360° GROUP INSURANCE

Your Group Insurance Plan

ONTARIO HOSPITAL ASSOCIATION

ST. JOSEPH'S HEALTH CENTRE

Policy No. 541198

St. Joseph's Villa of Sudbury

St. Gabriel's Villa

Proud Partner of

HEART & STROKE FOUNDATION

Desjardins Insurance

LIFE • HEALTH • RETIREMENT

Cooperating in building the future

Your Group Insurance Plan

ST. JOSEPH'S HEALTH CENTRE

Policy No. 541198

St. Joseph's Villa of Sudbury

St. Gabriel's Villa

This document is an integral part of the Insurance certificate. It is a summary of your Group Insurance Policy effective July 1, 2012. Only the Group Insurance Policy may be used to settle legal matters.

This electronic version of the booklet has been updated on June 23, 2014. Please be advised that this electronic version is updated more frequently than the printed copy of your booklet. Therefore, there may be discrepancies between the paper and electronic copies.

TABLE OF CONTENTS

DIVISIONS AND CLASSES

DIVISIONS

Division	Division Name
0017	St. Joseph's Villa of Sudbury
0018	St. Gabriel's Villa

CLASSES

Class	Class Name
017	St. Joseph's Villa of Sudbury
018	St. Gabriel's Villa

GENERAL GUIDELINES

Participation:

Full time employee: Coverage is mandatory and employee must be designated as full time and work an average of 37.5 hours per week to be eligible for the benefits.

Eligibility Requirements

Number of hours worked per week:

A minimum of 37.5 hours per week for permanent full time employees.

Waiting Period:

4 months

Waiver of Premium

Beginning of Waiver of Premium:

For Member Long Term Disability Benefit – First of the month following the end of the Qualifying Period

For all other benefits – First of the month following the date of disability

Benefits for which premiums are waived:

- Member Custom Life Insurance Benefit
- Member Accidental Death and Dismemberment Benefit
- Member Custom Voluntary Life Insurance Benefit
- Dependent Custom Voluntary Life Insurance Benefit
- Member Long Term Disability Benefit

BENEFIT SCHEDULE

MEMBER CUSTOM LIFE INSURANCE BENEFIT

Amount of Insurance:	1 times annual Earnings, rounded to the nearest $1,000, if not already a multiple, up to a maximum of $100,000. The maximum amount allowed is $350,000 combined with Member Custom Voluntary Life Insurance.
Non-Evidence Maximum:	$100,000
***Reduction of amount:**	On the 65th birthday of the Member, the amount applicable to the Member will be reduced to a maximum benefit of $5,000.
Benefit Termination:	Age 70 of the Member or retirement, whichever occurs

MEMBER ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

Amount of Insurance:	Same as Member Custom Life Insurance Benefit.
***Reduction of amount:**	Same as Member Custom Life Insurance Benefit.
Benefit Termination:	Age 70 of the Member or retirement, whichever occurs first.

DEPENDENT LIFE INSURANCE BENEFIT

Amount of Insurance:	Spouse: $5,000 Each Child: $2,500
Commencement of Newborn Children Insurance:	From birth.

Benefit Termination

Age Limit:	Age 70 of the Member, or retirement whichever occurs first.

MEMBER CUSTOM VOLUNTARY LIFE INSURANCE BENEFIT

Maximum Amount of Insurance:	Any multiple of $10,000 with a minimum of $10,000 and a maximum of $250,000. The maximum amount allowed is $350,000 combined with Member Custom Life Insurance Benefit.
Benefit Termination:	Age 65 of the Member or retirement, whichever occurs first.

DEPENDENT CUSTOM VOLUNTARY LIFE INSURANCE BENEFIT

Amount of Insurance:	Spouse: Any multiple of $10,000, with a minimum of $10,000 and a maximum of $250,000.
Non-Evidence Maximum of Insurability:	Evidence of insurability is required for any Amount of Insurance.
Benefit Termination:	Age 65 of the Member or retirement, whichever occurs first.

MEMBER LONG TERM DISABILITY BENEFIT

Percentage and Maximum of Benefit:	60% of monthly Earnings, rounded to the next $1, if not already a multiple, up to a maximum of $5,000.
Non-Evidence Maximum of Insurability:	$2,500
Qualifying Period:	119 days
Maximum Benefit Period:	To age 65
Taxability of Benefits:	Non-taxable
Benefit Termination:	Age 65 of the Member or retirement, whichever occurs first.

EXTENDED HEALTH CARE BENEFIT

Deductible Amount

Drug Co-pay:	10% per prescription.
Dispensing fee and mark-up:	The Insurer will reimburse the reasonable and customary mark-up and the dispensing fee up to a maximum of $8. The Insured Person will be responsible for any amounts in excess of these limits.
Drugs:	Nil
Vision Care:	Nil
Eyeglasses, Lenses and Eye surgery:	Nil
Other Expenses:	Nil
Drug Payment Card:	Direct

Percentage of Reimbursement

Drugs:	100%
Vision Care:	100%
Other Expenses:	100%

Eyeglasses, Lenses and Eye surgery

Eyeglasses, Contact Lenses and Eye surgery:	100%
Contact Lenses: (Special conditions)	100%

Limits for Eligible Expenses

Paramedical Services:

Eligible amount for each Specialist per Insured Person:

Eligible amount of $300 each Calendar Year:

- Acupuncturist
- Chiropractor
- Massage Therapist (this service requires Medical Recommendation)
- Naturopath
- Osteopath
- Physiotherapist
- Podiatrist/Chiropodist
- Psychologist
- Speech Therapist

Eyeglasses, Lenses and Eye surgery:

Eligible amount of $150 per Insured Person once in any 24 month period or $250 per Insured Person once in any 24 month period for medically necessary contact lenses.

Benefit Termination

Age Limit:

First of the month coincident with or following the Member attaining age 65.

DENTAL CARE BENEFIT

Fee Guide Year:	Current year
Deductible Amount:	Nil
Percentage of Reimbursement	
Preventive Services:	80%
Basic Services, Endodontics and Periodontics:	80%
Maximum Benefit	
Preventive Services, Basic Services, Endodontics and Periodontics:	Maximum of $1,000 per Insured Person each Calendar Year.
Frequency:	For recall oral examination, polishing, light scaling and fluoride treatment, once every 9 months.
Limitations:	Fees for composite restorations performed on either anterior or posterior teeth are eligible.
Benefit Termination	
Age Limit:	First of the month coincident with or following the Member attaining age 65.

DEFINITIONS

Wherever used in the policy:

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

Actively At Work means the performance for a Participating Employer of all of the regular duties of the person's own occupation for one full working day or shift.

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

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

Continuous Service means a period of unbroken employment with a Participating Employer from the date of employment plus any additional eligible service as a result of a transfer from another Participating Employer. This period will include:

- vacation days and holidays granted by Participating Employers
- approved leaves of absence
- temporary lay-offs
- interruptions of service approved by the Insurer.

Child means a person who:

1) is under 21 years of Age, and for whom the Member or the Spouse of the Member has legal guardianship or had legal guardianship until he reached the Age of majority; or

2) has no spouse, is 25 years old or under and is a full-time student at an accredited educational institution, and for whom the Member or the Spouse of the Member would have legal guardianship if he were a minor; or

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

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

Dependent means a Spouse or child who is domiciled in Canada.

Earnings means, on a given date, for full time Employees, the rate of the regular remuneration received by the Member on that date for regular employment excluding overtime, bonuses, shift premiums and special payments of any kind.

Employee means a person who is domiciled in Canada and who is working on a full time basis, as defined by the Participating Employer, for a Participating Employer.

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

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

Insured Person means the Member or his Spouse, as the case may be.

Insurer means Desjardins Financial Security Life Assurance Company.

Maternity Leave or Parental Leave means any official period of maternity or parental leave taken by a Member in accordance with provincial or federal legislation, or an agreement between the Member and the Participating Employer, or any other period during which a Member receives maternity benefits under the Employment Insurance program.

Member means a person employed by a Participating Employer on a full time basis, who is insured under the policy.

Month means the period of time from a date in one calendar month to the same date in the following calendar month.

Participating Employer means an employer that is a member of the Ontario Hospital Association and is participating in the policy.

Participating Group means any group of Employees defined by a Participating Employer as eligible to participate under the policy. Coverage is provided for Divisions listed in the Divisions and Benefits section of the policy.

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

Premium Due Date means the first day of each month.

Qualifying Period means the period of time as outlined in the Benefit Schedule during which the Member is continuously and totally disabled as defined in the applicable provision of the policy.

Retired Member means a member who is at least 55 years of age and has terminated membership in the Hospital of Ontario Pension Plan (HOOPP) and/or another pension plan provided by the Participating Employer, and who is in receipt of a normal or early retirement pension.

Spouse means the person who is married to the Member, except that a person of the opposite or same sex who is living with and has been living with the Member in a conjugal relationship will be considered to be the Member's Spouse.

Waiting Period means the period of time from the Employee's first day of active work which must pass before the Employee is eligible to be insured.

ELIGIBILITY

EMPLOYEE ELIGIBILITY

An Employee is eligible for insurance:

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

2) after the EFFECTIVE DATE, on the date on which he meets the Eligibility Requirements specified in the General Guidelines;

   unless the Employee is not Actively at Work on that day due to Illness or injury.

If, due to Illness or injury, an eligible Employee is not Actively At Work on the date the insurance would be effective, the insurance will not be effective until the day he has been Actively At Work on the immediately preceding 7 consecutive scheduled working days for full time Employees.

SPOUSE ELIGIBILITY

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

A Member without a Spouse who is insured under the policy will be eligible for Spouse insurance on the date he acquires a Spouse.

INSURANCE APPLICATION

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

COMMENCEMENT OF INSURANCE AND WAIVER OF PREMIUM

COMMENCEMENT OF MEMBER INSURANCE

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

1) the Effective Date of the policy;

2) the date on which he first becomes eligible, provided his written application, completed using the form required by the Insurer, is received within 31 days of his date of eligibility;

3) the date on which the insurability of the Employee is approved by the Insurer, if the application of the Employee for insurance is received more than 31 days after the date of his eligibility.

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

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

PORTABILITY

A Member, whose insurance under the policy terminated due to termination of employment and who is re-hired by any Participating Employer within 6 months immediately following the termination of his insurance, will be eligible for the reinstatement of his insurance on the date he resumes employment, provided application for reinstatement is made within 31 days of eligibility. If, due to Illness or injury, an eligible Employee is not Actively At Work on that date, the insurance will not be effective until the day he has been Actively At Work on the immediately preceding 7 consecutive scheduled working days for full time Employees.

The Member must ask his new Participating Employer to arrange this transfer of coverage within one month of his first day of employment and inform his new Participating Employer of all prior service to be counted toward coverage. If the Member fails to do so, he will have to provide evidence of insurability at his own expense, to complete the transfer of coverage.

COMMENCEMENT OF SPOUSE INSURANCE

The insurance for the Spouse of a Member will become effective on the latest of the following dates:

1) the date on which the insurance of a Member first becomes effective under the policy;

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

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

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

If a Spouse is confined to a Hospital on the date his insurance would have otherwise become effective, his insurance will commence on the day immediately following his discharge from the Hospital.

WAIVER OF PREMIUM

1) For the Benefits listed in the WAIVER OF PREMIUM provision in the General Guidelines, as of the Beginning of Waiver of Premium mentioned in the WAIVER OF PREMIUM provision in the General Guidelines, premiums will be waived for a Member who becomes Totally Disabled while insured under the policy but prior to attaining Age 65, if he submits Proof of Claim satisfactory to the Insurer. Premiums will continue to be waived for as long as the Total Disability persists. For the purpose of this provision, premiums will cease to be waived 31 days after the earliest of the following dates:

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

    b) the date on which the Member ceases to be Totally Disabled;

    c) for the Life Insurance Benefit, the date on which the Member converts his insurance under the CONVERSION PRIVILEGE provision;

    d) the date on which the Member attains Age 65 or retires, if earlier;

e) in respect of each of the Benefits listed in the WAIVER OF PREMIUM provision in the General Guidelines, the date on which each Benefit or the policy terminates except for the Member Custom Life Insurance Benefit, the Member Accidental Death and Dismemberment Benefit, the Member Custom Voluntary Life Insurance Benefit, the Dependent Custom Voluntary Life Insurance Benefit and the Member Long Term Disability Benefit.

2) Under the policy, any provision for an increase in coverage is suspended during a Total Disability.

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

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

   a) the Member became Totally Disabled while insured under this Benefit;

   b) the Total Disability of the Member was uninterrupted from the onset of his Total Disability to the date of his death;

   c) the Member dies within 12 months from the onset of his Total Disability;

   d) the Member did not convert any or all of his insurance under the CONVERSION PRIVILEGE provision at the time his insurance terminated; and

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

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

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

TERMINATION OF INSURANCE

TERMINATION OF MEMBER INSURANCE

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

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

2) the date on which the Member ceases to belong to a class of Members eligible for insurance;

3) the date on which the Member reaches the applicable Age Limit specified in the Benefit Schedule;

4) the end of the period for which required premiums were paid on behalf of the Member;

5) the date on which the Member ceases to be Actively At Work, unless otherwise specified in the policy;

6) the date of termination of the policy.

TERMINATION OF SPOUSE INSURANCE

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

1) the date on which the insurance of the Member terminates;

2) the date on which the Member no longer has a Spouse;

3) the end of the period for which required premiums for Spouse insurance were paid on behalf of the Member;

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

The insurance of a Spouse of a Member will terminate on the date the Spouse no longer qualifies as a Spouse, as defined in the policy.

CONTINUATION OF INSURANCE

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

CLAIMS

NOTICE AND PROOF OF CLAIM

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

Failure to submit notice or proof of claim within the prescribed time limit does not invalidate the claim, provided that the notice and proof of the claim are sent as soon as reasonably possible.

No action or proceedings may be brought against the Insurer for the recovery of any claim within 60 days or after 3 years following the expiration of the time in which proof of claim is required.

BENEFICIARY

Subject to legal provisions, a Member may designate or revoke, at any time, one or several beneficiaries of the insurance on written notice to the Head Office of the Insurer. The rights of a beneficiary who dies before the Member revert to the latter.

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

The death benefit payable when a Spouse dies is paid to the Member, if alive. If the Member is deceased, the death benefit is paid to the Spouse's estate.

CLAIMS

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

Any Early Payments will be paid to the Member unless otherwise indicated in the policy.

In case of a death, the beneficiary or the Member must submit to the Insurer proof of death, including a death certificate, proof of the Age, and Earnings of the Member or the insured Spouse, as well as any other information deemed useful by the Insurer.

At the Insurer's option and discretion, an advance payment of the proceeds of a Member Life Insurance Benefit in an amount not exceeding $10,000 may be provided if:

1) the Participating Employer requests the advance in writing;

2) the Participating Employer provides written confirmation that the Member was insured under the policy at the date of death;

3) the Beneficiary of record is not the estate;

4) the Insurer is provided with the name, certificate number and date of death of the Member, and the name and address of the Beneficiary.

Such payment will fully discharge the Insurer, and the other insurers, provided this payment is made in good faith.

MEDICAL EXAMINATIONS

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

MEMBER CUSTOM LIFE INSURANCE BENEFIT

DEFINITIONS

With respect to the Waiver of Premium,

Total Disability or Totally Disabled means

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

   a) the Member is absent from work and not engaged in any gainful occupation, and

   b) is in a state of incapacity, resulting from an Illness or Accident, which wholly prevents him from performing the regular duties of the occupation in which he participated immediately prior to the onset of Total Disability;

2) once the Qualifying Period and the succeeding 24 months have elapsed,

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

   If a Member is able to earn an income that is equal to or greater than the amount of monthly disability benefit payable under the Member custom long Term Disability Benefit (adjusted annually by the Consumer Price Index), he is no longer considered to be Totally Disabled.

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

PAYMENT OF BENEFIT

Upon receipt of Proof of Claim satisfactory to the Insurer that a Member died while insured under this Benefit, the Insurer will pay the amount of Life Insurance applicable to such Member in accordance with the Benefit Schedule and other applicable policy provisions. In order to be payable, the claim must be received by the Insurer within 6 years of the date of death.

EARLY PAYMENT

Subject to the approval of the Insurer, a Member may elect Early Payment of the death benefit equal to 90% of the amount of Life Insurance applicable to the Member in accordance with the Benefit Schedule, subject to the following conditions:

1) a Physician appointed by the Insurer determines that the Member is apparently certain to die within 12 months of the date of such determination;

2) the Member is competent to act;

3) the Member is under age 64 at the time he makes the election.

The Early Payment is in exchange for all other benefits under the Member Custom Life Insurance provisions.

Value of the Early Payment means the aggregate of the payments made under the Early Payment, plus the reasonable costs of verifying the medical condition of the Totally Disabled Member.

EARLY PAYMENT EXCLUSION

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

POST RETIREMENT COVERAGE

When a Member insured under this Benefit attains age 65 or retires, whichever comes first, he may be entitled to receive a Post Retirement Benefit, as indicated in the Benefit Schedule.

BENEFIT TERMINATION

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

CONVERSION PRIVILEGE

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

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

1) $200,000; or

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

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

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

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

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

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

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

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

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

If the Life Insurance of a Member aged 65 or over terminates or is reduced, the individual policy will be a permanent insurance policy under a regular plan being issued by the Insurer.

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

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

NOTICE AND PROOF OF CLAIM

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

Any death claim notice must be submitted to the Insurer within 6 years of the date of death.

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

The benefit payable on the death of a Member will be paid to the beneficiary designated by the Member within 31 days of receipt of satisfactory proof of claim to the Insurer.

DEPENDENT LIFE INSURANCE BENEFIT

PAYMENT OF BENEFIT

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

COMMENCEMENT OF NEWBORN CHILDREN INSURANCE

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

BENEFIT TERMINATION

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

SPOUSE CONVERSION PRIVILEGE

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

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

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

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

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

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

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

EXTENSION OF BENEFIT AFTER TERMINATION

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

NOTICE AND PROOF OF CLAIM

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

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

MEMBER ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

DEFINITIONS

As used in this Benefit

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

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

Immediate Family means the Member's spouse, son, daughter, father, mother, brother or sister.

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

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

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

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

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

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

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

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

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

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

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

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

Seat Belt means the straps that are part of the occupant restraint system.

PAYMENT OF BENEFIT

Upon receipt of Proof of Claim satisfactory to the Insurer that

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

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

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

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

SCHEDULE OF LOSSES

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

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

Loss of	Amount Payable
Life	100%
Hearing in Both Ears and Speech	100%
Sight of Both Eyes	100%
Both Hands or Both Feet	100%
Both Arms or Both Legs	100%
One Hand and Sight of One Eye	100%
One Foot and Sight of One Eye	100%
One Hand and One Foot	100%
Hearing in Both Ears or Speech	100%
One Arm or One Leg	75%
Sight of One Eye	75%
One Hand or One Foot	75%

Loss of	Amount Payable
Hearing in One Ear	50%
Thumb and Index Finger of the Same Hand	33 1/3%
At least Four Fingers of the Same Hand	33 1/3%
Four Toes of the Same Foot	25%

Loss of Use of	Amount Payable
Both Arms or Both Legs	100%
Both Hands or Both Feet	100%
One Hand and One Foot	100%
One Arm or One Leg	75%
One Hand or One Foot	75%
Hemiplegia, Paraplegia, Quadriplegia	200%

DISAPPEARANCE

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

EXPOSURE

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

REHABILITATION

If a Member, while insured under this Benefit, suffers a loss, other than a loss of life, for which an amount is payable under this Benefit, the Insurer will pay the reasonable and necessary training expenses actually incurred, up to a maximum of $15,000, provided that:

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

2) such expenses are incurred within 3 years of the date of the Accident.

The Insurer will not pay for this service to the extent that it is reimbursed from other sources or insured under another benefit of the policy.

REPATRIATION

If a Member, while insured under this Benefit, dies as a result of an Accident that occurs 50 kilometres or more from his normal place of residence and an amount is payable for a loss of life under this Benefit, the Insurer will pay all customary and reasonable expenses incurred for preparation of the body for burial or cremation and transportation of the body to the Member's place of residence in Canada, up to a maximum of $15,000.

The Insurer will not pay for this service to the extent that it is reimbursed from other sources or insured under another benefit of the policy.

SPOUSAL RETRAINING

If a Member, while insured under this Benefit, dies as a result of an Accident and if an amount is payable for a loss of life under this Benefit, the Insurer will pay all reasonable and necessary expenses that are actually incurred by the Spouse who takes part in a formal occupational training program, up to $15,000, provided that

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

2) such expenses are incurred within 3 years of the date of the Accident.

The Insurer will not pay for this service to the extent that it is reimbursed from other sources or insured under another benefit of the policy.

CHILD EDUCATION

If a Member, while insured under this Benefit, dies as a result of an Accident and if an amount is payable for a loss of life under this Benefit, the Insurer will pay all reasonable and necessary expenses for each dependent child's tuition fees in a post-secondary school. The Insurer will pay up to 5% of the amount for which the Member was insured under this Benefit on the date of his death and an overall maximum of $5,000 for each year, for a maximum of 4 years. Education expenses incurred prior to the Member's death are not included.

FAMILY TRANSPORTATION AND HOTEL ACCOMMODATION

If a Member, while insured under this Benefit, suffers a loss, other than a loss of life, for which an amount of insurance is payable under this Benefit, and, as a result of such loss, is confined in a Hospital located more than 150 kilometres from his normal place of residence as an in-patient under the regular care of a Physician (other than himself), the Insurer will pay the reasonable expenses incurred by members of his Immediate Family for hotel accommodation and transportation by the most direct route to the Hospital, up to a maximum of $15,000 for all these expenses.

The Insurer will not pay for this service to the extent that it is reimbursed from other sources or insured under another benefit of the policy.

DAY CARE BENEFIT

If a Member, while insured under this Benefit, dies as a result of an Accident and if an amount is payable for a loss of life under this Benefit, the Insurer will pay for reasonable and necessary cost of day care, up to 5% of the amount for which the Member was insured under this Benefit on the date of his death and an overall maximum of $5,000, for each dependent child under age 13. The child must be enrolled in a licensed day care centre within one year of the Member's death.

The Insurer will not pay for this service to the extent that it is reimbursed from other sources or insured under another benefit of the policy.

HOME OR VEHICLE CONVERSION

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

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

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

subject to one conversion for each of the eligible expenses described in paragraphs 1) and 2) above and up to a maximum of $10,000 for all these expenses, provided expenses are incurred within one year of the date of the Accident.

This Benefit only applies if

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

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

The Insurer will not pay for this service to the extent that it is reimbursed from other sources or insured under another benefit of the policy.

SEAT BELT

If a Member, while insured under this Benefit, is injured in a Motor Vehicle Accident and suffers a loss for which an amount of insurance is payable under this Benefit, the amount payable will be increased by 10%, up to a maximum of $25,000, if the Member was wearing a Seat Belt, provided that

1) the loss occurs while the Member is a passenger or the driver of a private Motor Vehicle;

2) the Seat Belt was properly fastened; and

3) verification of the use of the Seat Belt is specified in the official Accident report or is certified by the investigator.

EXCLUSIONS AND RESTRICTIONS

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

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

   b) disease;

   c) full time service in the armed forces of any country;

   d) riding in, or on, or boarding or alighting from an aircraft if when the injuries were received:

      i) the Member was operating, learning to operate or serving as a member of a crew of any aircraft, or

      ii) the aircraft was being used for crop dusting, crop spraying, seeding, skywriting, racing, testing, exploration or any other purpose except transportation.

2) Under the REHABILITATION, CHILD EDUCATION, DAY CARE BENEFIT and SPOUSAL RETRAINING provisions, no payment will be made for room and board or other ordinary travelling, clothing or living expenses.

BENEFIT TERMINATION

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

CONVERSION PRIVILEGE

If the Accidental Death and Dismemberment Benefit of a Member younger than age 65 terminates under any of the conditions specified under the CONVERSION PRIVILEGE of the Member Custom Life Insurance Benefit and not solely the Member's request, the Member will be entitled to convert that insurance to an individual policy, without evidence of insurability.

The terms, conditions and restrictions applicable under the CONVERSION PRIVILEGE of the Member Custom Life Insurance Benefit will apply to any individual policy available under this Benefit except that the maximum amount that may be converted under this Benefit will be the maximum specified under the CONVERSION PRIVILEGE of the Member Custom Life Insurance Benefit.

NOTICE AND PROOF OF CLAIM

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

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

Any other claim must be submitted to the Insurer within one year after the loss.

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

MEMBER CUSTOM VOLUNTARY LIFE INSURANCE BENEFIT

ELIGIBILITY AND EVIDENCE OF INSURABILITY

As a prior eligibility requirement for this Benefit, evidence of insurability satisfactory to the Insurer will be required of a Member in accordance with the Benefit Schedule.

PAYMENT OF BENEFIT

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

SUICIDE EXCLUSION

No Voluntary Life Insurance Benefit is payable in respect of a Member who commits suicide or dies as a result of a suicide attempt, while sane or insane, within two years of the effective date or reinstatement date of his insurance, or the effective date of any subsequent increase to the initial amount of insurance. The insurance or the increase, as the case may be, is then null and void and the Insurer's liability is limited to refunding the premiums paid.

INCOME OPTION

If a Member's Voluntary Life Insurance Benefit premiums are waived and if the Member has been permanently Totally Disabled for at least two years, this Member can choose the Income Option which allows him to receive a payout of one third of his Voluntary Life Insurance Benefit amount in force on the date the Member became Totally Disabled. The remaining two thirds of the Voluntary Life Insurance Benefit amount will remain in force and premiums will continue to be waived according to the WAIVER OF PREMIUM provisions.

To elect this option, the Member must submit a request in writing and provide satisfactory proof of Total Disability to the Insurer.

BENEFIT TERMINATION

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

CONVERSION PRIVILEGE

If the Voluntary Life Insurance of a Member younger than age 65 terminates under any of the conditions specified under the CONVERSION PRIVILEGE of the Member Custom Life Insurance Benefit and not solely the Member's request, the Member will be entitled to convert that insurance to an individual policy, without evidence of insurability.

If the Voluntary Life Insurance of a Member aged 65 or over terminates or is reduced, the individual policy will be a permanent insurance policy under a regular plan being issued by the Insurer.

The terms, conditions and restrictions applicable under the CONVERSION PRIVILEGE of the Member Custom Life Insurance Benefit will apply to any individual policy available under this Benefit except that the maximum amount that may be converted under this Benefit will be the maximum specified under the CONVERSION PRIVILEGE of the Member Custom Life Insurance Benefit, minus the amount of any Member Custom Life Insurance that may be converted.

EXTENSION OF BENEFIT AFTER TERMINATION

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

NOTICE AND PROOF OF CLAIM

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

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

Any death claim must be submitted to the Insurer within 6 years of the date of death.

DEPENDENT CUSTOM VOLUNTARY LIFE INSURANCE BENEFIT

ELIGIBILITY AND EVIDENCE OF INSURABILITY

As a prior eligibility requirement for this Benefit, evidence of insurability satisfactory to the Insurer will be required of a Spouse applying for any amount of Dependent Custom Voluntary Life Insurance.

PAYMENT OF BENEFIT

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

SUICIDE EXCLUSION

No Dependent Custom Voluntary Life Insurance Benefit is payable in respect of a Spouse who commits suicide or dies as a result of a suicide attempt, while sane or insane, within two years of the effective date or reinstatement date of his insurance, or the effective date of any subsequent increase to the initial amount of insurance. The insurance or the increase, as the case may be, is then null and void and the Insurer's liability is limited to refunding the premiums paid.

BENEFIT TERMINATION

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

CONVERSION PRIVILEGE

If the Voluntary Life Insurance of a Spouse younger than age 65 terminates for any reason other than at the Member's request, the Member, or the Spouse in the event of the death of such Member, may convert this insurance to an individual policy, without evidence of insurability, subject to the following conditions:

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

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

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

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

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

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

EXTENSION OF BENEFIT AFTER TERMINATION

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

NOTICE AND PROOF OF CLAIM

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

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

Any death claim must be submitted to the Insurer within 6 years of the date of death.

MEMBER CUSTOM LONG TERM DISABILITY BENEFIT

DEFINITIONS

As used in this Benefit

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

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

Total Disability or Totally Disabled means

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

   a) the Member is absent from work and not engaged in any gainful occupation, and

   b) is in a state of incapacity, resulting from an Illness or Accident, which wholly prevents him from performing the regular duties of the occupation in which he participated immediately prior to the onset of Total Disability;

2) once the Qualifying Period and the succeeding 24 months have elapsed,

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

   If a Member is able to earn an income that is equal to or greater than the amount of monthly disability benefit payable under the Member Long Term Disability Benefit (adjusted annually by the Consumer Price Index), he is no longer considered to be Totally Disabled.

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

PAYMENT OF BENEFIT

Upon receipt of Proof of Claim satisfactory to the Insurer that

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

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

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

Long Term Disability Benefits are payable at the end of each month from the later of:

1) the end of the Qualifying Period; or

2) the date the Member is no longer entitled to receive regular earnings or benefits under a salary continuance plan or short term disability income plan.

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

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

If a Member continues to be insured under this Benefit while on Authorized Leave of Absence, Maternity or Parental Leave, then the Qualifying Period for any Total Disability that begins during such leave will be deemed to commence on the date the Member is scheduled to return to active full-time employment with the Participating Employer, provided the Member is then still so disabled and insured under this Benefit.

REDUCTION OF LONG TERM DISABILITY BENEFITS, LIMITATIONS AND EXCLUSIONS

1) Reductions

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

   a) any benefits the Member is eligible to receive under any Workers' Compensation Act, Workplace Safety and Insurance Act or similar legislation; and

   b) any amount the Member is eligible to receive under a government plan including benefits under the Canada Pension Plan or the Quebec Pension Plan including early retirement benefits but excluding

      i) benefits payable on behalf of his Dependents; and

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

   c) any Old Age Security benefits initially payable; and

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

e) the amount of any disability or retirement pension receivable from an employer's pension plan and disability income benefits payable under any other disability income plan toward which the Participating Employer contributes.

As used in paragraph e) above, "receivable" means that the Member receives or is eligible to receive the income described in the said paragraph.

In addition, the Insurer will further reduce Long Term Disability Benefits by any amount by which the total monthly income of the Member from All Sources exceeds

a) 85% of his gross monthly Earnings immediately prior to Total Disability if the benefit payable to the Member is taxable; or

b) 85% of his net monthly Earnings reduced by income tax deductions immediately prior to Total Disability if the benefit payable to the Member is non-taxable.

“All Sources” are benefits or payments resulting from the Member's disability if, on or after the date the Member became totally disabled he qualifies to receive such benefits or payments, or would be entitled to receive them had he made satisfactory application. These include but are not limited to:

a) another group insurance policy (including a policy under which the Member is insured because he belongs to an association);

b) an automobile insurance policy;

c) a retirement income plan providing income that becomes payable after the Member is no longer Actively at Work, whether or not the retirement income is related to disability;

d) any government plan, law or agency, such as the Canada Pension Plan/Quebec Pension Plan, the Workers' Compensation Act, the Workplace Safety and Insurance Act, or other similar legislation, resulting from the Member's same, subsequent or related disability, including benefits or payments on behalf of a Dependent.

2) Income from the following sources will not reduce the Long Term Disability benefits:

a) a policy which is solely an individual disability income policy;

b) a disability attachment to an individual life insurance policy;

c) a government plan providing disability income if the Insurer receives proof that the initial application has been declined and an appeal (filed within one year of the original decision to decline for those disability benefits) has been declined.

Increases in the disability income payable under a government plan or the Participating Employer's pension plan may occur because of an automatic adjustment in the cost of living. These increases will not further reduce the amount of the Long Term Disability benefits.

3) Limitations and Exclusions

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

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

ii) civil disorder or war, whether or not war was declared;

iii) committing or attempting to commit a criminal offence, excluding operating a vehicle while the Member's blood contains more than 80 milligrams of alcohol per 100 millilitres of blood.

PARTIAL DISABILITY BENEFIT

If an insured Member is totally disabled but able to work under a program approved in writing by the Insurer and performs at any time during the first 24 months of disability:

1) any of the duties of the employee's own occupation on a part time basis; or

2) any of the duties of any other occupation on a full time or part time basis or, from then on, the duties of any occupation on a part time basis;

such employee will still be entitled to a benefit, which will only be reduced by the greater of:

1) 80% of the income received from such work; or

2) the amount needed to keep the disability benefit income plus the income received from such work at the same level as the employee's pre-disability earnings.

RECURRENT TOTAL DISABILITY

If a Member stops being Totally Disabled while satisfying a Qualifying Period and, within 3 consecutive weeks, becomes Totally Disabled again from the same or related causes, the disability will be considered to be a continuation of the previous disability.

If a Member stops being Totally Disabled following a disability for which benefits are payable and within 6 consecutive months becomes Totally Disabled again from the same or related causes, the disability will be considered to be a continuation of the previous disability.

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

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

REHABILITATION

Rehabilitation means any program for the purpose of returning a Totally Disabled Member to remunerative employment that would provide an income equal or greater than the disability benefit for which the Member was insured when Total Disability began, adjusted annually by the Consumer Price Index, and which:

1) is approved by the Insurer;

2) is medically approved by a Physician involved in treating the Member, and

3) may involve, but is not necessarily limited to, one or more of

    a) assessment;

    b) counselling;

    c) medical or psychological treatment;

    d) a vocational retraining or education program;

    e) trial work, part time work or modified work.

If a Member is receiving income under an approved rehabilitation program, this income will be coordinated with the monthly benefits payable under this Benefit. The monthly benefits payable will be reduced by 50% of the monthly rate of rehabilitation remuneration, except that the monthly benefits and the sources of income identified under Reduction section will be added to the rehabilitation income to provide an amount not exceeding 100% of the pre-disability Earnings.

TERMINATION OF BENEFITS

Long Term Disability Benefits will cease on the earliest of

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

2) the date the Member dies;

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

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

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

6) the date on which the Member refuses to participate in a rehabilitation program or to take up rehabilitative employment considered appropriate by the Insurer;

7) the date on which the Member attains the Age Limit specified in the Benefit Schedule.

EXTENSION OF BENEFIT AFTER TERMINATION

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

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

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

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

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

NOTICE AND PROOF OF CLAIM

Initial written notice of a claim must be submitted to the Insurer within 31 days of the expiry of the Qualifying Period and initial written proof, within 6 months of the expiry of the Qualifying Period.

In the event of the recurrence of Total Disability, written notice of a claim must be submitted to the Insurer within 31 days of the date of such recurrence and written proof within 60 days of the date of such recurrence.

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

EXTENDED HEALTH CARE BENEFIT

DEFINITIONS

As used in this Benefit

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

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

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

Hospitalization means

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

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

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

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

Medical Recommendation means the order to provide medication or care given by a Physician, dental surgeon or a podiatrist duly authorized to do so in the normal performance of his profession.

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

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

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

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

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

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

PAYMENT OF BENEFIT

Upon receipt of Proof of Claim satisfactory to the Insurer that a Member, or one of his Dependents, while insured under this Benefit, incurred Eligible Expenses, the Insurer will reimburse the portion of expenses in excess of the Deductible, where applicable, subject to the applicable Percentage of Reimbursement and the limits specified in the Benefit Schedule, and in accordance with the other applicable provisions of this Benefit and the policy.

To be eligible, the expenses must have been incurred as a result of Illness, pregnancy or an Accident, and cover care:

1) which is medically necessary to treat the Insured Person;

2) which is generally provided for an Illness or injury of similar type or seriousness; and

3) which, unless otherwise indicated, was on the prior recommendation of the attending Physician.

In addition, the Eligible Expenses will be limited to the reasonable and customary charges generally paid in the area where the services are provided.

Eligible Expenses will be considered to have been incurred on the date the service or supply was provided.

COMMENCEMENT OF DEPENDENT INSURANCE

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

DEDUCTIBLE

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

PERCENTAGE OF REIMBURSEMENT

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

CO-PAY

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

DRUG EXPENSE LIMITS

The maximum amount specified in the BENEFIT SCHEDULE is applicable to all drug expenses incurred by each Insured Person, per Calendar Year.

ELIGIBLE EXPENSES IN CANADA – EXTENDED HEALTH CARE

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

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

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

DRUGS

1) Generic Drugs that are included in the most recent Provincial Governmental Drug Program Formulary, any non-substitutable drugs or Therapeutic Cross Selected Drugs, dispensed by a licensed pharmacist, Physician or Dentist, that are available only on prescription from a licensed Physician or Dentist, for a pathologic condition or bodily injuries.

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

   cardiac problems;

   pulmonary problems;

   diabetes;

   arthritis;

   Parkinson’s disease;

   epilepsy;

   cystic fibrosis;

   glaucoma.

If the attending Physician will not permit the substitution of Generic Drugs for the drugs prescribed, Eligible Expenses will include the cost of the Brand Name Drug.

For an Insured Person domiciled in British Columbia, Saskatchewan or Manitoba, expenses for prescribed drugs must not exceed the Deductible and Co-insurance percentage prescribed from time to time under the British Columbia or Manitoba Pharmacare program, or under the Saskatchewan Prescription Drug Plan.

2) Oral contraceptives prescribed by a Physician.

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

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

5) Reagent strips and syringes for the treatment of diabetes.

6) Smoking cessation aids (products only), up to a lifetime maximum of Eligible Expenses of $1,000 per Insured Person.

HEALTH PROFESSIONALS

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

In the province of Ontario, Eligible Expenses incurred for the services of a podiatrist or a chiropodist are reimbursed after the annual benefit for such services covered under the provincial health insurance plan has been exhausted. Proof that the benefit has been exhausted will be required.

In all other provinces, reimbursement will be made as allowed under the relevant provincial health plan. If applicable, proof that the benefit has been exhausted will be required.

AMBULANCE

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

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

2) between Hospitals; and

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

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

MOBILITY AIDS

Conventional wheelchair:

Rental or purchase, at the discretion of the Insurer, of a wheelchair.

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

ORTHOPAEDIC SUPPLIES

Spinal brace: Purchase, but not repair.

Brace for a limb, truss and plaster: Purchase, but not the repair or replacement.

Conventional hospital bed: Purchase or rental, at the discretion of the Insurer.

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

ORTHESIS AND PROSTHESIS

Podiatric Orthesis or arch support: Purchase, up to a maximum of Eligible Expenses of $300 per Insured Person each Calendar Year.

Artificial limb: Purchase; the cost for the repair is also eligible; replacement is included when required due to physiological change.

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

External breast Prosthesis: Purchase of an external breast Prosthesis when required because of total or radical mastectomy that has been performed while the Insured Person is covered under this Benefit or a comparable benefit in force immediately before the effective date of this Benefit, including the purchase of 2 surgical brassieres, up to a maximum of Eligible Expenses of $200 per Insured Person for any period of 24 consecutive months.

Hearing aids: Purchase on the written prescription of a licensed otolaryngologist, up to a maximum of Eligible Expenses of $500 per Insured Person for any period of 5 consecutive years.

Wigs: Purchase of wigs required as a result of chemotherapy, up to a lifetime maximum of Eligible Expenses of $200 per Insured Person.

THERAPEUTIC EQUIPMENT

Glucometer or reflectant meter: Purchase, or rental, upon medical recommendation, up to an eligible amount of $200 and one device for any period of 36 consecutive months.

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

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

Drainage pump and chest percussion accessories: Purchase.

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

Other therapeutic equipment: Purchase or rental, at the discretion of the Insurer, provided such equipment is medically required and is intended to cure or treat the affliction, up to a lifetime maximum of Eligible Expenses of $10,000 per Insured Person. This category of equipment includes, for example, non-union bone stimulators, insulin pumps, aerosol therapy equipment and intermittent positive pressure breathing machines.

MEDICAL SUPPLIES

Colostomy, ileostomy or uretherostomy supplies: Purchase.

Elastic support stockings: Purchase of medium or firm (over 20 mm/Hg) support stockings dispensed in a pharmacy or a medical facility, up to an eligible amount of $500 each Calendar Year, per Insured Person.

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

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

Catheter: Purchase.

Medical supplies for gavage: Purchase.

Medical supplies necessary following a tracheotomy: Purchase.

Opaque glass necessary during radiotherapy or psoriasis treatments: Purchase.

Compressive garments for the treatment of burns: Purchase.

Medicated dressings: Purchase.

DIAGNOSTIC SERVICES

Imaging techniques and diagnostic laboratory tests, up to a maximum of Eligible Expenses of $1,000 per Insured Person each Calendar Year. Such procedures do not include services received in a Hospital.

DENTAL TREATMENT DUE TO AN ACCIDENT

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

VISION CARE

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

EYEGLASSES, LENSES AND EYE SURGERY

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

HEALTH ASSISTANCE

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

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

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

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

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

RESTRICTIONS, EXCLUSIONS AND LIMITATIONS

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

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

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

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

   d) expenses incurred for surgically implanted prostheses, except for crystalline lenses if covered under the policy;

   e) services, treatment or supplies provided to the Member by the Employer;

   f) wheelchairs adapted or designed for sports activities;

   g) electric beds;

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

   i) equipment such as "Obus form" type;

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

   k) diapers for incontinence;

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

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

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

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

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

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

ii) cosmetic treatment;

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

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

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

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

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

r) services, treatment or supplies for fertility treatment;

s) sunglasses or safety glasses.

2) Exclusions applicable to drugs

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

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

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

c) the following products, whether or not prescribed:

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

ii) beauty-care products;

iii) cosmetics;

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

v) sun-tan emulsions (sunscreens);

vi) soaps;

vii) over-the-counter laxatives;

viii) over-the-counter antacids;

ix) skin softeners;

x) disinfectants and ordinary dressings;

xi) mineral water;

xii) any infant milk formulas;

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

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

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

f) products used in fertility treatment.

3) Drug restrictions

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

CO-ORDINATION OF BENEFITS

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

Total benefits payable under this Benefit and, if applicable, the MEMBER ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT and the DEPENDENT ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT if included under the policy cannot exceed the amount of Eligible Expenses incurred.

If expenses incurred by the Insured Person are eligible for payment under both this Benefit and, if applicable, the MEMBER ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT and the DEPENDENT ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT if included under the policy, such expenses will be payable under the ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS prior to any payment under this Benefit. As such, the liability of the Insurer under this Benefit will be limited to the unpaid balance of these Eligible Expenses.

BENEFIT TERMINATION

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

BENEFIT EXTENSION AFTER TERMINATION

If a Member is Totally Disabled or a Dependent is confined to a Hospital on the date the insurance of the Member terminates for any reason other than policy termination, Eligible Expenses incurred as a result of such disability or confinement will continue to be reimbursed as if the insurance had not ended for such Insured Person, until the earliest of the following dates:

1) the date the Member ceases to be Totally Disabled;

2) the date the Dependent is no longer confined in a Hospital;

3) the 91st day after the date the insurance of the Member terminated;

4) the date this Benefit terminates.

DEPENDENT BENEFIT EXTENSION AFTER MEMBER'S DEATH

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

1) 24 months following the death of the Member;

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

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

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

NOTICE AND PROOF OF CLAIM

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

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

DRUG CLAIMS

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

DENTAL CARE BENEFIT

DEFINITIONS

As used in this Benefit

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

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

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

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

LATE APPLICATION

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

PAYMENT OF BENEFIT

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

To be eligible, the expenses must have been performed

1) by a Dentist; or

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

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

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

COMMENCEMENT OF DEPENDENT INSURANCE

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

DEDUCTIBLE

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

PERCENTAGE OF REIMBURSEMENT

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

ELIGIBLE EXPENSES IN CANADA

PREVENTIVE SERVICES

EXAMINATIONS

- Complete oral examination, once every 24 months
- Recall oral examination, according to the frequency specified in the Benefit Schedule
- Specific oral examination, once every 6 months
- Emergency oral examination

RADIOGRAPHS (X-RAYS)

- Complete series of periapical films or panoramic radiographs, limited to one series in any 24 months
- Intra oral films, including bitewing films, and radiographs to diagnose a symptom or examine progress of a particular course of treatment
- Interpretation of radiographs from another source
- Photography
- Radiograph of the hand and wrist as a diagnostic aid for dental treatment

LAB TESTS AND EXAMINATIONS

- Bacteriologic cultures/smears to determine pathological agents
- Biopsies
- Pulp vitality tests
- Unmounted diagnostic casts

CASE PRESENTATION AND EXPLANATION

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

PREVENTIVE SERVICES

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

BASIC SERVICES, ENDODONTICS AND PERIODONTICS

RESTORATIONS

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

ENDODONTICS

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

PERIODONTICS

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

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

b) curettage performed by a Dentist, once per period of 60 months

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

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

MAINTENANCE OF REMOVABLE DENTURES

- Repair
- Structure addition
- Relining
- Rebasing
- Adjustments to dentures, 3 months after insertion
- Denture adjustments including minor adjustments, once every 6 months.

ORAL SURGERY

- Extractions - uncomplicated and complex
- Removal of residual roots
- Surgical exposure of teeth
- Alveoplasty, gingivoplasty, stomatoplasty and osteoplasty
- Alveolar ridge reconstruction
- Extension of mucous folds
- Excisions
- Incisions
- Frenectomy
- Miscellaneous surgical procedures

OTHER SERVICES

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

RESTRICTIONS, EXCLUSIONS AND LIMITATIONS

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

Reimbursement will not be made for any portion of the charge in excess of the suggested fee in the appropriate Fee Guide, as specified in the Benefit Schedule. When there are two or more courses of treatment available to adequately correct a dental condition, this plan will provide reimbursement for the treatment that incurs the lowest cost consistent with good dental care.

Reimbursement of lab fees will be limited to the reasonable and customary charge for such services in the area where the services are provided. However, in no event will the total reimbursement of lab fees exceed 40% of the suggested fee in the appropriate Fee Guide, as specified in the Benefit Schedule, for the particular dental treatment requiring the lab services.

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

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

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

2) charges for nutritional counselling, oral hygiene and dental plaque control programs;

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

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

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

6) expenses incurred for implants;

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

8) expenses incurred for anaesthesia administered by acupuncture;

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

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

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

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

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

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

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

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

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

CO-ORDINATION OF BENEFITS

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

PRE-DETERMINATION OF BENEFIT

When the total cost of any proposed dental treatment for an Insured Person is expected to exceed $300, the Member should submit a detailed treatment plan to the Insurer before treatment commences. The Insurer will then advise the Member of the amount of reimbursement for which the Insured Person is eligible in accordance with the provisions of the policy. The treatment plan should outline the type of treatment to be provided, the anticipated treatment dates, and the cost of such treatment.

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

BENEFIT TERMINATION

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

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

DEPENDENT BENEFIT EXTENSION AFTER MEMBER'S DEATH

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

1) 24 months following the death of the Member;

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

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

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

PROOF OF CLAIM

For reimbursement of a dental claim, the Insured Person must pay all treatment charges and submit a benefit claim to the Insurer. All claims must be submitted to the Insurer along with any receipts every 120 day period, if the amount claimed justifies it, and within 12 months of the date the expense was incurred.

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

Our Commitment to Our Plan Members

As one of our valued Plan Members, you are entitled to our attention and respect. We make it a point to be available to provide you with any assistance you may require. You can rely on our knowledgeable team that is committed to settling your claims objectively and diligently, thereby delivering the kind of service you have come to expect.

At Desjardins Insurance, the needs of the Plan Members are at the heart of the organization. Your financial security is vital to us and, as such, we will provide financial support in the event of illness, an accident or death.

Please accept this brochure which summarizes our financial obligations toward you.

desjardinslifeinsurance.com

Desjardins
Insurance
LIFE • HEALTH • RETIREMENT

Cooperating in building the future

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.

This document was printed on Cascades Rolland Enviro100 paper.

BIOGAS ENERGY

03074E (13-12)