GROUP
INSURANCE

YOUR GROUP INSURANCE BOOKLET

iA Financial Group

THE CORPORATION OF THE COUNTY OF NORTHUMBERLAND

Golden Plough Lodge

Class 22 - Golden Plough Lodge Full-time Union Employees - (Canadian Union of Public Employees, Local 1748)

GROUP INSURANCE PLAN

Policyholder:	***THE CORPORATION OF THE COUNTY OF NORTHUMBERLAND***
Policy No.:	***28401***
Policy Effective Date:	***June 1, 2011***

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

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

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

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

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

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

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SUMMARY OF BENEFITS

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

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

SPECIAL PROVISIONS

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

Participants are insured under the following class:

Class

22 – Golden Plough Lodge Full-time Union Employees - (Canadian Union of Public Employees, Local 1748)

GENERAL PROVISIONS

ELIGIBILITY DATE

Subject to all other provisions of the group policy, each employee shall become eligible as stipulated by your employer.

NORMAL RETIREMENT AGE

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

PARTICIPANT'S LIFE INSURANCE

Sum Insured

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

Maximum: $150,000

Reduction:

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

Termination:

This benefit terminates on the participant's 70th birthday or the date of retirement, if earlier.

LONG-TERM DISABILITY INCOME INSURANCE

Monthly Indemnity

75% of the monthly salary, the result being rounded to the next higher dollar, if not already a multiple thereof.

Monthly maximum: $5,000

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

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

Elimination Period: 119 days

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

Benefits are taxable.

Termination:

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

PARTICIPANT'S CRITICAL ILLNESS INSURANCE

Sum Insured

$2,000

Reduction, Exclusions and Limitations:

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

Termination:

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

SUPPLEMENTAL HEALTH INSURANCE

HOSPITALIZATION IN THE PROVINCE OF RESIDENCE

Deductible:	Reimbursement:	Daily maximum:
None	100%	**For hospital coverage other than in a Chronic Care Institution:** Private room rate **For room and board in a Chronic Care Institution:** $3 per day; combined maximum of 120 days per calendar year for all periods of confinement due to the same cause.

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

Deductible:	Reimbursement:	Maximum per insured person:
None	100%	$1,000,000 per trip

DRUGS

Deductible:	$0.35 per prescription item or refill of a prescription item
Reimbursement:	100%
Maximum:	Unlimited

ALL OTHER MEDICAL EXPENSES INCURRED IN CANADA

Deductible:	None
Reimbursement:	100%
Maximum:	Unlimited

Termination:

This benefit terminates on the earliest of the first day of the month coincident with or next following the participant's 70th birthday or the date of retirement, if earlier.

SUPPLEMENTAL HEALTH INSURANCE

Medical Expenses

Covered Expenses	Maximums Per Insured Person
All covered expenses included under the Medical Expenses Incurred in Canada section of the Supplemental Health Insurance benefit, other than those listed below	Unlimited.
Fees for nursing care	90 eight hour shifts per calendar year.
Private hospital	$10 per day, maximum of 120 days per lifetime.
Licensed ambulance services	Unlimited.
Diagnostic laboratory tests	Unlimited.
X-rays	Unlimited.
Medical appliances and supplies	Unlimited.
Myoelectric and electric artificial prostheses	An amount equal to the cost of a regular (non-myoelectric) artificial prosthesis.
Artificial Prostheses	Unlimited.
Breast Prostheses	Unlimited.
Surgical brassieres	6 per calendar year.
Medical elastic stockings	6 pairs per calendar year.

SUPPLEMENTAL HEALTH INSURANCE

Medical Expenses

Covered Expenses	Maximums Per Insured Person
Orthopedic shoes (modified off the shelf, custom made or custom molded)	Unlimited.
Foot orthoses	2 pairs per calendar year.
Eyeglasses, contact lenses or intraocular lenses following cataract surgery	One pair per lifetime.
Wigs (required as a result of Chemotherapy)	Once per lifetime.
Dental care as a result of accidental injury	Unlimited.
Hearing aids or any related devices	$500 per period of 60 consecutive months.
Eye examinations	$100 per period of 24 consecutive months. One examination per period of 24 consecutive months.
Eyeglasses (including sunglasses and safety glasses) and contact lenses or corrective laser surgery	$375 per period of 24 consecutive months.

SUPPLEMENTAL HEALTH INSURANCE

Medical Expenses

Covered Expenses	Maximums Per Insured Person
Fees for the following paramedical practitioners: physical rehabilitation therapists and physiotherapists	**Effective January 1, 2020**: Combined maximum of $600* per calendar year.*Expenses are reimbursed according to the current Reasonable and Customary Fees for initial and subsequent treatment, subject to annual maximums.
Fees for the following paramedical practitioners: speech therapists	Maximum of $60 for the initial visit and $40 for subsequent visits, subject to a maximum of $260 per calendar year and one treatment per day.
Fees for the following paramedical practitioners: massage therapists	Maximum of $400* per calendar year.*Expenses are reimbursed according to the current Reasonable and Customary Fees for initial and subsequent treatment, subject to annual maximums.

SUPPLEMENTAL HEALTH INSURANCE

Medical Expenses

Covered Expenses	Maximums Per Insured Person
Fees for the following paramedical practitioners: chiropodists[1] and podiatrists [1] in Ontario and Saskatchewan only)	Combined maximum of $400* per calendar year. *Expenses are reimbursed according to the current Reasonable and Customary Fees for initial and subsequent treatment, subject to annual maximums.
Fees for the following paramedical practitioners: chiropractors	Maximum of $400* per calendar year. *Expenses are reimbursed according to the current Reasonable and Customary Fees for initial and subsequent treatment, subject to annual maximums.
X-rays by a chiropractor	$25 per calendar year.
Fees for the following paramedical practitioners: naturopaths and osteopaths	Maximum of $400* per calendar year for each practitioner. *Expenses are reimbursed according to the current Reasonable and Customary Fees for initial and subsequent treatment, subject to annual maximums.

SUPPLEMENTAL HEALTH INSURANCE

Medical Expenses

Covered Expenses	Maximums Per Insured Person
Fees for the following paramedical practitioners: psychologists, including marriage and family therapists	Maximum of $60 for the initial visit and $40 for subsequent visits, subject to a maximum of $420 per Calendar Year. Limited to one treatment per Day.

DENTAL CARE INSURANCE

Deductible	none
Reimbursement	
– Preventive treatments:	100%
– Basic treatments:	100%
– Major treatments:	75%
– Orthodontic treatments:	75%
Maximum per insured person	
– Preventive treatments:	Unlimited
– Basic treatments:	Unlimited
– Major treatments:	$2,500 per calendar year
– Orthodontic treatments:	$1,500 per lifetime

ORTHODONTIC TREATMENTS are limited to dependent children under 21 years of age.

Expenses are reimbursed according to the Dental Surgeons Association's Fee Guide for the current year or, if applicable, the Dental Hygienists Association's Fee Guide for the current year, subject to any limits which are stated under the Dental Care Insurance benefit. If there is no fee guide for the reference year, the insurer will determine the level of dental expenses to be reimbursed according to the latest fee guide plus an inflationary adjustment.

Termination:

This benefit terminates on the first day of the month coincident with or next following the participant's 70th birthday or the date of retirement, if earlier.

DEFINITIONS

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

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

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

Annual salary: The participant's annual gross base remuneration received from the employer and which the employer or policyholder has reported to the insurer including any additional income earned on a regular basis (overtime, bonuses, commissions, shift differentials, gratuities) which is included in accordance with the standards of the Employment Insurance Act.

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

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

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

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

a) Spouse

The person who is married to or is in a civil union with the participant, or the person designated by the participant, whom he declares publicly to be his spouse and with whom he has been living on a permanent basis for at least one year.

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

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

b) Child

An unmarried child of the participant or of his spouse who wholly depends on the participant for support and maintenance and who meets at least one of the following conditions:

i) He is under 21 year*s* of age; or

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

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

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

Employee: A person who is employed by his employer on a permanent, full-time basis and who is working a minimum number of hours as defined by the employer.

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

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

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

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

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

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

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

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

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

CHANGES IN GOVERNMENT PLANS

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

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

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

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

INCONTESTABILITY

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

a) insurance or a benefit for a participant or a dependent; or

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

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

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

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

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

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

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

LAWFUL CURRENCY

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

COVERAGE ELSEWHERE

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

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

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

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

ELIGIBILITY

Employee

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

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

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

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

d) He has satisfied the eligibility period specified in the Summary of Benefits.

However, an employee will not be eligible to become insured under the Long-Term Disability Income Insurance benefit if he will attain age 65 before the end of the elimination period specified for the benefit under the Summary of Benefits.

Dependents

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

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

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

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

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

APPLICATION FOR GROUP INSURANCE

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

EFFECTIVE DATE OF INSURANCE

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

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

However, if

a) the employee was not actively at work on the date his insurance would otherwise become effective, the insurance will not take effect until the earliest date thereafter on which he is again actively at work; or

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

Any amount of insurance which is in excess of the non-evidence maximum(s) specified in the Summary of Benefits will not take effect until the date the insurer receives and approves the employee's evidence of insurability. If the participant's evidence of insurability should not be approved by the insurer, any future increases in the non-evidence maximum(s) will not automatically result in an increase in the participant's insurance. The increase in the non-evidence maximum(s) will only result in an increase in the participant's insurance if he submits evidence of his insurability and it is approved by the insurer.

TERMINATION OF INSURANCE

Participant

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

a) The date the group policy is terminated;

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

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

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

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

f) The date of the participant's death;

g) The later of the following dates:

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

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

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

i) The date the participant ceases to qualify as an employee as defined in the group policy.

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

Dependents

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

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

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

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

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

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

f) The later of the following dates:

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

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

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

CLAIMS

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

  The insurer must receive notice of any claim for a Supplemental Health Insurance benefit or Dental Care Insurance benefit within 12 months of the date of the event which gives entitlement to the benefit.

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

- **Life Insurance:**

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

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

  The insurer must receive notice of any claim for a Long-Term Disability Income Insurance benefit within 90 days of the end of the participant's elimination period.

  If notice of a claim for a Long-Term Disability Income Insurance benefit is received more than 90 days after the end of the participant's elimination period, the insurer reserves the right to limit the participant's monthly indemnity benefit to the 90 days preceding the date the claim was received from the participant.

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

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

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

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

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

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

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

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

The insurer retains the right to audit all claims at any stage, including after payment has been made, for fraud or misrepresentation. If the insurer determines that a participant has intentionally submitted a claim that contains false or misleading information, the insurer shall have the right, at its sole discretion, to notify the policyholder, decline the claim or require reimbursement if the claim has been paid. In addition, the insurer will have the right to terminate the participant's entire coverage under this policy including any coverage for the participant's dependents, and will have the right to undertake the prosecution of the participant in accordance with provincial and/or federal law.

BENEFICIARY

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

All benefits, other than the Participant's Life Insurance benefit, Participant's Accidental Death and Dismemberment Insurance benefit, Participant's

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

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

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

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

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

INSURER'S RIGHT TO EXAMINATION, RECORDS AND INVESTIGATION

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

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

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

The insurer reserves the right to obtain the clinical notes and records or any other reports of a Participant who has submitted a claim or of any other

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

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

SUBROGATION

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

Without limiting the generality of this provision, the term “damages” will include any lump sum or periodic payments received on account of (i) past, present or future loss of income, loss of wages, or loss of earnings, and (ii) any other benefits paid or payable under the group policy. The participant or dependent shall reimburse the insurer up to the amount of any benefits paid in the past or that are payable in the future under the group policy out of the gross damages recovered whether recovered at trial, or prior to trial by way of any form of settlement, and without regard to whether the participant or dependent has obtained full recovery of his losses.

Where the participant or dependent recovers damages in a lump sum, either by way of settlement or court order, and no allocation has been made in that settlement for the benefits paid or payable by the insurer, the insurer shall be reimbursed, out of the gross damages recovered, the full amount of benefits that have been paid to the participant or dependent. The insurer shall also be entitled to be reimbursed an amount, as determined by the insurer, which reasonably reflects the value of the future benefits payable to the participant or dependent under the group policy. The insurer’s recovery in this regard shall not exceed the participant or

dependent's gross damages or settlement recovered. These rights of reimbursement shall be without regard to the terms of settlement or allocation that may have been agreed to by the participant or dependent and the third party or otherwise allocated.

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

(a) the total amount of benefits paid to the participant or dependent; and

(b) an amount that reasonably reflects, as determined by the insurer, the total amount or value of any future benefits payable to the participant or the dependent.

The insurer's recovery in this regard shall not exceed the participant or dependent's gross damages or settlement recovered. The insurer shall also have the right to seek recovery directly from the participant or dependent in the event that any overpayment has resulted from the lack of reimbursement.

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

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

LIMITATION ON LEGAL ACTIONS

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

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

PARTICIPANT'S LIFE INSURANCE

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

DEFINITION

As used in this benefit:

Disability and Disabled: A state of total and continuous incapacity, resulting from illness or injury, which prevents the participant from performing any work for which he is reasonably qualified by education, training or experience.

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

CONVERSION PRIVILEGE

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

a) his employment;

b) his group membership; or

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

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

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

a) permanent;

b) term to age 65; or

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

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

a) The amount selected by the participant;

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

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

d) $200,000 ($400,000 for participants living in the province of Quebec).

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

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

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

WAIVER OF PREMIUM

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

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

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

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

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

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

b) The amount of insurance for which the waiver of premiums applies will be that which was in force on the participant's life at the onset of the disability, and will be subject to any reductions and termination indicated in the Summary of Benefits which would have been applicable to the participant if he had been actively at work.

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

i) the day following completion of the elimination period under the Long-Term Disability Income Insurance benefit, if applicable;

ii) the day following a continuous period of disability of 6 months.

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

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

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

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

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

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

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

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

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

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

DEFINITIONS

As used in this benefit:

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

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

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

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

Pre-disability gross monthly salary: The monthly salary applicable to the participant immediately prior to the date his disability commenced.

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

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

PARTICULARS

Beginning of Benefit Payments

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

Amount of Benefit Payments

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

Reduction of Benefit Payments

The monthly indemnity benefit will be reduced, after the application of the monthly maximum amount, by any disability benefits which are payable or which would have been payable to the participant had a satisfactory application been made under:

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

b) a workers' compensation act;

c) a provincial automobile insurance law;

d) a provincial crime victims compensation act.

Moreover, the amount of the monthly indemnity income benefit payable by the insurer will be adjusted so that the sum of all income, compensation, indemnity and benefits which the participant would or could receive, due to his disability, from: (a) the policyholder, (b) his employer, excluding 50% of net salary received under an approved rehabilitation program, (c) any government body, (d) a franchise or association insurance plan, (e) any group insurance or pension plan to which the policyholder or employer contributes, and (f) a third party in the form of damages for loss of income,

will not exceed the overall maximum, as specified in the Summary of Benefits.

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

Termination of Benefit Payments

The monthly indemnity benefit payments cease on the earliest of the following dates:

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

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

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

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

e) The date of the participant's death;

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

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

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

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

SUCCESSIVE PERIODS OF DISABILITY

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

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

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

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

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

EXCLUSIONS AND LIMITATIONS

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

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

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

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

   iv) Committing, attempting to commit a criminal offence, or provoking an assault or criminal offence.

b) The monthly indemnity benefit will not be payable:

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

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

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

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

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

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

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

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

PRE-EXISTING CONDITION EXCLUSION

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

a) which was sustained or contracted, or

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

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

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

during the 3 months prior to the date on which the participant became covered under this benefit.

No monthly indemnity benefit will be payable for a disability

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

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

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

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

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

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

d) satisfies the pre-existing condition exclusion period under the group policy, giving consideration towards continuous time covered under both policies, or the prior policy giving consideration towards continuous time covered under both policies.

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

WAIVER OF PREMIUMS

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

WORK RE-ENTRY

If a disabled participant participates in

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

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

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

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

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

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

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

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

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

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

SURVIVOR BENEFIT

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

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

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

As used above:

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

If the participant suffers any of the conditions or undergoes any of the surgeries which are described in the Covered Conditions and Surgeries provision of this benefit, the insurer undertakes to pay to the participant the sum insured, as indicated in the Summary of Benefits, subject to the terms and conditions of this benefit and policy.

If at the time the payment is to be made, the participant is no longer living, the payment will be made to the participant's estate.

CONDITIONS

Payment will made for the covered condition or surgery provided:

a) the condition was diagnosed or the surgery took place while the participant was covered under this benefit; and

b) the participant survived for at least 30 days after the date the condition was diagnosed or the surgery took place, unless otherwise indicated under this benefit.

Once a participant has received payment due to a covered condition or surgery, his coverage under this benefit will terminate.

COVERED CONDITIONS AND SURGERIES

Heart Attack (Myocardial Infarction)

"Heart attack" means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. For payment to be made under this benefit, diagnosis of the heart attack must be based on a specific event consisting of both of the following:

a) new electrocardiographic (ECG) changes which support the diagnosis of a heart attack; and

b) elevation of cardiac (heart) enzymes to levels which support the diagnosis of a heart attack.

ECG changes which are associated with a previous heart attack will not result in a payment being made under this benefit.

Stroke

"Stroke" means a cerebrovascular accident producing neurological sequelae lasting more than 30 days and which was caused by an

a) intra-cranial thrombosis or hemorrhage; or

b) embolism from an extra-cranial source.

For payment to be made under this benefit, there must be evidence of a measurable objective neurological deficit with respect to the participant.

No payment will be made under this benefit for Transient Ischemic Attacks.

Life Threatening Cancer

"Life threatening cancer" means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. For payment to be made under this benefit, the cancer must be diagnosed by an appropriate specialist licensed and practicing in Canada or the United States. In addition, the cancer must be diagnosed as being life threatening to the participant.

No payment will be made under this benefit, if

a) the date of the diagnosis of the cancer; or

b) the date the signs and/or symptoms and/or medical consultations or tests that led to the diagnosis of the cancer,

is within the moratorium period. For the purpose of this covered condition, the moratorium period shall mean the first 90 days following the date the participant becomes covered under this benefit.

No payment will be made under this benefit for any of the following forms of cancer:

a) carcinoma in situ;

b) Stage 1A malignant melanoma;

c) any non-melanoma skin cancer that has not become metastatic;

d) Stage A prostate cancer (t1a or t1b); and

e) any tumor in the presence of the Human Immunodeficiency Virus.

In addition, no payment will be made under this benefit for any diagnosis of cancer after the end of the moratorium period, if during the moratorium period the participant had

a) been diagnosed with any form of cancer, or

b) shown signs and/or symptoms and/or undertaken medical consultations or tests that led to the diagnosis of cancer.

LIMITATION

No payment will be made under this benefit with respect to a covered surgery, if the surgery is performed outside Canada.

PRE-EXISTING CONDITION EXCLUSION

As used in this provision, “pre-existing condition” means a condition:

a) which was sustained or contracted; or

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

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

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

during the 24 months prior to the date on which the participant became covered under this benefit.

No payment will be made under this benefit for a covered condition or surgery

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

b) which occurred during the first 24 months after the participant became covered under this benefit.

EXCLUSIONS

No payment will be made under this benefit if the covered condition or surgery resulted directly or indirectly from

a) suicide, attempted suicide or voluntarily self-inflicted injury, regardless of any impairment, Illness, or state of mind;

b) committing or attempting to commit a criminal offense or provoking an assault;

c) civil unrest, insurrection or war, whether war be declared or not, or participation in a riot;

d) use of drugs, poisonous substances, intoxicants or narcotics, other than as prescribed and administered by or in accordance with the instructions of a legally licensed physician;

e) abuse of alcohol;

f) the operation of a motor vehicle, if the participant at the time of the accident had a blood alcohol concentration rate in excess of the limit permitted by law;

g) flight in an aircraft, except as riding as a passenger and not as a pilot, operator or member of the crew, in or on any aircraft provided (i) the flight was a regularly scheduled flight, (ii) the aircraft has a current and valid certificate of air worthiness and is piloted by a person who holds a current and valid pilot's license of a rate authorizing him to pilot the aircraft and (iii) the aircraft is not owned, operated, chartered or licensed by the policyholder or the participant's employer; or

h) participation in any of the following activities:

    i) underwater activities, including but not limited to, scuba diving and snuba diving;

    ii) hang-gliding;

    iii) parachuting; and

    iv) motor vehicle race or speed competition on land and/or water.

In addition, no payment will be made under this benefit if the covered condition or surgery resulted directly from any form of cancer or benign

brain tumor, if during the moratorium period, as specified under Life Threatening Cancer and Benign Brain Tumor, the participant had

a) been diagnosed with any form of cancer or brain tumor, or

b) shown signs and/or symptoms and/or undertaken medical consultations or tests that led to the diagnosis of cancer or a brain tumor.

SUPPLEMENTAL HEALTH INSURANCE

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

DEFINITIONS

As used in this benefit:

Hospital: An institution which

a) is legally licensed by the appropriate government body;

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

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

This definition will also include a chronic care institution and convalescent home. Nursing homes, homes for the aged, rest homes, residential and long-term care centres and drug and alcohol treatment centres are excluded.

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

Original or generic drug: If mention is made of these two types of drugs, the *original* drug refers to the drug that was first developed and launched in the marketplace. The *generic* drug refers to any reproduction of the original drug.

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

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

HOSPITALIZATION IN THE PROVINCE OF RESIDENCE

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

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

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

c) the insured person was hospitalized for acute care and not chronic or convalescent care (other than care in a chronic care institution or in a convalescent home).

EMERGENCY MEDICAL EXPENSES INCURRED OUTSIDE THE PROVINCE OF RESIDENCE

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

a) the medical emergency occurs during the first 60 days of the insured person's absence from his province of residence, or if the absence is due to his attendance at an accredited education institution on a full-time basis, the medical emergency occurs during the school year for which he is enrolled at the institution;

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

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

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

a) Services of a physician;

b) Accommodation in a hospital up to the level specified for the Hospitalization in the Province of Residence benefit;

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

d) Diagnostic, medical imaging and laboratory services;

e) Paramedical services provided during a hospital confinement;

f) Hospital out-patient services and supplies;

g) Drugs;

h) Medical appliances and supplies provided out of hospital;

i) Professional ambulance service to transport the insured person to the nearest hospital equipped to provide the required medical treatment.

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

Limitations For Emergency Medical Expenses Incurred Outside The Province Of Residence

If the insured person should become hospitalized outside of his province of residence due to a medical emergency, the insured person will be required to contact the insurer's Medical Assistance Service provider as soon as the person is reasonably able to do so after the commencement of his hospitalization. Failure to do so may result in the insurer limiting or denying the insured person's claim resulting from the medical emergency.

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

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

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

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

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

a) Medical status;

b) Medical treatment, examination, consultation or hospitalization;

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

d) Change in medical treatment or in medication;

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

within a period of 90 days prior to that absence.

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

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

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

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

   ii) the services are medically necessary;

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

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

b) Licensed ambulance service in a medical emergency for transportation to the nearest hospital equipped to provide the

required treatment, or for transportation therefrom, when the physical condition of the insured person precludes the use of any other means of transportation.

c) Drugs which by law can only be obtained with the written prescription of a physician or dentist and dispensed by a licensed pharmacist, physician, dentist or hospital, other than those drugs that are excluded under the Exclusions and Reductions provision of this benefit.

Charges for injected allergy sera.

Extemporaneous preparations or compounds provided one of the ingredients is an eligible drug as defined herein.

Drugs that do not require a written prescription of a physician or dentist which (i) have been obtained on a written prescription of a physician or dentist, (ii) have been dispensed by a licensed pharmacist, physician, dentist or hospital, (iii) are considered “Life Sustaining” drugs, and (iv) are included under one of the following categories of drugs:

Anti-Anginal Agents	Hypercholesterolemia Therapy
Anti-Cholinergic	Hyperthyroidism
Anti-Partkinsonian Agents	Oral Fibrinolytic
Anti-Arrhythmic Therapy	Parasympathomimetic
Bronchodilator	Enzymatic Zonulolytic
T.B. Therapy	Floride

Potassium Replacement Therapy

Topical Enzymatic Debriding Agents

Drugs that do not require a written prescription of a physician or dentist which (i) have been obtained on a written prescription of a physician or dentist, (ii) have been dispensed by a licensed pharmacist, physician, dentist or hospital, and (iii) are included under one of the following categories of drugs:

Analgesic	Antipyretic
Anemia Therapy	Antiseborrheic

Anaesthetic	Antispasmodic
Anorectal	Antitussive
Antacid	Calcium Preparations
Anthelmintic	Dandruff Therapy
Antibacterial	Decongestants
Antibiotic	Hematinic
Antidiarrheal	Hemorrhoidal Therapy
Antiemetic	Keratolytic/Keratoplastics
Antiflatulent	Laxatives
Antifungal	Muscle Relaxants
Antihistaminic	Oral Sclerosing Agents
Antimalarial	Oxyusiasis Therapy
Antiparasitic	Pediculicide
Antiphlogistic	Rubefacient
Antipruritics	Scabicides
Antipsoriatic	Wart Therapy

Insulin when dispensed by a licensed pharmacy, physician or hospital.

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

Mirena

Dispensing Limitations

The quantity of drugs which may be dispensed for any one prescription will be limited to that amount sufficient for up to a 34 Day period, except in the case of drugs for long-term therapy (maintenance drugs) for which up to a 100 Day supply is allowable.

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

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

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

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

d) Room and board in a private hospital when certified as necessary by the attending physician.

e) Diagnostic laboratory tests and x-ray charges from a commercial establishment, other than x-rays by a chiropractor, provided the x-rays were required for the diagnosis of an illness or injury or to determine the effectiveness of the treatment being prescribed or received.

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

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

g) Charges for x-rays by a chiropractor.

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

i) oxygen tent and oxygen supplies;

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

iii) artificial eyes, including repairs and replacements;

iv) artificial prostheses, including repairs and replacements;

v) manual wheelchairs or electric wheelchairs when the insured person is incapable of operating a manual wheelchair due to a medical condition;

vi) manually operated hospital beds or electrically operated hospital beds when the insured person is incapable of operating a manually operated hospital bed due to a medical condition, including bed rails and trapeze bars;

vii) apnea monitors for respiratory dysrhythmias;

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

ix) transcutaneous nerve stimulator;

x) intermittent positive pressure breathing machine;

xi) breast prostheses;

xii) surgical brassieres;

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

xiv) orthopedic shoes which have been custom made, customized or custom molded for the insured person (includes modifications to stock items);

xv) foot orthoses which have been specifically designed and constructed for the insured person;

xvi) glasses, contact lenses or intraocular lenses following cataract surgery;

xvii) races with rigid support; back supports; shoulder harnesses; head halters and cervical collars;

xviii) splints, other than dental splints, and casts;

xix) canes, crutches and walkers;

xx) hernia belts;

xxi) wigs required as a result of chemotherapy;

xxii) colostomy and ileostomy apparatus and supplies;

xxiii) catheters.

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

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

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

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

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

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

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

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

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

EXCLUSIONS AND REDUCTIONS

This benefit does not cover any expense

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

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

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

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

e) For an illness or injury resulting from the commission of or attempted commission of a criminal offence or provoking of an assault;

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

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

h) For any care or treatment included in the protocol of a research and development program for a product whose use has not been recommended by the manufacturer or which does not comply with government standards;

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

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

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

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

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

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

o) For care or treatment related to fertility or infertility, but not including drugs for the treatment of infertility;

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

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

r) For care or treatment of (including breaking the addiction to) such conditions as, but not limited to, smoking, drug addiction and alcoholism, other than drugs for the treatment of obesity;

s) For the administration of serums, vaccines and injectable medications;

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

- products for the care of contact lenses;
- proteins or dietary supplements, amino acids;
- baby food;
- mouthwash, bandages and throat lozenges;
- shampoos, oils, creams;
- toilet products including soaps and emollients;

- skin softeners and protectors;
- vitamins, vitamin supplements or multivitamins;
- minerals;
- homeopathic products;
- anabolic steroids;

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

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

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

x) For any care or treatment received outside of the province of residence due to a Medical Emergency which is related to (i) a pregnancy, false labour, delivery or resulting complications, if the Medical Emergency occurs after the 32nd week of gestation; or (ii) the deliberate inducement of a miscarriage.

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

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

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

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

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

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

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

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

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

CALCULATION OF REIMBURSEMENT

Deductible

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

Carry-over Provision

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

Reimbursement

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

Maximum Benefit Per Insured Person

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

Co-ordination of Benefits

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

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

ii) any government sponsored plan, and

iii) any non-insured employee benefit plan.

SURVIVOR BENEFIT

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

a) 24 months after the participant's death;

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

c) The termination date of this benefit.

EXTENSION OF BENEFITS

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

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

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

As used in this provision, “disabled” and “disability” mean

a) with respect to a participant, his complete incapacity due to an illness or injury to perform any work for which he is reasonably qualified by education, training or experience; and

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

CONVERSION PRIVILEGE

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

a) his employment; or

b) his group membership,

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

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

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

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

SUPPLEMENTAL HEALTH INSURANCE – EMERGENCY OUT OF PROVINCE ASSISTANCE

The services listed herein will be provided in connection with a medical emergency or personal emergency which occurs while the insured person is absent from his province of residence provided:

a) the insured person is covered by the Supplemental Health Insurance benefit at the time of the emergency;

b) the emergency occurs during the first 60 days of the insured person's absence from his province of residence, or if the absence is due to his attendance at an accredited educational institution on a full-time basis, the emergency occurs during the school year for which he is enrolled at the institution;

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

d) in case of a medical emergency, the emergency is covered under the Emergency Medical Expenses Incurred Outside the Province of Residence section of the Supplemental Health Insurance benefit.

The services will be provided by the insurer's Medical Assistance Service provider. The insured person will be required to contact the Medical Assistance Service provider to request the services in an emergency.

DEFINITION

As used in this benefit:

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

MEDICAL EMERGENCY ASSISTANCE SERVICES

The following services will be provided during a medical emergency:

a) 24 Hour Telephone Access

- The Medical Assistance Service provider will provide a 24 hour hotline, 365 days a year, staffed by multilingual co-ordinators to connect the insured person to a network of specialists who will handle the emergency.

b) Medical Care

The Medical Assistance Service provider will:

- If the insured person is unable to locate a physician or hospital, provide a referral to a physician or an appropriate hospital;
- Upon request of the insured person, organize consultations with general practitioners or specialists in order to obtain the best medical care available in the area;
- Provide assistance with admittance to a hospital;
- Confirm to doctors and hospitals that the insured person's group policy will cover the insured person's medical expenses.

c) Medical Transportation

The Medical Assistance Service provider will:

- Arrange and pay for the transportation or transfer of the insured person by appropriate means to a hospital as recommended by the attending physician, and which the Medical Assistance Service provider agrees to;
- Arrange and pay for the return of the insured person to his residence or to a hospital near his residence after initial medical care has been provided, by an appropriate means of transportation, provided the return is medically necessary and permissible based on his medical condition. The Medical Assistance Service provider will arrange for the insured person's

return using the most appropriate means of transportation: air ambulance, helicopter, commercial airline, train or ambulance.

d) Payment of Medical Expenses and Cash Advance

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

e) Return of Deceased

- Should the insured person die, the Medical Assistance Service provider will make all arrangements and pay all expenses associated with returning the body of the deceased person to the place of burial in his province of residence, up to a maximum of $3,000. Funeral expenses will not be covered.

f) Return of Dependent Children

- The Medical Assistance Service provider will organize the return of the insured person's dependent children under age 16 who are left unattended due to the hospitalization of the insured person. In addition, the Medical Assistance Service provider will arrange and pay for economy transportation for the children, with an escort if necessary, to their usual place of residence. If the return tickets are still valid, only the additional cost incurred for the return transportation, after deducting the value of the tickets, will be paid.

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

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

immediate family who has lost the use of his return ticket due to the insured person's hospitalization or death. The Medical Assistance Service provider will arrange and pay for economy transportation to return the insured person and/or member of the immediate family to his usual place of residence. If the return tickets are still valid, only the additional cost incurred for the return transportation, after deducting the value of the tickets, will be paid.

h) Visit from a Member of the Immediate Family

- The Medical Assistance Service provider will arrange and pay for round-trip economy class transportation for a member of the immediate family to visit the insured person if the person is hospitalized for at least 7 consecutive days and the attending physician feels that the visit would be beneficial to him.

i) Expenses for Commercial Accommodation and Meals

- When a return is delayed due to the hospitalization of an insured person for a period of more than 24 hours or because of an insured person’s death, the expenses for commercial accommodation and meals incurred due to the delay by the insured person, by a member of the immediate family accompanying the insured person or visiting the insured person in accordance with h) will be reimbursed, subject to a daily maximum of $150 per person, and an overall maximum of $1,500.

  Receipts must be provided before reimbursement will be made by the Medical Assistance Service provider.

j) Vehicle Return

- The Medical Assistance Service provider will pay up to $1,000 to return the insured person's vehicle, either private or rental, to the insured person's residence or the nearest appropriate vehicle rental location.

k) Emergency Drugs

- Should an insured person require drugs for the treatment of a medical condition and such drugs are not available locally, the Medical Assistance Service provider will co-ordinate a search for the drugs and once located arrange for the delivery of the drugs. The insured person will be responsible for the cost of the drugs unless they are covered under the Supplemental Health Insurance benefit.

PERSONAL EMERGENCY TRAVEL ASSISTANCE SERVICES

The following services will be provided during a personal emergency:

a) Telephone Interpretation Service

- The Medical Assistance Service provider will provide the insured person with telephone interpretation services in most foreign languages.

b) Messages

- The Medical Assistance Service provider will relay a message, upon request, from the insured person to his home, office or elsewhere, or hold messages for the insured person or the members of his immediate family for up to 15 days.

c) Legal Assistance

- The Medical Assistance Service provider will assist the insured person in finding local legal aid when required, and will also help the insured person obtain a cash advance from his credit cards, family and friends, in order to pay for any bail or legal fees.

d) Travel Information

- The Medical Assistance Service provider will provide the insured person with travel information related to transportation, vaccinations and precautionary measures before, during and after the insured person's trip.

e) Lost Baggage or Travel Documents

- If the insured person loses or has his travel documents and/or baggage stolen, the Medical Assistance Service provider will help him contact the appropriate authorities.

EXCLUSIONS

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

LIABILITY

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

The doctors, hospitals, clinics, lawyers and other authorized practitioners or institutions to which the Medical Assistance Service provider directs insured persons are independent contractors and act on their own behalf and are not employees, agents or subordinates of the Medical Assistance Service provider or the insurer.

The Medical Assistance Service provider and the insurer are not responsible and assume no liability for the negligence or other acts or omissions by the doctors, hospitals, clinics, lawyers or other authorized practitioners or institutions to which the insured person is directed by the Medical Assistance Service provider.

REIMBURSEMENT

If a cash advance was made to cover a charge that had been made or a charge was paid, and the participant submits to the insurer such charge as a covered expense under the Supplemental Health Insurance benefit at a

later date, the insurer will only reimburse the participant an amount, less that which was previously advanced or paid for such expense, subject to the deductible and reimbursement level that is applicable to the expense.

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

DENTAL CARE INSURANCE

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

DEFINITIONS

As used in this benefit:

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

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

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

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

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

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

DENTAL EXPENSES

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

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

a) Examinations and Diagnoses
   - i) complete oral examination: once every 2 years
   - ii) recall examination: once every 6 months
   - iii) emergency oral examination
   - iv) specific oral examination

b) X-rays
   - i) intra-oral - periapical: one complete series every 2 years
   - ii) intra-oral - occlusal
   - iii) intra-oral - interproximal (bitewing)
   - iv) extra-oral
   - v) sialography
   - vi) panoramic: once every 2 years
   - vii) radiopaque dyes

c) Tests and Laboratory Examinations
   - i) microbiologic culture
   - ii) biopsy of oral tissue - soft
   - iii) biopsy of oral tissue - hard
   - iv) cytologic smear

v) pulp vitality tests

vi) caries susceptibility tests

d) Preventive Services

i) polishing of coronal portion of teeth (prophylaxis): 1 unit every 6 months

ii) scaling of coronal portion of teeth: 1 unit every 6 months.

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

iii) topical application of fluoride: once every 6 months

iv) initial oral hygiene instruction

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

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

a) Basic Services

i) finishing restorations

ii) pit and fissure sealant

iii) caries control

iv) interproximal discing

v) prophylactic odontotomy

b) Restorative

i) amalgam restorations

ii) composite restorations

c) Endodontics

i) pulp capping

ii) pulpotomy (excluding final restoration)

iii) emergency pulpotomy

iv) endodontic trauma

v) root canal therapy

vi) endodontic surgery

vii) apexification

d) Periodontics

i) surgical services

ii) provisional matching

iii) adjunctive periodontal procedures

Root planing is covered. Coverage will be combined with any units of scaling which are in excess of the limit stated under the Preventive Services section.

e) Dentures - removable

i) adjustments

ii) repairs

iii) rebasing and relining

iv) prophylaxis and polishing

f) Oral Surgery

i) removal of erupted tooth (uncomplicated)

ii) surgical removals (complicated)

iii) surgical exposure and movement of tooth

- transplantation: maximum of $150
- surgical repositioning: maximum of $150

iv) enucleation of tooth

v) remodelling and recontouring of oral tissues

- alveoloplasty
- gingivoplasty and/or stomatoplasty

- vestibuloplasty
- remodelling of floor mouth
- extension of mucous folds

vi) surgical excision and incision

- excision of tumors and cysts
- enucleation of cysts/granulomas
- cheiloplasty (lip shave)
- graft of bone to jaw
- marsupialization
- incision and drainage and/or exploration
- incision for removal of foreign bodies: maximum of $150

vii) treatment of fractures

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

viii) frenectomy/frenoplasty

ix) antral surgery

g) Adjunctive General Services

i) anaesthesia

Major Treatments

a) Dentures - removable

i) complete dentures

ii) partial dentures

b) Dentures - fixed

i) cast post

ii) pontic

iii) butterfly bridge

iv) abutments

v) retainers (excluding transitional retainers) and retentive pins for retainers

- stress breakers and or precision attachments: maximum of $150 plus lab
- telescoping of crown unit: maximum of $450 plus lab

Initial installation of fixed or removable dentures will be covered only in the case of teeth extracted while the person is insured under this benefit or a similar benefit.

Replacement of fixed or removable dentures will be covered only if it is necessary for one of the following reasons:

i) extraction of one or more additional natural teeth, while the person is insured under this benefit or a similar benefit; or

ii) the dentures are at least 5 years old and can no longer be used; or

iii) replacement of temporary dentures fitted less than 12 months before.

However, in no event will replacement dentures be covered if due to lost or stolen dentures.

c) Restorative

i) crowns

ii) gold foil restorations (if other substances are inappropriate)

iii) metal inlay and onlay restorations

iv) porcelain inlay and onlay restorations (if other substances are inappropriate)

v) prefabricated post (pivot)

vi) recementing of inlays, onlays and crowns

vii) removal of inlays, onlays and crowns

Initial provision of crowns, inlays or onlays will be covered only if the tooth of the insured person is broken down by decay or injury and cannot be restored with an amalgam or composite restoration.

Replacement of crowns, inlays or onlays will be covered only if:

i) the insured person's tooth is further broken down by decay or injury and cannot be restored with an amalgam or composite restoration; and

ii) a period of 5 years has elapsed since the last date on which the crown, inlay or onlay was provided.

d) Space Maintainers (for loss of primary teeth)

i) stainless steel crown types

e) Implants

All services and treatments related to implants will be covered. These will include, but will not be limited to:

i) examination and diagnosis

ii) surgical installation of implant

iii) surgical re-entry

iv) placement of attachment

v) post-surgical care

vi) placement of prosthetic post and crown on implant

vii) laboratory fees

Whenever laboratory fees are incurred for services listed under the Major Treatments section, they will be limited to 60% of the fee established for the service.

Orthodontic Treatments: limited to children under 21 years of age at time treatment begins

i) oral examination
ii) observation and diagnosis
iii) cephalometric radiographs
iv) diagnostic casts - unmounted
v) removable active appliances for tooth guidance
vi) fixed or cemented appliances
vii) appliances to control harmful habits
viii) retention appliances
ix) comprehensive treatment

EXCLUSIONS AND REDUCTIONS

This benefit does not cover any expenses:

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

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

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

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

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

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

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

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

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

j) For services and supplies resulting from the commission of, or attempted commission of, a criminal offence or provoking an assault.

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

TREATMENT PLAN

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

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

PAYMENT OF BENEFITS

Fees

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

Expenses incurred in Canada, other than expenses related to services provided by a denturist, will be limited to the normal rate suggested for general practitioners in the insured person's province of residence.

Expenses incurred for services provided by a denturist are limited to the normal suggested fee for denturists in the insured person's province of residence.

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

Proof

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

Alternative Treatment Plan

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

CALCULATION OF REIMBURSEMENT

Deductible

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

Carry-over Provision

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

Reimbursement

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

Maximum Benefit Per Insured Person

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

Co-ordination of Benefits

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

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

ii) any government sponsored plan, and

iii) any non-insured employee benefit plan.

SURVIVOR BENEFIT

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

a) 24 months after the participant's death;

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

c) The termination date of this benefit.

EXTENSION OF BENEFITS

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

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

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

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

CONVERSION PRIVILEGE

A participant whose coverage under this group policy is cancelled due to termination of

a) his employment; or

b) his group membership,

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

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

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

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

COPY OF CONTRACT AND ENROLLMENT MATERIAL

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

SUBMITTING CLAIMS

Health and Dental Claims

To benefit from an accelerated processing, the Participant may submit claims in any of the following ways, if offered as part of his group insurance plan:

- **on our secure website *My Client Space* accessible via *ia.ca*; or**
- **via *iA Mobile*, if offered as part of your plan.**

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

For Participants residing in Quebec

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

For Participants residing outside Quebec

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

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

SUBMITTING CLAIMS

Disability Claims

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

For Participants residing in Quebec

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

For Participants residing outside Quebec

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

IMPORTANT NOTICE

For Persons Hospitalized Outside their Province of Residence

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

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

PROTECTING PERSONAL INFORMATION

Industrial Alliance Insurance and Financial Services Inc. (hereafter "the Company") is committed to protecting the privacy of a Participant's (including his or her Dependent's) personal information that it collects while providing services under the Group Plan issued to the Policyholder. The Company recognizes and respects a person's right to privacy concerning his or her personal information.
When a Participant enrolls under the Group Plan, the Company will establish a confidential file containing the personal information collected. The file will be kept at the Company's offices.

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

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

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

Participant's Right to Access His or Her Personal Information

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

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

To request access to his or her personal information or to have his or her name removed from the list to be shared within the Company, the Participant must send a written request to:
Industrial Alliance Insurance and Financial Services Inc.
Access Officer
1080 Grande Allée West
P.O. Box 1907, Station Terminus
Quebec City, Quebec G1K 7M3

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Policy No. 100008556 issued by iA Special Markets,

a division of Industrial Alliance Insurance and Financial Services Inc.

COVERAGE

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

AMOUNT OF INSURANCE

Your amount of insurance (Principal Sum) is 2 times your annual salary, rounded to the next higher $1,000 if not already a multiple thereof, to a maximum of $150,000. The Principal Sum reduces by 50% upon attainment of age 65.

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

BENEFITS

Accidental Death, Dismemberment and Specific Loss Indemnity

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

Life	100%
Both Hands or Both Feet	100%
Entire Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and Entire Sight of One Eye	100%
One Foot and Entire Sight of One Eye	100%
Speech and Hearing in both Ears	100%
One Arm or One Leg	80%
One Hand or One Foot	75%
Entire Sight of One Eye	75%
Speech or Hearing in both Ears	75%
Thumb and Index Finger of Either Hand	40%
Four Fingers of Either Hand	40%
Hearing in One Ear	40%
All Toes of One Foot	33 1/3%
Quadriplegia (total paralysis of all four limbs)	200%
Paraplegia (total paralysis of the lower limbs)	200%
Hemiplegia (total paralysis of one side of the body)	200%

Bereavement Benefit ($2,500)

If an injury results in loss of life, the Company will pay the reasonable and necessary expenses actually incurred by the Spouse and Dependent

Children for up to six sessions of grief counselling, by a professional counsellor.

Burn Benefit

If an injury results in disfigurement due to a third degree burn, the Company will pay according to the burn schedule below. If the insured sustains burns in more than one area as a result of any one accident, the total benefits for all such burns will not exceed the Principal Sum.

Burn Schedule

Body Part	Maximum Percentage of Principal Sum Payable
Face	100% of The Principal Sum
Neck	100% of The Principal Sum
Head	100% of The Principal Sum
One Hand and Forearm	25% of The Principal Sum
One Upper Arm	15% of The Principal Sum
Front or Back Torso	35% of The Principal Sum
One Thigh or One Lower Leg (below Knee)	10% of The Principal Sum

Continuation of Coverage

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

Conversion Option

Upon termination of active employment with the Policyholder, an insured may convert his/her insurance to an individual accident insurance plan, with no evidence of insurability, for an amount of principal sum equal to or lower than the amount of principal sum in force at the time of termination. Application for conversion must be made within 31 days. Premiums

become payable annually in advance. This benefit is restricted to Canadian residents only.

Day Care Benefit ($5,000)

If an injury results in loss of life, the Company will pay 5% of the principal sum for each year the dependent child is enrolled in a legally licensed day care (not to exceed 4 years) for each dependent child who is under 13 years of age and enrolled in the day care centre on the date of, or within 12 months following the accident.

Education Benefit ($10,000)

If an injury results in loss of life, the Company will pay 5% of the principal sum for each year the dependent child continues education as a full-time student in an institution of higher learning beyond the secondary school level (not to exceed 4 years) for each dependent child who was enrolled as a full-time student in an institution of higher learning beyond the secondary school level, or at the secondary school level but enrolls in an institution of higher learning beyond the secondary school level within 12 months following the accident. If, at the time of loss, none of the dependent children are eligible for the Education Benefit, the Company shall pay an additional amount of $2,500 to the designated beneficiary.

Family Transportation Benefit ($20,000)

If an injury results in confinement as an inpatient in a hospital located at least 150 km from the insured's residence, and such injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity, the Company will pay the expenses actually incurred by a member of the immediate family for hotel accommodation and transportation by the most direct route to the confined insured.

If transportation occurs in a private vehicle, then reimbursement of transportation expenses will be limited to a maximum of $0.35 per kilometre travelled.

Funeral Expense Benefit ($5,000)

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

Indemnity payable under this part shall be limited to only one policy if this benefit is contained in two or more policies issued by the company.

Home Alteration and Vehicle Modification Benefit ($50,000)

If an injury requires the use of a wheelchair to be ambulatory, the Company will pay the cost of alterations to the insured's principal residence and/or the cost of modification to one motor vehicle utilized by the insured, provided such injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity, subject to the greater of $15,000 or 10% of the principal sum to a maximum of $50,000.

Hospital Indemnity Expense Benefit ($2,500)

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

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

Identification Benefit ($20,000)

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

Parental Care Benefit ($5,000)

If an injury results in loss of life, the Company will pay 5% of the principal sum to an eligible dependent parent who, at the time of the accident, is a resident in a licensed nursing care facility, or enrolled in a home health care

program, or living in the insured's residence, or receiving support and care provided by the insured.

Permanent Total Disability Benefit

If an injury totally and permanently disables an insured, under age 65, within 12 months of the date of the accident, preventing the insured from engaging in any and every occupation, the Company will pay, provided such disability has continued for a period of 12 consecutive months and is total, continuous and permanent at the end of this period, the principal sum less any amounts already paid or payable under the Accidental Death, Dismemberment and Specific Loss Indemnity as the result of the same accident.

Psychological Therapy Benefit ($5,000)

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

Rehabilitation Benefit ($20,000)

If an injury requires that the insured undergo special training in order to be qualified to engage in a special occupation in which the insured would not have engaged except for such injury, the Company will pay the reasonable and necessary expenses incurred for such training within 3 years of the date of the accident, provided such injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity.

Repatriation Benefit ($20,000)

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

Seat Belt Benefit

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

Spousal Retraining Benefit ($20,000)

If an injury results in loss of life, the Company will reimburse the spouse for the reasonable and necessary expenses actually incurred for a formal occupational training program in order to become qualified for active employment in an occupation in which the spouse would not otherwise have sufficient qualifications.

Waiver of Premium Benefit

In the event of total disability and waiver of premium has been approved and accepted by the group life carrier, then premium under this plan will be waived until the earlier of: death, recovery, attainment of age 65 or the date the policy is cancelled.

Limited Air Travel Coverage

Coverage includes injury sustained in consequence of riding as a passenger and not as a pilot or member of the crew; in boarding or alighting from or being struck by; or making a forced landing with or from:

(a) any aircraft having a current and valid airworthiness certificate and which is operated by a person holding a current and valid pilot's license of a rating authorizing him to pilot such aircraft, or

(b) any transport-type aircraft operated by the Canadian Armed Forces or by the similar air transport service of any duly constituted governmental authority of the recognized government of any nation anywhere in the world, provided the aircraft is not being used for test or experimental purposes.

Notwithstanding (a) and (b) above, coverage excludes injury sustained while and in consequence of riding as a passenger, pilot, operator or member of the crew, in or on, boarding or alighting from or being struck by or making a forced landing with or from any aircraft owned, operated or leased by the policyholder.

EXCLUSIONS

- declared or undeclared war or any act thereof;
- active full-time service in the armed forces of any country;
- suicide or any attempt thereat or intentionally self-inflicted Injury, while sane or insane;

- injury sustained in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as provided in the part titled “Limited Air Travel Coverage”.

TERMINATION OF INSURANCE

Coverage will terminate immediately on the earliest of:

(a) the policy termination date;

(b) the premium due date if the Policyholder fails to pay the insured’s premium, except as a result of an inadvertent error;

(c) the premium due date coinciding with or immediately following the date an insured attains age 65 for the Permanent Total Disability benefit and age 70 for all other benefits;

(d) the premium due date next following the date an insured is ineligible for coverage, except as provided under the part titled “Continuation of Coverage”.

BENEFICIARY

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

- Bereavement Benefit
- Day Care Benefit
- Education Benefit
- Family Transportation Benefit
- Funeral Expense Benefit
- Identification Benefit
- Parental Care Benefit
- Repatriation Benefit
- Spousal Retraining Benefit

In the situation where the policy replaces an existing policy issued to the Policyholder, the designation recorded under the replaced policy will be deemed to be valid and of full force and effect under this policy until changed in writing by the insured.

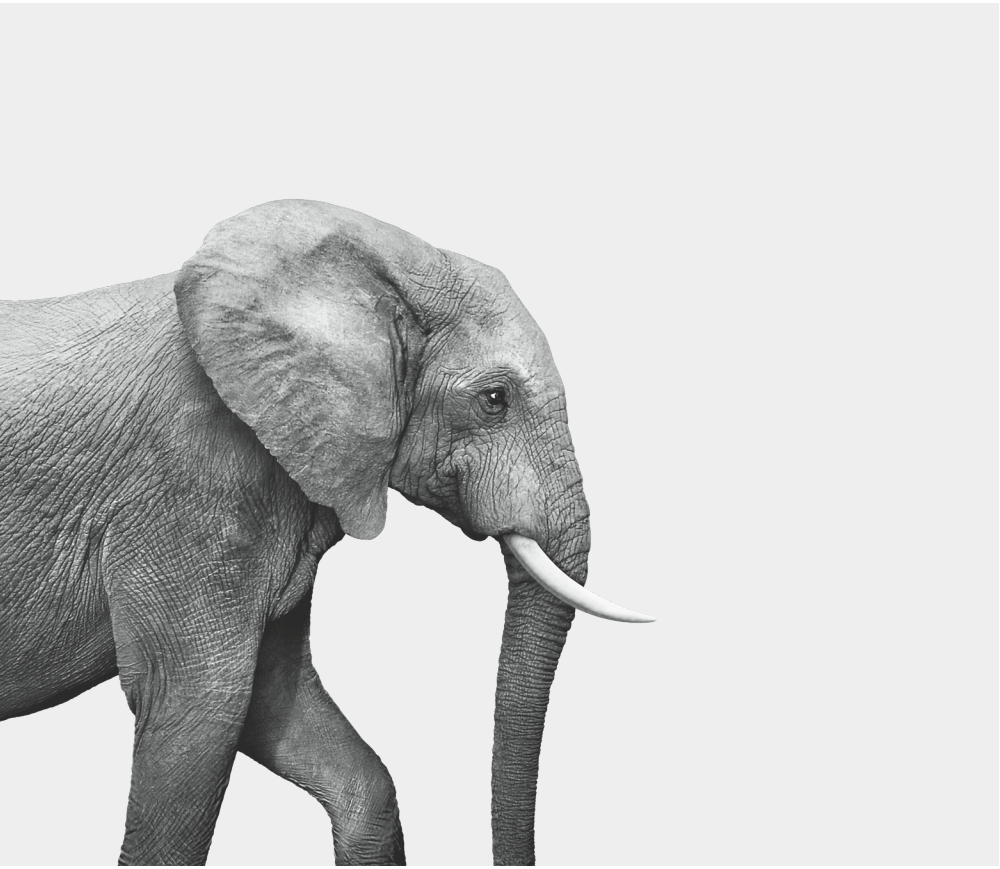
BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act or other applicable legislation.

This summary is for information purposes only. For further details, refer to the Master Policy which is on file with the Policyholder. The Master Policy sets forth in detail the terms and conditions of the Plan and all rights and obligations are determined in accordance with the Master Policy issued by iA Special Markets, a division of Industrial Alliance Insurance and Financial Services Inc., not this summary.

NOTES

NOTES



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