Accident.

FAMILY TRANSPORTATION AND HOTEL ACCOMMODATION

If a Participant, while insured under this Benefit, suffers a loss, other than a loss of life, for which an amount of insurance is payable under this Benefit, and, as a result of such loss, is confined in a Hospital located more than 150 kilometres from his normal place of residence as an in-patient under the regular care of a Physician (other than himself), the Insurer will pay the reasonable expenses incurred by members of his Immediate Family for hotel accommodation and transportation by the most direct route to the Hospital, up to a lifetime maximum of $1,500 for all these expenses.

REPATRIATION

If a Participant, while insured under this Benefit, dies as a result of an Accident that occurs 100 kilometres or more from his normal place of residence and an amount is payable for a loss of life under this Benefit, the Insurer will pay all customary and reasonable expenses incurred for preparation of the body for burial or cremation and transportation of the body to the Participant's place of residence in Canada, up to a maximum of $10,000.

HOME OR VEHICLE CONVERSION

If a Participant, while insured under this Benefit, suffers a loss, other than a loss of life, for which an amount is payable under this Benefit and then requires (for the same reason that entitled him to that Benefit payment) a wheelchair, the Insurer will pay, upon presentation of proof of payment,

1) the initial costs of converting his home so that it is wheelchair-accessible; and

2) the initial costs of converting a Motor Vehicle belonging to him so that he can access this vehicle and drive it;

subject to one conversion for each of the eligible expenses described in paragraph 1) and 2) above and up to a maximum of $10,000 for all these expenses.

This Benefit only applies if

1) the modifications made to the home are done by one or more people experienced in this field and who are recommended by a licensed organization that offers support and assistance to wheelchair users; and

2) the modifications made to the vehicle are done by one or more people experienced in this field and who are authorized by the provincial motor vehicle office in the Participant's province of residence.

SPECIAL EDUCATION

If the Dependents of a Participant are insured under the policy on the date the Participant dies as a result of an Accident and if an amount is payable for a loss of life under this Benefit, the Insurer will pay a Special Education benefit for each Dependent Child who, on the date of the Accident, was insured under this Benefit and was enrolled as a full-time student in an institution of higher learning above the secondary school level, or was in a secondary school and subsequently enrols as a full-time student in an institution of higher learning within 365 days of the death of such Participant.

Under this Benefit, reimbursement will be made for all reasonable and necessary expenses incurred for tuition and related costs, up to 2% of the amount for which the Participant was insured under this Benefit on the date of his death and an overall maximum of $5,000 for each year, for a maximum of 4 years, provided that the Dependent Child who is eligible for this Special Education benefit continues his education on a full-time basis in an institution of higher learning, without any interruption longer than the normal school vacation.

SPOUSAL RETRAINING

If the Spouse of a Participant is insured under the policy on the date the Participant dies as a result of an Accident and if an amount is payable for a loss of life under this Benefit, the Insurer will pay all reasonable and necessary expenses that are actually incurred by the Spouse who takes part in a formal occupational training program, up to $10,000, provided that

1) the Spouse requires such training in order to become specifically qualified for active employment in an occupation for which the Spouse would not otherwise have sufficient qualifications; and

2) such expenses are incurred within 2 years of the date of the Accident.

EXCLUSIONS AND RESTRICTIONS

1) No payment will be made for a loss resulting directly or indirectly, solely or partly from any of the following:

   a) suicide or intentionally self-inflicted injury, while sane or insane;

   b) an Illness that does not result from an Accident but that appears at the time of the Accident;

   c) dental or medical treatment, a surgical procedure or the administration of anaesthesia;

   d) war, whether the war be declared or not, service in the armed forces of any country or participation in a riot, insurrection or civil commotion;

   e) travel or flight aboard any aircraft except solely as a passenger (and not as a pilot or crew member) in an aircraft that

      i) has a certificate of airworthiness or flight permit issued under the Aeronautics Act (Canada) or under the laws of the country where the aircraft is registered, and all the conditions under which the certificate or permit was issued have been complied with; and

      ii) is used for the sole purpose of transportation and not for aviation training or practice, or for experimental or test purposes;

   f) committing, or attempting to commit a criminal offence.

2) The Insurer will not pay the sum insured in the event of an Accident if such Accident leads to the loss as a result of the Participant driving a Motor Vehicle while under the influence of drugs or while his blood alcohol level exceeds the limits set by the Criminal Code of Canada.

3) Under the REHABILITATION, SPECIAL EDUCATION and SPOUSAL RETRAINING provisions, no payment will be made for room and board or other ordinary travelling, clothing or living expenses.

4) For multiple losses to the same limb due to any one Accident, only one loss, corresponding to the most significant loss, will be paid. For all losses due to any one Accident, the aggregate amount payable will not exceed 100% of the Amount of Insurance specified in the Benefit Schedule, except in the case of Hemiplegia, Paraplegia and Quadriplegia, where the total amount payable will not exceed 200% of the Amount of Insurance specified in the Benefit Schedule.

BENEFIT TERMINATION

This Benefit terminates on the date the Participant attains the Age Limit specified in the Benefit Schedule or on the earliest of the dates indicated in the TERMINATION OF PARTICIPANT INSURANCE provision.

NOTICE AND PROOF OF CLAIM

Before settling any death claim, the Insurer will require written satisfactory proof of the occurrence, cause and circumstances of the death, the eligibility of the deceased at the time of death, the date of birth of the deceased, and the right of the claimant to receive the proceeds.

Subject to applicable legislation, the Insurer may request an autopsy in order to assess its liability in connection with a death claim.

Any other claim must be submitted to the Insurer within 30 days of the Accident and written proof within 90 days of such Accident.

In the case of a disappearance, as specified under the DISAPPEARANCE provision of this Benefit, the Insurer will pay the claim on presentation of a declaratory judgment of death.

PARTICIPANT LONG TERM DISABILITY BENEFIT

DEFINITIONS

As used in this Benefit

Elimination Period means the period, as specified in the Benefit Schedule, of continuous Total Disability that must be completed before Long Term Disability Benefits commence under this Benefit.

If a Participant can and does continue his coverage under this Benefit throughout any absence or leave (other than a Maternity, Parental or Family-Related absence or leave) as described in the policy, and such Participant becomes Totally Disabled during such leave, the Elimination Period will be deemed to commence on the date the Participant is scheduled to return to active work.

Net Monthly Earnings means the monthly Earnings in effect immediately prior to commencement of Total Disability less all income taxes and contributions to the Canada/Quebec Pension Plan and Employment Insurance payable thereon, or any other contribution to a public income replacement plan.

Maximum Benefit Period means the maximum period during which monthly benefits are payable, as specified in the Benefit Schedule.

Total Disability or Totally Disabled means

1) during the Elimination Period and the succeeding 24 months,

   a state of incapacity, resulting from an Illness or Accident, which wholly prevents the Participant from performing each and every essential duty of his regular occupation;

2) after the Elimination Period and the succeeding 24 months have elapsed,

   a state of incapacity, resulting from an Illness or Accident, which wholly prevents the Participant from working in any occupation for which he is suited by education, Training and Experience.

   Whether or not any such gainful occupation is available in the area where the Participant is domiciled does not affect his entitlement to Long Term Disability Benefits.

A Participant who needs a driver's licence issued by the government to perform the duties of his regular occupation is not considered disabled simply because his licence has been revoked or has not been renewed.

Training and Experience means all of the knowledge and skills the Participant acquired while in school, in the performance of his current or former professional activities or during his non-working hours.

EVIDENCE OF INSURABILITY

Evidence of insurability satisfactory to the Insurer will be required of a Participant applying for any benefit amount of Long Term Disability in excess of the amount specified in the Benefit Schedule as the Non-Evidence Maximum of Insurability under the Participant Long Term Disability Benefit.

PAYMENT OF BENEFIT

Upon receipt of Proof of Claim satisfactory to the Insurer that

1) a Participant became Totally Disabled while insured under this Benefit and remained Totally Disabled during the Elimination Period; and

2) the Participant is under Continuing Medical Care of a Physician, as defined under the DEFINITIONS provision of the policy;

the Insurer will pay monthly Long Term Disability Benefits for as long as the Participant is Totally Disabled, in accordance with applicable policy provisions, up to the Maximum Benefit Period.

The "health related portion" of the Maternity Leave taken by a Participant is considered to be a period of Total Disability for the purposes of benefit payment under this Benefit, whether the Participant's insurance was continued during the leave or not. The maternity benefits payable under any public or private plan are deducted from the benefits payable to the Participant for this period, in accordance with the provisions of this contract.

For a Total Disability that begins during the voluntary leave portion of a Maternity Leave, or during a Parental or Family-Related Leave, benefits are payable from the later of the following dates, provided the current benefit remained in force and provided the Participant is still Totally Disabled and insured under this Benefit:

1) the end of Elimination Period;

2) the scheduled date of return to work.

The amount of Long Term Disability Benefit payable under this Benefit will be the amount specified in the Benefit Schedule based on the monthly Earnings in effect immediately prior to commencement of Total Disability.

Long Term Disability Benefits are payable at the end of each monthly period of Total Disability, commencing on the date the Elimination Period is completed.

The Elimination Period commences on the later of the following dates:

1) the day after the last day the Participant was Actively At Work, if he consults a Physician within 14 days of the beginning of Total Disability; or

2) the first day the Participant consults a Physician if he does so more than 14 days after the Total Disability began.

Any payments for a period of less than one month will be at the daily rate of 1/30 of the monthly benefit.

Long Term Disability Benefits may be taxable in accordance with the Benefit Schedule.

REDUCTION OF LONG TERM DISABILITY BENEFITS, LIMITATIONS AND EXCLUSIONS

1) Direct Offset

Long Term Disability Benefits otherwise payable to the Participant under this Benefit will be reduced by

a) any benefits the Participant is eligible to receive under any Workers' Compensation Act or similar legislation; and

b) any disability benefit the Participant is eligible to receive under the Canada Pension Plan or the Quebec Pension Plan excluding

i) benefits payable on behalf of his Dependents; and

ii) any increase in benefits due solely to cost-of-living, after benefit payments commence; and

c) any indemnity payable for loss of time under any government plan requiring or providing automobile insurance benefits on a no-fault basis;

d) any disability benefit payable by a private pension plan.

2) Indirect Offset

In addition, the Insurer will further reduce Long Term Disability Benefits by any amount by which the total monthly income of the Participant from all sources exceeds

a) 85% of his gross monthly Earnings immediately prior to Total Disability, if the Long Term Disability Benefits are included in his income under the Income Tax Act (Canada); or

b) 85% of his Net Monthly Earnings immediately prior to Total Disability, if the Long Term Disability Benefits are not included in his income under the Income Tax Act (Canada).

The total monthly income of a Participant from all sources, whether he receives or is eligible to receive this income, will include all of the following:

a) any Long Term Disability payments under this Benefit;

b) any monthly Earnings or payments from the Employer;

c) any disability benefits payable under the Quebec Pension Plan, excluding benefits payable on behalf of Dependents and any increase in benefits after benefit payments commence due solely to the cost-of-living;

d) any disability benefits payable under the Canada Pension Plan, excluding benefits payable on behalf of Dependents and any increase in benefits after benefit payments commence due solely to the cost-of-living;

e) any disability benefits payable under any Workers' Compensation Act or similar legislation or any other government plan, excluding the Employment Insurance Act;

f) any disability benefits payable under any other group or association insurance plan;

g) any disability benefit payable by a private pension plan, excluding any increase in benefits after benefit payments commence due solely to cost of living;

h) any indemnity for loss of time payable under any government plan requiring or providing automobile insurance benefits on a no-fault basis.

3) In the event that a lump-sum payment is made under any of the above-mentioned sources in 1) and 2) in lieu of monthly payments, monthly benefits will be reduced by the equivalent monthly payment over a period of 60 months or by the number of months of disability for which the lump sum is paid, whichever is the lesser.

The Insurer may also reduce the monthly Long Term Disability payments even if the Participant, who is required to make the necessary application, fails or refuses to exercise his rights under the above-mentioned legislation or plans.

The Insurer may, at its discretion, estimate the amount of a government plan award pending notice of the actual award.

4) Limitations

No benefits are payable for a period of Total Disability

a) during which the Participant is not under Continuing Medical Care, for the Illness or bodily injury causing the Total Disability;

b) during the voluntary leave portion of the Maternity Leave as described under the DEFINITIONS section, for a Total Disability occurring during this period;

c) during a Parental or Family-Related Leave taken by a Participant, as provided for under provincial or federal legislation, for a Total Disability occurring during this period;

d) during any work stoppage due to a strike, lock-out, Leave of Absence or lay-off, for a Total Disability occurring during this period;

e) during the imprisonment of the Participant due to conviction of an offence;

f) if the Participant remains outside Canada for longer than 3 months for any reason whatsoever, unless the Insurer gives prior written consent to continue paying benefits during this period.

No benefits are payable for any period of Total Disability commencing during the first 12 months of coverage of a Participant, if such Total Disability was directly or indirectly the result of a sickness or injury that was treated by a Physician or for which prescribed drugs were taken during the 3 month period immediately prior to the effective date of such coverage.

However, if the policy has been in force for less than 12 months, and the Participant has been covered under a comparable benefit under the Employer's previous group insurance policy, for any period of time immediately prior to the Effective Date of the policy, that period of time will apply in determination of the 12 month coverage period.

5) Exclusions

No benefits are payable for a Total Disability resulting directly or indirectly from any one of the following:

a) intentionally self-inflicted injuries while sane or insane;

b) war, whether the war be declared or not, or service in the armed forces of any country, or participation in a riot, insurrection or civil commotion;

c) committing, or attempting to commit a criminal offence;

d) cosmetic surgery or treatment, unless such surgery or treatment is required as a result of an Accident which occurred while the Participant was insured under this Benefit;

e) alcohol or drug abuse unless, for such abuse, the Participant is actively taking part in a therapeutic program supervised by a Physician on an on-going basis, is receiving Continuing Medical Care or treatment for rehabilitation and is staying in an established treatment centre qualified to provide the necessary treatment or care;

f) driving a motorized vehicle while impaired by drugs, or with an alcohol level that exceeds the limit set under the Criminal Code of Canada.

RECURRENT TOTAL DISABILITY

Successive periods of Total Disability due to the same cause or related causes are considered to be the same period of Total Disability unless they are separated by at least

1) 2 consecutive weeks of active full-time employment during the Elimination Period; or

2) 6 consecutive months of active full-time employment immediately following a period of Total Disability for which Long Term Disability Benefits were paid under this Benefit.

Successive periods of Total Disability due to entirely unrelated causes are considered to be the same period of Total Disability, unless they are separated by at least 1 day of active full-time employment.

Whenever successive periods of Total Disability are considered to be the same period of Total Disability, the Elimination Period will not be applied a second time and the same amount as for the initial Total Disability minus any payments already made will be payable for the remainder of the Maximum Benefit Period.

DISABILITY MANAGEMENT

The Insurer may at any time require a Totally Disabled Participant to participate in a disability management program or to take up rehabilitative employment that is considered appropriate by the Insurer.

The Insurer will actively co-ordinate all disability management program services listed below and will also facilitate and ensure case follow-up:

1) co-ordination of access to health care services;

2) support program for returning to work;

3) negotiations for a gradual return to work,

4) rehabilitation program, which may include evaluation, treatment, training, placement and job search services.

If a Totally Disabled Participant, while receiving Long Term Disability Benefits, takes part in a disability management program or takes up rehabilitative employment under the supervision of his Physician and with the approval of the Insurer:

1) the Participant will still be considered Totally Disabled while taking part in this program, subject to a maximum of 24 months;

2) if, while taking part in this program, a Participant becomes Totally Disabled again, the terms and conditions of this Benefit will re-apply to the Participant as if he had been Totally Disabled during the rehabilitation period;

3) the Maximum Benefit Period during any period of Total Disability will continue to apply even if the Participant is taking part in an approved disability management program or rehabilitative employment;

4) if, while taking part in this program, the Participant earns any income, the Long Term Disability Benefits payable by the Insurer to the Participant will be reduced by the amount produced by the following formula:

$$(A \div B) \times C$$

A = Monthly Income earned from any rehabilitative activity

B = Monthly Earnings of the Participant immediately prior to the commencement of Total Disability

C = Long Term Disability Benefits otherwise payable under this Benefit

5) while the Participant is taking part in a disability management program, the Insurer will reduce his Long Term Disability Benefits so that his total income from all sources, if any, as listed in the INDIRECT OFFSET provision of the REDUCTION OF LONG TERM DISABILITY BENEFITS, LIMITATIONS AND EXCLUSIONS section of this Benefit, does not exceed 100% of his Net Earnings immediately prior to the commencement of Total Disability if this Benefit is non-taxable, or 100% of his gross Earnings immediately prior to the commencement of Total Disability if this Benefit is taxable.

A Participant who refuses to take part in a disability management program, does not participate in such program in good faith or does not take up rehabilitative employment considered appropriate by the Insurer will no longer be eligible for monthly benefits payable under this Benefit.

TERMINATION OF BENEFITS

Long Term Disability Benefits will cease on the earliest of

1) the date on which the Participant ceases to be Totally Disabled;

2) the date on which the Participant engages in any gainful occupation other than an approved gainful occupation for the purpose of rehabilitation;

3) the date set by the Insurer on which the participant was required to provide satisfactory proof of total disability or to undergo a medical examination requested by the Insurer, but neglected or refused to do so;

4) the date on which payments have been paid up to the Maximum Benefit Period for any one period of Total Disability;

5) the date on which the Participant refuses to participate in a disability management program or to take up rehabilitative employment considered appropriate by the Insurer; and

6) the date on which the Participant attains the Age Limit specified in the Benefit Schedule.

WAIVER OF PREMIUM

Premiums due under this Benefit are waived for any Totally Disabled Participant who is receiving Long Term Disability Benefits under this Benefit.

EXTENSION OF BENEFIT AFTER TERMINATION

If a Participant is Totally Disabled on the date his insurance terminates, the Insurer will continue insurance for that Total Disability as if the insurance under this Benefit for that Participant were still in force, provided such Total Disability continues uninterrupted, subject to all other provisions of the policy.

If a Participant is not Totally Disabled on the date this Benefit terminates but was receiving Long Term Disability Benefits under this Benefit less than 6 months prior to such date, such Participant will be eligible to a resumption of Long Term Disability Benefits if he again becomes Totally Disabled from the same or related causes prior to

1) 90 days after the termination of this Benefit; or

2) 180 days after the last day he was Totally Disabled.

The reinstated Long Term Disability Benefits will be equal to those which the Participant was previously eligible to receive and will continue for the remainder of the Maximum Benefit Period.

NOTICE AND PROOF OF CLAIM

Initial written notice of a claim must be submitted to the Insurer within 30 days of the expiry of the Elimination Period and initial written proof, within 60 days of the expiry of the Elimination Period.

In the event of the recurrence of Total Disability, written notice of a claim must be submitted to the Insurer within 30 days of the date of such recurrence and written proof within 60 days of the date of such recurrence.

Subsequent written proof satisfactory to the Insurer of continuing Total Disability must be submitted to the Insurer at its request.

EMPLOYEE ASSISTANCE PROGRAM 360º

DEFINITIONS

E.A.P. means the Employee Assistance Program 360º Benefit.

Policy Year means the 12 month period following the Effective Date of the policy and every 12 month period thereafter.

Subcontractor means the company that provides the Employee Assistance Program 360º services.

PURPOSE OF THE BENEFIT

1) Description of the product

   a) The E.A.P. is a prevention tool designed to help improve health, productivity and attendance at work. It provides troubled Participants and their immediate family with fast and confidential access to professional resources to help them deal with various types of problems.

   b) The E.A.P. provides a wealth of information and promotional tools to help policyholders improve the quality of the work environment and reduce absenteeism.

   c) If a Participant or one of his insured Dependents uses the E.A.P. services offered by the Subcontractor and described below, the cost of these services will be covered under this Benefit and the Insured Person has no out-of-pocket expenses and no receipts to submit, subject to any applicable limitations or exclusions.

   d) For confidential access to the service, the Participant or one of his insured Dependents can call the service's toll-free number 24 hours a day, 7 days a week. A specialist verifies the Insured Person's eligibility at the time of the call. After identifying the nature of the problem, the user receives a confidential file number. A counsellor then contacts the Insured Person within the next few hours to arrange a mutually convenient time for either face-to-face, telephone or cyber-counselling meeting.

2) Interventions for the Insured Person

   a) The following E.A.P. counselling services are included:

      FACE-TO-FACE, TELEPHONE OR CYBER-COUNSELLING

      i) family difficulties: assistance for the Insured Person with relationship issues, problems associated with a separation or divorce, marital conflicts, communication problems, parenting problems, etc.;

ii) work-related difficulties: assistance for the Insured Person with stress, burnout, interpersonal problems with supervisors or co-workers, difficulties adjusting to change in duties, loss of interest in work, dealing with career change, etc.;

iii) personal problems: assistance for the Insured Person suffering from fatigue, sleep disturbances, general anxiety, loss of motivation, loss of self-esteem, stress, overwork, depression, isolation, bereavement or following an event, transition or turn of life, etc.;

iv) dependency problems: assistance for the Insured Person suffering from dependency problems such as alcohol, drugs or medication abuse, compulsive gambling, Internet addiction, etc.;

TELEPHONE COUNSELLING

v) legal problems: support on matters of family law, separation, divorce, child support and custody, etc.;

vi) financial problems: support with credit and debt management, bankruptcy, budget planning, financial aspects of divorce, etc.;

vii) eldercare: support and specific educational materials, assistance researching retirement homes, home care, psychological support, etc.;

viii) childcare: support and specific educational materials, assistance researching daycares and home daycare services, home care nursing, vacation camps, etc.;

ix) support to parents to assist their children with the school planning.

b) For the purposes of this Benefit, the use of counselling services related to the E.A.P. is limited as follows:

i) 12 hours per Policy Year, for the Participant and his Dependents, for services described in subparagraphs i), ii) iii) and iv) of paragraph a);

ii) 30 minutes per call for a same problem, for services described in subparagraphs v) and vi) of paragraph a);

iii) no limit for services described in subparagraphs vii) and viii) of paragraph a); and

iv) 3 hours per Policy Year per family, for services described in subparagraph ix) of paragraph a).

EXCLUSIONS

No benefits are payable for

1) physical problems; or

2) services paid for or covered under legislation applicable to the Insured Person.

BENEFIT TERMINATION

This Benefit terminates on the date the Participant attains the Age Limit specified in the Benefit Schedule or on the earliest of the dates indicated in the TERMINATION OF PARTICIPANT INSURANCE provision.

DEPENDENT BENEFIT EXTENSION AFTER PARTICIPANT'S DEATH

In the event of the death of the Participant and subject to policy provisions, insurance under this Benefit will continue for Insured Dependents, without premium payment, to offer counselling services for the bereavement period, until the earlier of the following dates:

1) three months following the death of the Participant; or

2) the date this Benefit or policy terminates.

EXTENDED HEALTH CARE BENEFIT

DEFINITIONS

As used in this Benefit

Calendar Year means the period extending from January 1st to December 31st inclusive.

Convalescent/Rehabilitation Centre means any facility or institution in Canada which is licensed as a convalescent hospital by the licensing body having jurisdiction for the care and treatment of sick and injured persons who require supervision of either a Physician or a registered nurse. This institution must provide nursing care 24 hours a day by a registered nurse and maintain a daily record of each patient under the care of a Physician. However, it does not include a nursing home, home for the aged, or the chronically ill, home for the mentally ill, rest home, or an institution for the care and treatment of alcoholism or drug addiction.

Day Surgery means any surgery performed by a Physician that requires local or general anaesthesia, with the exception of any minor surgery performed in the office of the Physician.

Dentist means a person who is licensed to practise dentistry by the appropriate authority of the jurisdiction where the services are provided.

Drugs available on prescription means drugs prescribed by a Physician or a dental surgeon. This will also include certain drugs requiring a prescription when prescribed by other health practitioners where permitted to do so by provincial law.

Equivalent drug means a brand or generic drug, deemed interchangeable under the provincial law applicable where the drug is sold.

Hospitalization means

1) to be admitted to a Hospital as an In-patient for more than 18 consecutive hours; or

2) any Hospital stay in order to receive Day Surgery.

In-patient means a person admitted to and assigned a bed in a Hospital In-patient area on the order of a Physician.

Medical Emergency means any acute and unexpected condition, Illness or injury requiring immediate medical treatment.

Orthesis means any orthopaedic appliance constructed of rigid material, such as metal or plastic, used to maintain a part of the body in the correct position. Elastic supports are not included in this category.

Palliative Care Establishment means any establishment in Canada designated as such by law that provides, under the supervision of a Physician, care and treatment to patients, mainly during the terminal phase of their Illness, and that provides nursing care 24 hours a day by a registered nurse and maintains daily records of each patient under the care of a Physician. An active treatment Hospital designated as such by law, extended care facility, rest home, Convalescent or Rehabilitation Centre, home for the aged or the chronically ill, home for the mentally ill, sanatorium, convalescent hospital, or institution for the care and treatment of alcoholism or drug addiction is not considered a Palliative Care Establishment.

Patient support program means the program providing support to help Insured Persons manage their health and medication.

Exclusion: If an Insured Person refuses to enrol in such a program, this person might not be eligible for reimbursement of the drug expenses.

Patient assistance program means the program offered by some drug manufacturers to provide Insured Persons with information, education and financial assistance if they are prescribed certain drugs.

Exclusion: If an Insured Person refuses to enrol in such a program, this person might not be eligible for reimbursement of the drug expenses.

Period Of Hospitalization means any continuous period of Hospitalization in a Canadian Hospital or successive periods of Hospitalization resulting from the same Illness or Accident and separated by less than 60 consecutive days during which the Insured Person was not hospitalized. If, during a given period, Hospitalization results from an Illness or Accident entirely unrelated to the Illness or Accident that resulted in the previous Hospitalization, this Hospitalization will be treated as a new Period Of Hospitalization.

Prosthesis means an appliance used to replace all, or part, of a limb or organ.

Reasonable and Customary Charges means the charges generally paid in the area where the services or supplies are provided for a like service or supply and limited to the prevailing charge in the area for the like service or supply. A like service or supply is one of the same nature and duration, that requires the same skill and is performed by a provider of similar training and experience.

Sound Tooth means a natural tooth that is not afflicted with any pathology either itself or in the adjacent structures. In addition, a tooth that has been treated or repaired and restored to normal function will be considered sound.

Stable refers to the health condition of an Insured Person who, within 30 days prior to the trip departure date, is not affected by any medical condition, or is affected by a medical condition that:

1) does not require a change or for which no change was recommended in the treatment or dosage of prescribed drugs; and

2) does not demonstrate any symptoms that would indicate a deterioration of the medical condition in the course of the trip.

Total Disability or Totally Disabled means a state of incapacity, resulting from an Illness or Accident, which wholly prevents the Participant from working in any occupation for which he is suited by education, training and experience.

Vehicle means a car, a motor home or a van with a maximum load of 1,000 kilograms.

PAYMENT OF BENEFIT

When DFS receives satisfactory Proof of Claim that a Covered Person incurred Eligible Expenses while covered under this Benefit, DFS will reimburse those expenses according to policy provisions.

For all Eligible Expenses, the Insurer will reimburse the portion of the reasonable and customary charges in excess of the Deductible, subject to the Percentage of Reimbursement.

To be eligible, the expenses must be medically necessary for the treatment of the Insured Person and incurred in Canada as a result of an Illness, a pregnancy or an Accident, and cover drug or product that:

1) is prescribed by a Physician or other health professional as authorized by law, before the expense is incurred,

2) is recognized throughout the medical field as appropriate and consistent with the diagnosis, and

3) cannot be omitted without endangering the person's health or the quality of medical care.

The incurred date for any Eligible Expense is the date the drug or product is purchased or supplied.

Preferred providers network

The Insurer may select suppliers for the distribution of drugs and supplies and may restrict payment for Eligible Expenses incurred at another supplier.

COMMENCEMENT OF DEPENDENT INSURANCE

If a Dependent is hospitalized on the day his insurance would normally become effective, the effective date of insurance will be delayed, and his insurance will commence 24 hours after his discharge from the hospital. However, the newborn Child of a Participant, with Dependents who are already covered, will become insured at birth.

DEDUCTIBLE

The Deductible is the amount of Eligible Expenses that the Participant must pay in any Calendar Year before reimbursement will be made under this Benefit. The Deductible is specified in the Benefit Schedule.

CO-PAY

The Co-pay is the portion of Eligible Expenses that the Participant must pay for each drug for which expenses were incurred before reimbursement will be made under this Benefit. The Co-pay is specified in the Benefit Schedule.

PERCENTAGE OF REIMBURSEMENT

The Percentage of Reimbursement specified in the Benefit Schedule is the percentage of Eligible Expenses in excess of the Deductible that will be reimbursed by the Insurer, in accordance with the provisions of this Benefit.

ELIGIBLE EXPENSES IN CANADA – EXTENDED HEALTH CARE

Eligible Expenses include charges for the following and must be incurred:

1) in the Participant's province of residence; and

2) outside the Participant's province of residence, but in Canada, for any reason other than a Medical Emergency.

HOSPITALIZATION EXPENSES

Hospital: Charges for confinement in a Hospital for each day of acute care Hospitalization, with no limit as to the number of days, up to the maximum specified in the Benefit Schedule.

Palliative Care Establishment: Charges for confinement for palliative care up to the maximum specified in the Benefit Schedule.

Convalescent/Rehabilitation Centre: Charges for confinement in a licensed Convalescent or Rehabilitation Centre, provided that the Insured Person was admitted within 14 days of discharge from a Hospital to which he was confined as an In-patient and that this stay was primarily required for rehabilitation and not custodial care, up to the maximum specified in the Benefit Schedule.

DRUGS

1) Drugs that are necessary for treatment in respect of an Illness or injury and that are available only on prescription from a Physician or a dental surgeon (code "PR", "C" or "N" in the Compendium of Pharmaceuticals and Specialties) and dispensed by a pharmacist, or by a Physician, if there is no pharmacist.

   Also eligible are drugs available on prescription that are necessary for the treatment of certain pathological conditions, excluding homeopathic preparations, and for which the therapeutic indication suggested by the manufacturer in the Compendium of Pharmaceuticals and Specialties is directly linked to the treatment of the following pathological conditions:

   cardiac problems;

   pulmonary problems;

   diabetes;

   arthritis;

   Parkinson's disease;

   epilepsy;

   cystic fibrosis;

   glaucoma.

2) Injectable drugs and vaccines prescribed by a Physician for preventing or treating an Illness. Preventive vaccines are limited to a payable amount of $100 per Calendar Year per Insured Person.

3) Sclerosing injections used in the treatment of varicosities, when this treatment is primarily for therapeutic and not cosmetic purposes, up to an eligible amount of $20 per visit per Insured Person.

4) Anaesthetic administered during surgery that is not performed in a Hospital, up to an eligible amount of $20 per operation.

PRIOR AUTHORIZATION DRUGS

Prior authorization by DFS is required for certain drugs listed on DFS's website. A prior authorization form completed by the Physician must be submitted to DFS in order to determine whether the prescribed drug meets the prior authorization criteria established by DFS. The criteria are based, in particular, on clinical practice guidelines and recommendations issued by health technology assessment agencies and they include verification that:

a) the drug is prescribed for a therapeutic indication approved by Health Canada, and

b) the drug's effectiveness is satisfactory compared to its associated cost.

Proof of the effectiveness of the approved drug, including medical results, may be requested during the course of treatment to determine if the drug is having the desired effect so that it may remain eligible for reimbursement.

DFS reserves the right to reimburse an equivalent or biosimilar drug when a less expensive equivalent or biosimilar drug is available on the market.

PATIENT SUPPORT PROGRAM AND PATIENT ASSISTANCE PROGRAM

The Insurer may require Insured Persons to enrol in such programs.

HEALTH PROFESSIONALS

Nursing Care: Services of a registered nurse or a licensed practical nurse are eligible, up to the payable amount specified in the Benefit Schedule per Insured Person, provided the patient is not confined in a Hospital and the services are medically necessary, are not rendered solely for custodial care, supervision or companionship, and come within the competence of such nurse. In addition, the nurse must not be related to the Participant or to any of his Dependents by birth or marriage, and must not ordinarily reside in his or his Dependent's home.

Paramedical Services: Services of the following practitioner disciplines, provided that the practitioner is operating within his recognized field, that he is a member in good standing of his professional association, and that the association is recognized by the Insurer, up to the payable amount specified in the Benefit Schedule per Insured Person:

These services do not require prior Medical Recommendation:

- acupuncturist
- audiologist or hearing therapist *
- chiropractor
- dietician or nutritionist *
- occupational therapist
- homeopath
- massage therapist, kinesitherapist, kinotherapist & orthotherapist *
- naturopath
- osteopath
- physiotherapist, physiatrist, physical rehabilitation therapist or sports therapist *
- podiatrist or chiropodist *
- psychologist, social worker, guidance counselor, psychotherapist, registered clinical counsellor or psychoeducator *
- speech therapist

* The maximum benefit amount specified in the Benefit Schedule applies to all specialists of this discipline.

Imaging techniques ordered by a chiropractor, a podiatrist, an osteopath or chiropodist are covered, up to a payable amount of $40 per Insured Person each Calendar Year for each of these specialists.

AMBULANCE

In the event of a Medical Emergency, or if the Insured Person must be transferred to another Hospital, transportation by a licensed ground ambulance

1) from the place of the Accident or Illness to the nearest Hospital where adequate medical treatment is available;

2) between Hospitals; and

3) from the Hospital to the place of residence of the Insured Person, when his condition warrants it.

Medical Emergency transportation by a licensed air ambulance to the nearest Hospital where adequate treatment is available, or to another Hospital when certified as medically necessary by the attending Physician.

MOBILITY AIDS

Wheelchair: Purchase and repair, or rental, at the discretion of the Insurer, up to one wheelchair for any period of 60 consecutive months and a lifetime maximum payable amount of $3,000 per Insured Person. Expenses for a motorized wheelchair are eligible if the Insured Person's health condition requires such a wheelchair.

Walkers, canes or crutches: Purchase or rental, at the discretion of the Insurer.

ORTHOPAEDIC SUPPLIES

Spinal brace: Purchase, but not repair.

Rigid or semi-rigid brace for a limb, truss or cast: Purchase and repair.

Non-electric hospital bed: Purchase and repair, or rental, at the discretion of the Insurer, up to one hospital bed for any period of 60 consecutive months per Insured Person. Expenses for an electric hospital bed are eligible if the Insured Person's health condition requires such a bed.

Orthopaedic shoes: Purchase of one pair for adults and two pairs for Children under age 18, up to a maximum of Payable Expenses of $400 per Insured Person each Calendar Year. Orthopaedic shoes are defined as custom-molded shoes specifically designed for an individual to correct a foot defect, as well as open-toed shoes, in-flare or out-flare shoes, straight-laced shoes and shoes required for Denis Browne braces. Modified or adjusted stock item footwear and modifications or adjustment to stock item footwear is also eligible; in-depth shoes and off-the-shelf shoes that are regular stock are excluded.

ORTHESIS AND PROSTHESIS

Foot Orthesis: Purchase, up to one pair for adults and two pairs for Children under age 18 and to a maximum payable amount of $200 per Insured Person each Calendar Year.

Artificial limb and myoelectric prosthetics: Purchase, up to a maximum payable amount of $10,000 per prosthesis. Repair, up to a maximum payable amount of $10,000 per prosthesis. Replacement is covered when required due to physiological change, up to a maximum payable amount of $10,000 per prosthesis.

Artificial eye: Purchase, including reimbursement for one polishing or one re-making of the artificial eye each Calendar Year, per Insured Person.

Breast Prostheses: Purchase, when required due to a mastectomy that has been performed while the Insured Person is covered under this Benefit or a comparable benefit in force immediately before the effective date of this Benefit, including the purchase of 2 mastectomy brassieres, up to the cost of external prostheses and a maximum payable amount of $200 per Insured Person for any period of 24 consecutive months.

Hearing aids: Purchase, on the written prescription of a licensed otolaryngologist, up to a maximum of Payable Expenses of $500 per Insured Person for any period of 36 consecutive months, including initial batteries.

Wigs: Purchase of wigs when required for temporary hair loss due to alopecia, chemotherapy or radiotherapy, up to a lifetime maximum of Payable Expenses of $200 per Insured Person.

THERAPEUTIC EQUIPMENT

Glucometer or reflectant meter: Purchase, or rental, upon presentation of a complete medical report certifying that the Insured Person is insulin-dependent and that his condition requires the use of such device, up to a payable amount of $200 and one device for any period of 36 consecutive months.

Insulin pump supplies: Purchase.

Oxygen, and equipment required for its administration: Purchase or rental, at the discretion of the Insurer.

Apnea monitor: Purchase or rental, at the discretion of the Insurer.

Lymphoedema pump and chest percussion accessories: Purchase.

Enuresis sensors: Purchase or rental, at the discretion of the Insurer.

Traction apparatus: Purchase or rental, at the discretion of the Insurer.

Standing aids: Purchase or rental, at the discretion of the Insurer.

TENS nerve stimulators: Purchase or rental, at the discretion of the Insurer, up to a lifetime maximum of payable Expenses of $700 per Insured Person.

Other therapeutic equipment: Purchase or rental, at the discretion of the Insurer, provided such equipment is medically required and is intended to cure or treat the affliction, up to $1,500 payable per Insured Person each Calendar Year. This category of equipment includes, for example, non-union bone stimulators, insulin pumps, aerosol therapy equipment and intermittent positive pressure breathing machines.

MEDICAL SUPPLIES

Colostomy, ileostomy or uretherostomy supplies: Purchase.

Elastic support stockings: Purchase of medium or firm (at least 20 mm/Hg) support stockings dispensed in a pharmacy or a medical facility, up to 4 pairs and a Payable amount of $500 each Calendar Year, per Insured Person.

Intra-uterine devices and diaphragms: Purchase, up to a combined maximum of Payable Expenses of $50 per Insured Person each Calendar Year.

Supplies for paraplegics: Purchase, provided such supplies are required for the treatment and the care of a paraplegic Insured Person.

Catheter: Purchase.

Medical supplies for gavage: Purchase.

Medical supplies necessary following a tracheotomy: Purchase

Opaque glass necessary during radiotherapy or psoriasis treatments: Purchase

Compressive garments for the treatment of burns: Purchase.

Medicated dressings: Purchase.

Stump-socks: 10 each Calendar Year, per Insured Person.

DIAGNOSTIC SERVICES

Imaging techniques (including X-ray, ultrasound or MRI examinations), diagnostic laboratory tests, prenatal screening test and radiotherapy or radium therapy, up to a maximum of Payable Expenses of $1,000 per Insured Person each Calendar Year. Such procedures do not include services received in a Hospital.

DENTAL TREATMENT DUE TO AN ACCIDENT

The services of a dentist required to repair and replace healthy teeth as a result of an accidental blow to the mouth received while the insured is covered under this Benefit or a comparable benefit in force immediately before the effective date of this Benefit, but not as a result of voluntarily or involuntarily putting food or any other object in his mouth. Dental services must be rendered within 12 months of the accident; otherwise, a treatment plan deemed satisfactory by the Insurer will be required before that deadline. No benefit is payable for services provided more than 2 years after the date of the accident. Reimbursement of Eligible Expenses is governed by the current year Dental Association Fee Guide for General Practitioners where the Participant resides.

VISION CARE

Eye examinations: Including eye refraction, provided they are performed by a qualified ophthalmologist or a licensed optometrist, up to a maximum payable amount of $100 per Insured Person for any period of 24 consecutive months in the case of adults, and 12 months in the case of children under Age 18.

Intraocular lenses: Purchase, as a replacement for natural crystalline if the Insured Person has cataracts, up to a maximum payable amount of $200 per Insured Person each Calendar Year.

EYEGLASSES, LENSES AND EYE SURGERY

Eyeglasses or contact lenses and their replacement, provided they are prescribed in writing by a qualified ophthalmologist or a licensed optometrist and dispensed by a qualified ophthalmologist, a licensed optometrist or a qualified optician; or surgery to correct myopia, hypermetropia and astigmatism, up to the maximum payable amount specified in the Benefit Schedule.

> Contact lenses: Purchase, up to a maximum payable amount of $250 per Insured Person per period of 24 consecutive months in the case of adults, and 12 months in the case of children under Age 18, provided that they are required as a result of cataract surgery and that vision can be improved to at least 20/40.

HEALTH ASSISTANCE

Health Assistance is a confidential telephone service that is available 24 hours a day enabling the Insured Person to speak with experienced health care professionals and to obtain information immediately.

This telephone service provides the Insured Person with information on the following topics:

- health
- immunization
- nutrition
- lifestyle
- physical fitness
- child care
- availability of local resources

Health Assistance should be considered as a complement to medical consultations and emergency medical services (911 or other); it is not intended to replace the regular health care provider of the Insured Person, nor the emergency medical services of a municipality.

This information service may be of use in improving the quality of life of the Participant and of his Dependents.

The Insured Person may contact HEALTH ASSISTANCE at any time.

Calls from	**Dial**
Anywhere in Canada	1 877 875-2632

ELIGIBLE EXPENSES - REFERRAL TREATMENT

Eligible Expenses incurred outside the province of residence of the Insured Person as a result of a referral include those provided for in the TRAVEL INSURANCE section below, subject to the following provisions:

1) This service or treatment must not be available in Canada or in the normal province of residence of the Insured Person;

2) The Insured Person must provide the Insurer with a letter of referral from a Physician in his normal province of residence, indicating that he is being referred to another Physician;

3) The Insurer must give prior written approval;

4) The provincial health and/or hospital insurance plans must pay a portion of the Eligible Expenses.

The maximum amount payable by the Insurer under this provision is limited to the percentage specified in the Benefit Schedule and the following Eligible Expenses:

1) Expenses incurred outside the province of residence, but in Canada - no maximum limitation;

2) Expenses incurred outside Canada - up to $50,000 of Eligible Expenses per Insured Person each Calendar Year.

ELIGIBLE EXPENSES - TRAVEL INSURANCE

If an Insured Person incurs Medical Emergency expenses during the first 180 days of a stay outside his province of residence, the Insurer will reimburse the Eligible Expenses in accordance with the Benefit Schedule and the following conditions:

1) the Insured Person must be covered under government health and hospital insurance plans;

2) expenses must be eligible under the Extended Health Care Benefit; and

3) expenses must be related to a Stable health condition prior to the trip departure date.

The Participant must contact the Insurer if the duration of the stay outside the province of residence is, or may be, longer than 180 days. Otherwise the Insured Person may not be covered under the Travel Insurance benefit.

1) Eligible Health Care Expenses

    a) Hospital services and room and board charges in a semi-private room until the Insured Person is discharged from the Hospital;

    b) Services of a Physician, a surgeon and an anaesthetist;

c) All other Eligible Expenses that are covered under this Benefit in the normal province of residence of the Insured Person, excluding Hospital and Convalescent Care Eligible Expenses, if insured.

2) Eligible Transportation Expenses

a) Expenses incurred for the repatriation of the Insured Person to his place of residence by a suitable means of public transportation to receive appropriate care as soon as his state of health allows it, provided the means of transportation originally arranged for the return trip cannot be used; repatriation must be approved and arranged by "Voyage Assistance". Furthermore, if "Voyage Assistance" recommends repatriation and the Insured Person declines, his insurance under the Travel Insurance provision will terminate.

b) Expenses incurred for the repatriation (at the same time as the repatriation provided for above) of any Immediate Family member insured under this Benefit, if he cannot return to the point of departure by the means of transportation originally arranged for the return trip; repatriation must be approved and arranged by "Voyage Assistance".

c) Round-trip economy transportation for a qualified medical attendant who is not a family member, a friend, or a travelling companion, provided the presence of this attendant is ordered by the attending Physician and approved by "Voyage Assistance".

d) Round-trip economy air, bus or train transportation by the most direct route for one Immediate Family member to the Hospital where the Insured Person must be confined for at least 7 days (expenses will be reimbursed only if the Insured Person remains in Hospital for at least 7 days). This visit is eligible for reimbursement provided that the Insured Person is not accompanied by an Immediate Family member age 18 or over. The cost of meals and accommodation for the Immediate Family member up to $1,500 are also covered. The visit must be considered beneficial to the patient by the attending Physician, and prior approval must be obtained from "Voyage Assistance".

e) Cost of returning the personal or rented Vehicle of the Insured Person if the Insured Person suffers from a disability as a result of a Medical Emergency, certified by a Physician, that prevents him from operating this Vehicle and none of the Immediate Family members accompanying him are able to return it. A commercial agency may be hired to return the Vehicle, but the return must be arranged and approved by "Voyage Assistance". The amount reimbursed is limited to $2,500 per Participant.

f) If the Insured Person should die, round-trip economy air, bus or train transportation by the most direct route for one Immediate Family member of the deceased to identify the body before repatriation (the trip must be pre-approved and arranged by "Voyage Assistance"). These expenses are not reimbursed if the Insured Person was accompanied by an Immediate Family member age 18 or over.

g) If the Insured Person should die, the costs of preparation and the return of the body or ashes to the place of residence by the most direct route (plane, bus or train), up to $5,000; the cost of the burial coffin is not covered. The return must be pre-approved and arranged by "Voyage Assistance".

3) Eligible Daily Allowance

The cost of meals and accommodations for an Insured Person who must delay his return because of an Illness or bodily injury suffered by the Insured Person himself, an accompanying member of his Immediate Family or a travelling companion, as well as additional child care expenses for Children not accompanying the Insured Person. Eligible Expenses are limited to $200 per day per Insured Person for a maximum of 10 days and the Illness or injury must be certified by a Physician.

4) Eligible Long-distance Telephone Charges

Long-distance telephone charges to reach a member of the Immediate Family if the Insured Person is hospitalized, provided that the transportation allowance, provided under section d) above, to visit that person is not used and that the Insured Person is not accompanied by an Immediate Family member age 18 or over - up to $50 per day, and up to an overall maximum of $200 per Period Of Hospitalization.

5) Medical Decisions

Decisions by a Physician or other health care professional employed by, under contract to, or designated by "Voyage Assistance", regarding the medical need for providing any of the covered services outlined above are medical decisions based on medical factors and, as such, will be conclusive in determining the need for these services.

6) Voyage Assistance service

"Voyage Assistance" will take the necessary steps to provide the following services to any Insured Person who requires them:

a) 24 hour toll-free telephone assistance;

b) referral to Physicians or health-care facilities;

c) assistance for Hospital admission;

d) cash advances to the Hospital when required by the facility;

e) repatriation of the Insured Person to his home city, as soon as his state of health permits it;

f) establishing and staying in contact with the Insurer;

g) handling arrangements in the event of death;

h) repatriation of the Children of the Insured Person, if the Insured Person cannot be moved;

i) delivery of medical assistance and drugs to an Insured Person who is too far from health care facilities to be transported there;

j) arrangements to bring a member of the Immediate Family to the bedside of the Insured Person if he must be confined to Hospital for at least 7 days, provided that such visit is ordered by the attending Physician;

k) assistance in replacing lost or stolen travel documents so that the Insured Person can continue his trip;

l) referral to lawyers if legal problems arise;

m) translation services for emergency calls;

n) transmission of urgent messages to close friends or family in case of emergency; or

o) information prior to departure concerning passports, visas and vaccinations required in the country of destination.

In the event of a **MEDICAL EMERGENCY**, the insured must contact the travel assistance firm immediately.

Calls from	**Dial**
Montreal area	(514) 875-9170
Canada and United States	1-800-465-6390 (toll-free)
Elsewhere (excluding North and South America)	overseas code + 800 29485399 (toll-free)
Collect call (Anywhere worldwide)	(514) 875-9170

RESTRICTIONS, EXCLUSIONS AND LIMITATIONS

1) No reimbursement will be made under this Benefit for the following:

   a) services or treatment that a government health plan prohibits from being paid in whole or in part, except to the extent that it permits reimbursement of the excess amount;

   b) services, treatment or supplies that a person receives without charge or that are reimbursed under a provincial or federal law. If a person is not covered under the laws in question, the Insurer will not reimburse the expenses that would normally be covered under the hospital or health insurance legislation in force in the Insured Person's province of residence;

   c) services, treatment or supplies which are experimental in nature;

   d) services, treatment or supplies provided to the Participant by the Employer;

   e) services, treatments or supplies provided to the Insured Person by an immediate relative,

   f) wheelchairs adapted or designed for sports activities;

   g) robotic walking aid apparatus,

   h) charges for any surgically implanted item,

   i) monitoring devices such as stethoscopes, sphygmomanometers and similar equipment, and domestic appliances such as air purifiers, humidifiers, air conditioners, whirlpools and other similar equipment;

   j) equipment such as "Obus form" type;

   k) training, exercise programs, physical fitness programs using equipment or floor exercises, floating baths, mud baths, therapeutic baths, relaxation exercises, gym exercises, stretching and strengthening exercises, postural evaluations and ear candling;

   l) appliances, supplies and equipment conceived or customized for participation in sporting activities,

   m) diapers for incontinence;

   n) dental services, except those provided for in this Benefit;

   o) dental services and supplies for the purposes of full mouth reconstructions, for vertical dimension correction or for any other temporomandibular joint dysfunction;

   p) travel for health reasons or for medical examinations required for insurance, consultation or assessment purposes;

q) services, treatment or supplies not included in the list of Eligible Expenses;

r) Eligible Expenses which result directly or indirectly from the following:

i) intentionally self-inflicted injuries while sane or insane;

ii) cosmetic treatment;

iii) committing, or attempting to commit a criminal offence, including operating a vehicle while impaired as set out under the Criminal Code of Canada;

iv) any cause for which payment is provided under any Workers' Compensation Act or similar legislation or under any other government plan;

v) war, whether the war be declared or not, or service in the armed forces of any country, or participation in a riot, insurrection or civil commotion;

vi) driving a motorized Vehicle while impaired by drugs, or with an alcohol level that exceeds the limit set under the Criminal Code of Canada; the Eligible Expenses incurred for detoxification treatment are not subject to this exclusion;

s) services, treatment or supplies for the treatment of alcoholism and drug addiction;

t) services, treatment or supplies for fertility treatment;

u) sunglasses or safety glasses.

Benefits may be limited or no reimbursement made for services or supplies available at a supplier of the preferred providers network but obtained from another supplier.

2) Exclusions applicable to drugs

No reimbursement will be made under this Benefit for the following:

a) products, hormones and injections used in the treatment of obesity;

b) contraceptives (prophylactics and contraceptive jellies and foams) except those provided for under this Benefit;

c) the following products, whether or not prescribed:

i) shampoos and other scalp care products, including hair growth products;

ii) beauty-care products;

iii) cosmetics;

iv) so-called "natural" products and homeopathic preparations;

v) sun-tan emulsions (sunscreens);

vi) soaps;

vii) over-the-counter laxatives;

viii) over-the-counter antacids;

ix) skin softeners;

x) disinfectants and ordinary dressings;

xi) mineral water;

xii) any infant milk formulas;

xiii) proteins and food supplements (i.e. products used to supplement or complement a diet);

d) sclerosing injections used in the treatment of varicosities, telangiectasia and minor dilation when this treatment is primarily for cosmetic and not therapeutic purposes;

e) products and drugs used in the treatment of sexual dysfunctions;

f) products used as smoking cessation aids;

g) products used in fertility treatment.

h) expenses incurred for services, products or drugs that are used to treat specific conditions other than those for which they are approved by Health Canada; or

i) expenses incurred for services, products or drugs that are taken in a higher dose, greater quantity or at a frequency that exceeds the Insurer's criteria of good clinical practice.

Benefits may be limited or no reimbursement made for drugs or supplies available at a supplier of the preferred providers network but obtained from another supplier.

3) Exclusions applicable to drugs requiring prior authorization

The Insurer reserves the right to apply certain restrictions, exclusions and limitations namely to services, products or drugs that do not meet the Insurer's prior authorization criteria as of the date the expense is incurred.

4) Drug restrictions

a) The Insurer reserves the right to apply certain restrictions for the reimbursement of drugs for which a less expensive equivalent drug is available on the market;

b) Any one prescription for drugs or medicines must not be in excess of a 34 day supply and a 100 day supply in the case of maintenance drugs.

5) Additional Limitations Applicable to Drugs

For biologic drugs, the Insurer reserves the right to reimburse a less expensive biosimilar drug if available on the market.

6) Additional Exclusions Applicable to Drugs

No reimbursement is made for:

a) Drugs or products that are on the Insurer's list of excluded drugs or products. This list is available on the Insurer's website. In part, the list is based on the drug or product's effectiveness and cost, clinical practice guidelines and recommendations issued by health technology assessment agencies.

b) Drugs or products that are or should be administered in a hospital or hospital setting, as determined by the Insurer. This includes drugs or products that require special supervision during treatment due to the severity of the patient's condition, the complexity of the treatment or for safety reasons. In part, the Insurer uses information from Health Canada approved product monographs and recommendations issued by health technology assessment agencies to make its determination.

7) Exclusions and limitations applicable to Travel Insurance

If an Insured Person fails to contact "Voyage Assistance" immediately when he requires Medical Emergency services that require Hospitalization outside the country, the Insurer may reduce or deny reimbursement of a portion of the incurred Eligible Expenses. It is understood that the Insurer is not responsible for the availability or quality of such services.

Exclusions applicable to the Extended Health Care Benefit also apply to the Travel Insurance provision. Furthermore, the Insurer will not pay any of the benefits provided for under the Travel Insurance provision in the following circumstances:

a) if the Insured Person is not covered under government health and hospital insurance plans;

b) if the purpose of the trip is to receive medical or paramedical treatment or Hospital services, unless the Insured Person was referred to another Physician, in accordance with the provisions of the REFERRAL TREATMENT section of this Benefit;

c) for elective, non-emergency treatment or surgery, when this service could have been provided in the province of residence of the Insured Person without endangering his life or health, even if such service is provided as a result of a Medical Emergency;

d) if the Insured Person does not agree to repatriation as recommended by "Voyage Assistance";

e) for health care and Hospital expenses incurred for an Insured Person who cannot be repatriated in his province of residence and who refuses medical treatment prescribed by the Physician, and approved by "Voyage Assistance";

f) for any Medical Emergency incurred in a country or region for which the Canadian government issued, prior to the trip departure date, one of the following travel warnings:

   i) avoid non-essential travel; or

   ii) avoid all travel.

   The Insured Person who is in the country or region for which a travel warning is issued during his trip is not subject to this exclusion. However, he must make the necessary arrangements to leave the country or region as soon as possible;

g) if the Insured Person refuses to disclose to the Insurer necessary information regarding other insurance plans under which he also has travel insurance coverage, or if he refuses the use of such information by the Insurer;

h) if the expenses incurred are related to a health condition that was not Stable prior to the trip departure date.

Travel Insurance benefits are limited to a lifetime maximum reimbursement of $5,000,000 per Insured Person.

CO-ORDINATION OF BENEFITS

This Benefit is subject to the CO-ORDINATION OF BENEFITS provision in the CLAIMS section of the policy.

CO-ORDINATION OF BENEFITS FOR TRAVEL INSURANCE

If an individual covered under Travel Insurance is also covered under any other plan or insurance policy that provides similar benefits, Travel Insurance only covers Eligible Expenses in excess of the amounts payable by the other plans or insurance policies.

If the other plans or insurance policies include a similar clause or Co-ordination of Benefits provision, benefits are co-ordinated between all plans or insurance policies so that the total amounts paid do not exceed 100% of the individual's incurred Eligible Expenses.

BENEFIT TERMINATION

This Benefit terminates on the date the Participant attains the Age Limit specified in the Benefit Schedule or on the earliest of the dates indicated in the TERMINATION OF PARTICIPANT INSURANCE provision.

DEPENDENT BENEFIT EXTENSION AFTER PARTICIPANT'S DEATH

In the event of the death of the Participant and subject to policy provisions, insurance under this Benefit will continue for Insured Dependents, without premium payment, until the earliest of the following dates:

1) 24 months following the death of the Participant;

2) the date on which the Dependent ceases to be eligible as a Dependent for a reason other than the death of the Participant;

3) the date on which Dependent insurance would have terminated if the Participant had not died; or

4) the date on which this Benefit or policy terminates.

NOTICE AND PROOF OF CLAIM

All claims, other than drug claims, must be submitted to the Insurer along with any receipts every 120 day period, if the amount claimed justifies it, and within 12 months of the date the expense was incurred. In the event of an Accident for which the Participant must submit a claim, written notice must be sent to the Insurer within the 30 days immediately following the Accident.

Subsequent written proof satisfactory to the Insurer of continuing Total Disability must be submitted to the Insurer in accordance with any request made by the Insurer.

DRUG CLAIMS

When incurring drug expenses, the Insured Person must show his payment card to the pharmacist. With this method of payment, which is referred to as “direct”, the Insured Person only pays the pharmacist for the uninsured portion of the drug expenses incurred and, therefore, the Participant is not required to submit a claim to the Insurer.

DENTAL CARE BENEFIT

DEFINITIONS

As used in this Benefit

Calendar Year means the period from January 1st to December 31st inclusive.

Dental Hygienist means a person licensed by an accredited dental faculty to perform dental prophylaxis.

Dentist means a person who is licensed to practise dentistry by the appropriate authority of the jurisdiction where the services are provided.

Fee Guide means the Dental Association Fee Guide for General Practitioners of the Province in which the Insured Person is resident, for the Calendar Year mentioned in the BENEFIT SCHEDULE.

LATE APPLICATION

With respect to this Benefit, if the Participant applies for coverage for himself or his Dependents more than 31 days after the date of his eligibility, evidence of insurability will not be required by the Insurer. However, in all cases, the Insurer will limit the amount of Eligible Expenses in accordance with the RESTRICTIONS, EXCLUSIONS AND LIMITATIONS provision under this Benefit.

PAYMENT OF BENEFIT

On receipt of Proof of Claim satisfactory to the Insurer that an Insured Person, while covered under this Benefit, incurred Eligible Expenses which were necessary and which were for services recommended by a Dentist, the Insurer will reimburse the expenses in excess of the Deductible, if any, subject to the Percentage of Reimbursement and maximums specified in the Benefit Schedule, and in accordance with other applicable policy provisions.

To be eligible, the expenses must have been performed

1) by a Dentist; or

2) by a Dental Hygienist under the supervision of a Dentist; or

3) by a licensed denturist when such services are within the scope of his licence.

Eligible Expenses will be considered to have been incurred on the date the service or supply was provided. However, with respect to a bridge, crown or denture, the date of insertion of such appliance will be the date such expense was incurred, and with respect to root canal therapy, the date of the final treatment will be the date that expense was incurred.

COMMENCEMENT OF DEPENDENT INSURANCE

If a Dependent is hospitalized on the day his insurance would normally become effective, the effective date of insurance is delayed, and his insurance will commence 24 hours after his discharge from the Hospital. However, the newborn Child of a Participant with Dependents who are already covered becomes insured at birth.

DEDUCTIBLE

The Deductible is the amount of Eligible Expenses that the Participant must pay in any Calendar Year before reimbursement will be made under this Benefit. The Deductible is specified in the Benefit Schedule.

PERCENTAGE OF REIMBURSEMENT

The Percentage of Reimbursement specified in the Benefit Schedule is the percentage of Eligible Expenses in excess of the Deductible that will be reimbursed by the Insurer, in accordance with the provisions of this Benefit.

ELIGIBLE EXPENSES IN CANADA

PREVENTIVE SERVICES

EXAMINATIONS

- Complete oral examination, once every 36 months
- Recall oral examination, according to the frequency specified in the Benefit Schedule
- Specific oral examination, once every 6 months
- Emergency oral examination

RADIOGRAPHS (X-RAYS)

- Complete series of periapical films or panoramic radiographs, limited to one series in any 36 months
- Intra oral films, including bitewing films, and radiographs to diagnose a symptom or examine progress of a particular course of treatment
- Interpretation of radiographs from another source
- Photography
- Radiograph of the hand and wrist as a diagnostic aid for dental treatment

LAB TESTS AND EXAMINATIONS

- Bacteriologic cultures/smears to determine pathological agents

- Biopsies
- Pulp vitality tests
- Unmounted diagnostic casts

CASE PRESENTATION AND EXPLANATION

- Consultation with a patient (a day other than the examination date)

PREVENTIVE SERVICES

- Oral hygiene instruction (once in a lifetime)
- Polishing, according to the frequency specified in the Benefit Schedule
- Light scaling for preventive purposes rather than therapeutic, according to the frequency specified in the Benefit Schedule
- Topical application of fluoride, according to the frequency specified in the Benefit Schedule
- Pit and fissure sealants, for Children under Age 16
- Interproximal discing
- Space maintainers for missing primary teeth, for Children under Age 16
- Prophylactic odontotomy/enameloplasty

BASIC SERVICES, ENDODONTICS AND PERIODONTICS

RESTORATIONS

- Amalgam (silver)
- Composite restorations in accordance with the LIMITATIONS provision of the Dental Care section in the Benefit Schedule
- Retentive pins for amalgam and composite restorations
- Preformed stainless steel and polycarbonate crowns, for Children under Age 16
- Caries / trauma / pain control, separate procedure from restoration

ENDODONTICS

- Treatment of disease of the pulp chamber and pulp canals (root canal therapy)

PERIODONTICS

Treatment of the soft tissue (gums) and bone supporting the teeth. However the following expenses are limited:

a) post-operative visits, 4 visits per Calendar Year

b) curettage performed by a Dentist, once every 60 months

c) scaling for therapeutic purposes limited to a maximum of 12 units per Calendar Year

d) adjustments to periodontal appliance to control bruxism only, limited to one adjustment per Calendar Year

e) occlusal equilibration, limited to 8 units per period of 12 months or one major and 3 minors per period of 12 months

MAINTENANCE OF REMOVABLE DENTURES

- Repair
- Structure addition (to existing removable dentures)
- Relining
- Rebasing
- Adjustments to dentures, 3 months after insertion

ORAL SURGERY

- Extractions - uncomplicated and complex
- Removal of residual roots
- Surgical exposure of teeth
- Alveoplasty, gingivoplasty, stomatoplasty and osteoplasty
- Excisions
- Incisions
- Frenectomy
- Miscellaneous surgical procedures

OTHER SERVICES

Only general anaesthesia and conscious sedation are covered. These expenses are eligible if they are administered in conjunction with extractions.

MAJOR RESTORATIVE SERVICES

PROSTHODONTICS

Expenses incurred for a permanent initial prosthodontic appliance, such as partial or full removable denture or fixed bridge, are covered if such appliance was necessary because of the extraction of at least one natural tooth while the insured is covered under this Benefit or a comparable benefit in force immediately before the effective date of this Benefit.

Replacement of an existing denture or bridge by a permanent denture or bridge:

a) if the replacement was necessary because of the extraction of one or more natural teeth while the insured is covered under this Benefit or a comparable benefit in force immediately before the effective date of this Benefit, or

b) if the existing denture or bridge is at least 5 years old; or

c) if the existing denture or bridge is temporary and is being replaced with a permanent denture or bridge within 12 months of the installation of the temporary appliance. With respect to a permanent appliance that replaces a temporary one, the amount eligible for reimbursement will be reduced by the amount previously reimbursed by the Insurer for the temporary appliance.

A temporary appliance which is at least 12 months old will be considered to be a permanent denture or bridge for the purposes of this provision.

Denture adjustments including minor adjustments are limited to once every 6 months.

REMOVABLE DENTURES

- Complete denture
- Immediate complete denture
- Complete or partial Overdenture
- Transitional denture
- Partial denture including cast in chrome (but not in gold)
- Partial denture remake
- Remount with occlusal equilibration
- Therapeutic tissue conditioning

FIXED PROSTHODONTICS (bridges)

- Abutments and pontics
- Repairs
- Bridge removal
- Recementation

OTHER SINGLE RESTORATIONS

- Onlays, veneers applications, inlays, crowns

a) for a tooth that is fractured due to caries or traumatic injury and cannot be filled by amalgam or composite

b) temporary crowns are considered to be part of the final restoration

c) replacement of an existing onlay, veneer application, inlay or crown is included if such restoration is at least 5 years old.

d) only metal crowns on molars are reimbursed

- Porcelain repair
- Retentive pins, posts, cores
- Recementation
- Removal of an inlay or crown

ELIGIBLE EXPENSES OUTSIDE CANADA

Payment will be made for dental treatment rendered while travelling outside Canada, but only to the extent that payment would have been made under this Benefit if such treatment had been rendered in the normal province of residence of the Insured Person and provided that such treatment was rendered for emergency purposes only.

RESTRICTIONS, EXCLUSIONS AND LIMITATIONS

In the event of late application of the Participant or his Dependents, in accordance with the Late Application provision under this Benefit, reimbursement will be limited to $250 per Insured Person for the first 12 months of coverage.

Reimbursement will not be made for any portion of the charge in excess of the suggested fee in the appropriate Fee Guide, as specified in the Benefit Schedule, for the least expensive treatment that will provide a professionally adequate result.

Reimbursement of lab fees will be limited to the reasonable and customary charge for such services in the area where the services are provided. However, in no event will the total reimbursement of lab fees exceed 50% of the suggested fee in the appropriate Fee Guide, as specified in the Benefit Schedule, for the particular dental treatment requiring the lab services.

Reimbursement of fees for composite restorations performed on posterior teeth may be limited to the fees for amalgam restorations as specified in the LIMITATIONS provision of the Dental Care section in the Benefit Schedule.

No reimbursement will be made under this Benefit for the following:

1) any dental treatment which is for cosmetic purposes when the form and function of the teeth are satisfactory and no pathological condition exists;

2) charges for nutritional counselling;

3) any dental services or supplies, including X-rays, provided for full mouth reconstruction, for vertical dimension correction, for the correction of temporomandibular joint dysfunction or for permanent splinting of teeth;

4) charges levied by a Dentist for broken appointments, completion of claim forms or advice by telephone;

5) expenses incurred for bacteriologic cultures/smears followed by a Chlorzoïn treatment;

6) expenses incurred for implants;

7) expenses incurred for duplicate diagnostic casts (unmounted);

8) expenses incurred for anaesthesia administered by acupuncture;

9) any dental treatment that is not yet approved by the Canadian Dental Association or that is for experimental purposes;

10) dental services, treatment or supplies that the individual received without charge or that a government health plan prohibits from being paid;

11) services, treatment or supplies provided to the Participant by the Employer;

12) any dental treatment rendered outside Canada except as specifically provided under the ELIGIBLE EXPENSES OUTSIDE CANADA provision;

13) dental services and supplies not included in the list of Eligible Expenses;

14) Eligible Expenses that result directly or indirectly from the following:

    a) intentionally self-inflicted injuries while sane or insane;

    b) committing, or attempting to commit a criminal offence;

c) any cause for which payment is provided under any Workers' Compensation Act or similar legislation or under any other government plan;

d) war, whether war be declared or not, or service in the armed forces of any country, or participation in a riot, insurrection or civil commotion.

EXCLUSIONS RELATED TO PROSTHESES AND CROWNS

No reimbursement will be made under this Benefit for the following:

1) expenses incurred for the replacement of dentures and appliances that are lost, mislaid or stolen;

2) prosthetics with precision attachments or stress breakers;

3) precision attachments and telescoping crown units for fixed bridgework;

4) preformed stainless steel or polycarbonate crowns, except in the case of primary teeth;

5) transfer coping for crowns.

CO-ORDINATION OF BENEFITS

This Benefit is subject to the CO-ORDINATION OF BENEFITS provision in the CLAIMS section of the policy.

PRE-DETERMINATION OF BENEFIT

When the total cost of any proposed dental treatment for an Insured Person is expected to exceed $500, the Participant should submit a detailed treatment plan to the Insurer before treatment commences. The Insurer will then advise the Participant of the amount of reimbursement for which the Insured Person is eligible in accordance with the provisions of the policy. The treatment plan should outline the type of treatment to be provided, the anticipated treatment dates, and the cost of such treatment.

The treatment plan submitted must be completed by the Dentist who first proposed the treatment, otherwise the Participant will be required to submit a new treatment plan to the Insurer for re-assessment.

BENEFIT TERMINATION

This Benefit terminates on the date the Participant reaches the Age Limit specified in the Benefit Schedule or on the earliest of the dates indicated in the TERMINATION OF PARTICIPANT INSURANCE provision.

No benefits are payable for expenses incurred after the date the insurance of the Participant terminates, even if a detailed treatment plan under the PRE-DETERMINATION OF BENEFIT provision was filed and benefits were determined by the Insurer prior to such termination date.

DEPENDENT BENEFIT EXTENSION AFTER PARTICIPANT'S DEATH

In the event of the death of the Participant and subject to policy provisions, insurance under this Benefit will continue for Insured Dependents, without premium payment, until the earliest of the following dates:

1) 24 months following the death of the Participant;

2) the date on which the Dependent ceases to be eligible as a Dependent for a reason other than the death of the Participant;

3) the date on which Dependent insurance would have terminated if the Participant had not died;

4) the date on which this Benefit or policy terminates.

PROOF OF CLAIM

The Insured Person domiciled in Quebec must show his government health card and payment card to a Dentist participating in the payment card program to be reimbursed for dental expenses. A simple telephone call allows the Dentist to validate the payment card, confirm that the care provided or prescribed is covered, and obtain confirmation of the amount payable directly to the Dentist by the Insurer and the amount payable by the Insured Person. The Dentist submits the benefit claim to the service provider and gives a copy to the Insured Person who only pays the uninsured portion of the dental expenses incurred. In the case of a Dentist who is not participating in the payment card program, the Insured Person must pay all treatment charges and submit a benefit claim to the Insurer.

For an Insured Person domiciled outside Quebec or if the Dentist uses the Electronic Data Interchange (EDI), the Participant is not required to submit a claim to the Insurer. EDI allows the Dentist to validate the Insured Person's eligibility, confirm that the care provided or prescribed is covered, and obtain confirmation of the amount payable directly to the Participant, or the Dentist, by the Insurer, and the amount payable by the Insured Person. The Dentist submits the benefit claim through EDI and gives a copy of the confirmation to the Insured Person. If the Dentist does not use the Electronic Data Interchange (EDI), the Insured Person must submit a benefit claim to the Insurer.

All claims must be submitted to the Insurer along with any receipts every 120 day period, if the amount claimed justifies it, and within 12 months of the date the expenses were incurred.

The Insurer reserves the right to require radiographs and other types of diagnostics such as specialist reports, periodontal charts and study models.

Our commitment to you

We will always be here to answer your questions. You can rely on our knowledgeable team to deliver outstanding service and process your claims efficiently. We are here to help you stay healthy and to give you advice and financial support when you need them most.

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