GROUP INSURANCE

Your Group Insurance Plan

GARDA OF CANADA
TORONTO AIRPORTS

Policy No.Q834

Money working for people

Life, health, retirement

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TORONTO AIRPORTS

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This document is an integral part of the Insurance certificate. It is a summary of your Group Insurance Policy effective July 1, 2009. Only the Group Insurance Policy may be used to settle legal matters.

This electronic version of the booklet has been updated on April 27, 2010. 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.

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DIVISIONS AND CLASSES

DIVISIONS

Division	Division Name
AQ834	Garda/Toronto Airports (Full Time and Part Time Members)

CLASSES

Class	Category
001	Full Time Members
002	Part Time Members

BENEFIT SCHEDULE

GENERAL GUIDELINES

Participation:

Optional

However, since the premium is paid in full by the Employer, participation in this plan is an employment condition.

Eligibility Requirements

Eligibility Period:

The first day of the month following the end of the probation period as determined by the Employer.

BASIC PARTICIPANT LIFE INSURANCE BENEFIT

CLASSES 001 AND 002

Amount of Insurance:	**Class 001**: * $30,000
	Class 002: * $10,000
*** Reduction of Amount:**	**Class 001**: On the 70th birthday of the Participant, the amount applicable to the Participant will be reduced to $3,000.
	Class 002: On the 70th birthday of the Participant, the amount applicable to the Participant will be reduced to $1,000.

Benefit Termination

Age Limit:	Retirement of the Participant.

PARTICIPANT ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

CLASSES 001 AND 002

Amount of Insurance:	**Class 001**: $30,000
	Class 002: $10,000

Benefit Termination

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

EXTENDED HEALTH CARE BENEFIT

CLASS 001

Deductible Amount

Dispensing fee and mark-up:	The Insurer will reimburse the reasonable and customary mark-up and the dispensing fee up to a maximum of $5. The Insured Person will be responsible for any amounts in excess of these limits.
All Eligible Expenses including Drugs:	Nil
Drug Payment Card:	Direct

Percentage of Reimbursement

Drugs:	Generic Drug: 100% Brand Name Drug: 80% However, when no generic drug is available for any prescribed drug necessary for the pathological conditions listed under the DRUGS provision, the percentage of reimbursement is 100%
Hospitalization Expenses in province of residence:	100%
Travel Insurance Emergency Expenses outside province of residence:	100%
Other Eligible Expenses:	100%

Limits for Eligible Expenses

Ambulance:	Payable amount of $45 per trip.

Hospitalization Expenses in province of residence:

Payable amount of $50 per day and a maximum of 120 days of Hospitalization provided the Insured Person is hospitalized for at least 3 consecutive days and subject to the conditions set forth in the Benefit description.

Nursing Care:

Payable amount of $10,000 per Insured Person for any period of 3 Calendar Years.

Paramedical Services:

Payable amount of $300 for each specialist indicated below per Insured Person each Calendar Year, up to a maximum of $800 per Insured Person each Calendar for all specialists combined:

- Acupuncturist
- Chiropractor (including imaging techniques used by a chiropractor)
- Massage Therapist (must be prescribed by a Physician)
- Naturopath
- Osteopath (including imaging techniques used by an osteopath)
- Physiotherapist
- Podiatrist or Chiropodist * (including imaging techniques used by a podiatrist or chiropodist)
- Psychologist
- Speech therapist

* The maximum benefit amount applies to all specialists of this discipline.

Eyeglasses, Lenses and Eye Surgery for adults:	Payable amount of $250 per Insured Person for any period of 24 consecutive months (including one eye examination for an Insured Person between the ages of 20 and 64, up to a maximum payable amount of $50).
Eyeglasses, Lenses and Eye Surgery for Children under Age 18:	Payable amount of $250 per Insured Person for any period of 24 consecutive months.
Travel Insurance Emergency Expenses outside province of residence:	For the first 45 days of a trip and a lifetime payable amount of $5,000,000 per Insured Person.
Maximum for All Other Eligible Expenses:	Lifetime payable amount of $1,000,000 per Insured Person.

Benefit Termination

Age Limit:	Retirement of the Participant. Hospital Expenses and Travel Insurance benefits: Age 70 or retirement of the Participant, whichever occurs first.

EXTENDED HEALTH CARE BENEFIT

CLASS 002 (does not include coverage for Dependents)

Deductible Amount

Dispensing fee and mark-up:	The Insurer will reimburse the reasonable and customary mark-up and the dispensing fee up to a maximum of $5. The Insured Person will be responsible for any amounts in excess of these limits.
All Eligible Expenses including Drugs:	Nil
Drug Payment Card:	Direct

Percentage of Reimbursement

Drugs:	70%
Hospitalization Expenses in province of residence:	100%
Other Eligible Expenses:	70%

Limits for Eligible Expenses

Ambulance:	Payable amount of $45 per trip.
Hospitalization Expenses in province of residence:	Payable amount of $50 per day and a maximum of 120 days of Hospitalization provided the Insured Person is hospitalized for at least 3 consecutive days and subject to the conditions set forth in the Benefit description.
Maximum for All Eligible Expenses:	Lifetime payable amount of $100,000 per Insured Person.

Benefit Termination

Age Limit:	Retirement of the Participant. Hospital Expenses benefit: Age 70 or retirement of the Participant, whichever occurs first.

DENTAL CARE BENEFIT

CLASS 001

Fee Guide Year:	Current year
Deductible Amount:	Nil
Percentage of Reimbursement	
Preventive Services:	100%
Basic Services, Endodontics and Periodontics:	100%
Major Restorative Services:	50%
Orthodontics:	50%. Eligible Expenses for Children under Age 19 only.
Maximum Benefit	
Preventive Services, Basic Services, Endodontics, Periodontics and Major Restorative Services:	Combined maximum of $2,000 per Insured Person each Calendar Year.
Orthodontics:	Lifetime maximum of $2,500 per Insured Person.
Frequency:	For recall oral examination, polishing, light scaling and fluoride treatment: 9 months
Limitations:	Fees for composite restorations performed on either anterior or posterior teeth are eligible.
Electronic Data Interchange (EDI):	Yes

Benefit Termination

Age Limit: Retirement of the Participant.

DENTAL CARE BENEFIT

CLASS 002 (does not include coverage for Dependents)

Fee Guide Year:	Current year
Deductible Amount:	Nil
Percentage of Reimbursement	
Preventive Services:	100%
Basic Services, Endodontics and Periodontics:	100%
Major Restorative Services:	50%
Orthodontics:	Expenses not covered
Maximum Benefit	
Preventive Services, Basic Services, Endodontics, Periodontics and Major Restorative Services:	Combined maximum of $2,000 per Insured Person each Calendar Year.
Orthodontics:	Expenses not covered
Frequency:	For recall oral examination, polishing, light scaling and fluoride treatment: 9 months
Limitations:	Fees for composite restorations performed on either anterior or posterior teeth are eligible.
Electronic Data Interchange (EDI):	Yes

Benefit Termination

Age Limit: Retirement of the Participant.

DEFINITIONS

Wherever used in the policy:

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

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

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

Child means a person who:

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

2) has no spouse, is under 25 years of Age and is, or is deemed to be, a full-time student at an accredited educational institution, and for whom the Participant or the Spouse of the Participant 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 Participant or the Spouse of the Participant 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.

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

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

Earnings means the regular rate of pay of an Employee paid by the Employer, including dividends, but excluding bonuses, overtime pay and any non regular form of remuneration.

For the Participant Weekly Indemnity Insurance benefit that is registered for premium reduction under the Employment Insurance Act, if applicable, bonuses, overtime pay or any other form of pay included in regular compensation and declared to the Insurer is part of Earnings.

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

Employee means a person who is domiciled in Canada and who is employed by the Employer on a permanent full-time or part-time basis. However, if an Employee is domiciled outside Canada, such Employee may be deemed to be domiciled in Canada provided prior written approval is obtained from the Insurer.

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

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

Hospital means any hospital that is designated as such by law and is intended for the care and treatment of sick and injured individuals, and which has organized facilities for diagnosis and major surgeries as well as 24 hour nursing service. The term does not include a nursing home, home for the aged or chronically ill, rest home, Convalescent Hospital, or a place for the care and treatment of alcoholism or drug abuse.

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

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

Immediate Family means a person who is the Spouse, son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law of the Participant.

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

Insurer means Desjardins Financial Security Life Assurance Company.

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

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

Participant means an Employee who is insured under the policy.

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

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

Spouse means a person who is domiciled in Canada and who is

1) the legal Spouse of the Participant by virtue of a religious or civil marriage ceremony; or

2) the common-law Spouse of the Participant with whom the Participant has been living in a conjugal relationship continuously for a period of at least 12 months.

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

ELIGIBILITY

EMPLOYEE ELIGIBILITY

An Employee is eligible for insurance:

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

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

A Participant, whose insurance under the policy terminated due to termination of employment and who is re-hired by the Employer within six 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.

DEPENDENT ELIGIBILITY

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

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

INSURANCE APPLICATION

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

EXEMPTION PRIVILEGE

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

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

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

2) the Dental Care Benefit will be effective on the date on which the written application is signed by the Participant.

EVIDENCE OF INSURABILITY

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

COMMENCEMENT OF INSURANCE AND WAIVER OF PREMIUM

COMMENCEMENT OF PARTICIPANT INSURANCE

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

1) the Effective Date of the policy,

2) the date on which he first becomes eligible, provided his written application, completed using the form required by the Insurer, is received by the Insurer on or before that date,

3) the date on which his written application, completed using the form required by the Insurer, is signed by him, provided this application is received by the Insurer within 31 days of his date of eligibility,

4) the date on which the insurability of the Employee is approved by the Insurer, if the application of the Employee for insurance is received by the Insurer more than 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.

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

With respect to the Dental Care Benefit, if included in the policy, if the Employee applies more than 31 days after the date of his eligibility, evidence that the insurability of an Employee is satisfactory will not be required.

COMMENCEMENT OF DEPENDENT INSURANCE

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

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

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

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

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

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

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

TERMINATION OF INSURANCE

TERMINATION OF PARTICIPANT INSURANCE

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

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

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

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

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

5) the date the Participant retires,

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

7) the date of termination of the policy.

TERMINATION OF DEPENDENT INSURANCE

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

1) the date the insurance of the Participant terminates,

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

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

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

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

CONTINUATION OF INSURANCE

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

CLAIMS

NOTICE AND PROOF OF CLAIM

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

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

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 Participant 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 Participant revert to the latter.

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

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

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

   to the Spouse's legal heirs;

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

   a) to the Spouse, if alive, or

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

CLAIMS

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

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

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

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

MEDICAL EXAMINATIONS

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

CO-ORDINATION OF BENEFITS

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

Coordination of benefits under the policy will be done in accordance with the guidelines of the Canadian Life and Health Insurance Association so that the total payments under all Plans will not exceed the individual's total incurred eligible expenses.

As used in this provision, "Plan” means the policy and any plan providing benefits or services under

1) other group insurance programs;

2) any other arrangement of coverage for individuals in a group, whether on an insured or uninsured basis;

3) government programs or any insurance required by statute.

The term "Plan" will be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion which does not.

BASIC PARTICIPANT LIFE INSURANCE BENEFIT

DEFINITIONS

As used in this Benefit

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

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

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

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

EVIDENCE OF INSURABILITY

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

PAYMENT OF BENEFIT

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

LIVING BENEFIT

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

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

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

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

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

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

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

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

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

LIVING BENEFIT EXCLUSION

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

BENEFIT TERMINATION

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

CONVERSION PRIVILEGE

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

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

1) $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 Participant is eligible under another group life insurance at the time of exercising his conversion right.

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

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

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

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

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

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

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

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

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

EXTENSION OF BENEFIT AFTER TERMINATION

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

NOTICE AND PROOF OF CLAIM

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

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

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

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

PARTICIPANT ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

DEFINITIONS

As used in this Benefit

Brain Death means irreversible unconsciousness with total loss of brain function; and complete absence of electrical activity of the brain, even though the heart is still beating.

Dependent Parent means the Insured Person's parents or grandparents who are dependent upon the Insured Person for support, maintenance and care.

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

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

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

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

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

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

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

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

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

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

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

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

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

Professional Counsellor means the treatment or counselling by a therapist or counsellor who is licensed, registered or certified to provide such treatment.

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

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

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

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

SCHEDULE OF LOSSES

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

Loss of	Amount Payable
Life	100%
Hearing in Both Ears and Speech	100%
Sight of Both Eyes	100%
Both Hands or Both Feet	100%
One Hand and Sight of One Eye	100%
One Foot and Sight of One Eye	100%
One Hand and One Foot	100%
Brain Death	100%
One Arm or One Leg	75%
Hearing in Both Ears or Speech	75%
Sight of One Eye	75%
One Hand or One Foot	75%
Thumb and Index Finger of the Same Hand	33 1/3%
At least Four Fingers of the Same Hand	33 1/3%

Loss of	Amount Payable
Hearing in One Ear	33 1/3%
All Toes of One Foot	25%
Thumb of Either Hand	25%
One Finger of Either Hand	16 2/3%

Loss of Use of	Amount Payable
Both Arms or Both Hands or Both Feet	200%
One Arm or One Leg	75%
One Hand or One Foot	75%
Thumb and Index Finger of the Same Hand	33 1/3%
Hemiplegia, Paraplegia, Quadriplegia	300%

COSMETIC DISFIGUREMENT BENEFIT

If a Participant suffers a third degree burn in a non-occupational Accident, the Insurer will pay a percentage of the Amount of Insurance indicated in the Benefit Schedule, depending on the area of the body which was burned according to the following table:

Body Part:	(A) Area Classification	(B) Maximum Allowable % for Area Burned	(C) Maximum % of Amount of Insurance Payable
Face, Neck, Head	11	9%	99%
Hand and Forearm	5	4.5%	22.5%
Either Upper Arm	3	4.5%	13.5%
Torso (Front or Back)	2	18%	36%
Either Thigh	1	9%	9%
Either Lower Leg (below knee)	3	9%	27%

The Maximum percent of Amount of Insurance Payable (C) is determined by multiplying the Area Classification (A) by the Maximum Allowable percent for Area Burned (B). In the event of a 50% surface burn, the Maximum Allowable percent for Area Burned (B) is reduced by 50%. This table only represents the Maximum percent of Amount of Insurance Payable for any one Accident. If the Insured Person suffers burns in more than one area as a result of any one Accident, benefits will not exceed $25,000.

REPATRIATION BENEFIT

If a Participant dies as a result of an Accident that occurs 150 kilometres or more from his normal place of residence or outside Canada and an amount is payable for a loss of life under this Benefit, the Insurer will pay all customary and reasonable expenses actually incurred for preparation of the body for burial or cremation and transportation of the body to the Participant's place of residence in Canada, up to a maximum of $15,000.

REHABILITATION BENEFIT

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

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

FAMILY TRANSPORTATION BENEFIT

If a Participant 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 or outside Canada as an In-patient under the regular care of a Physician (other than himself), the Insurer will pay the reasonable expenses actually incurred by members of his Immediate Family for transportation by the most direct route to the Hospital, up to a maximum of $15,000.

IN-HOSPITAL CONFINEMENT MONTHLY INCOME

If a Participant suffers a loss, other than a loss of life, for which an amount of insurance is payable under this Benefit, and if such Participant is confined in a Hospital as an In-patient under the regular care of a Physician or surgeon (other than himself), the Insurer will pay for each full month, one percent (1%) of the Amount of Insurance indicated in the Benefit Schedule, subject to a maximum benefit of $2,500, or one-thirtieth of such monthly benefit for each day of partial month, retroactive to the 1st full day of such confinement but not to exceed 365 days in the aggregate for each period of hospital confinement.

SPOUSAL RETRAINING BENEFIT

If the Spouse of a Participant is insured under the policy on the date the Participant dies as a result of an Accident and if an amount is payable for a loss of life under this Benefit, the Insurer will pay all reasonable and necessary expenses that are actually incurred by the Spouse who takes part in a formal occupational training program, up to $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 365 days of the date of the Accident.

DAY CARE BENEFIT

If the Dependents of a Participant are insured under the policy on the date the Participant dies as a result of an Accident and if an amount is payable for a loss of life under this Benefit, the Insurer will pay a Day Care benefit for each Dependent Child aged 12 years or under who, on the date of the Accident, was insured under the policy and enrolled in a legally licensed Day Care centre or who enrols in a legally licensed Day Care centre within 365 days following the date of the Accident.

Under this benefit, reimbursement will be made for all reasonable and necessary expenses actually incurred, subject to the lesser of 5% of the amount for which the Participant was insured under this Benefit on the date of his death or a maximum of $5,000 for each year, for a maximum of four consecutive years, provided that the Insurer receives satisfactory proof that the Dependent Child is enrolled in a legally licensed Day Care centre.

PARENTAL CARE BENEFIT

If a Participant dies as a result of an Accident and an amount is payable for a loss of life under this Benefit, the Insurer will pay a Parental Care benefit for an eligible Dependent Parent who, at the time of the Accident:

1) is resident in a licensed nursing care facility; or

2) is enrolled in a home health care program; or

3) is living in the Insured Person's residence; or

4) is receiving support and care provided by the Insured Person as evidenced by:

    a) cancelled cheques

    b) Income Tax returns showing the parent as a Dependent; or

    c) other similar forms of proof.

The amount of the Parental Care benefit will be the lesser of 10% of the Insured Person's Amount of Insurance indicated in the Benefit Schedule or $5,000.

SPECIAL EDUCATION BENEFIT

If the Dependents of a Participant are insured under the policy on the date the Participant dies as a result of an Accident and if an amount is payable for a loss of life under this Benefit, the Insurer will pay a Special Education benefit for each Dependent Child who, on the date of the Accident, was insured under the policy and was enrolled as a full-time student in any institution of higher learning above 12th grade level, or was at the 12th grade level and subsequently enrols as a full-time student in an institution of higher learning within 365 days of the date of the Accident.

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

BEREAVEMENT BENEFIT

If a Participant dies as a result of an Accident and an amount is payable for a loss of life under this Benefit, the Insurer will pay the reasonable and necessary expenses actually incurred by the Spouse and Dependent Children of the Insured Person for up to six sessions of grief counselling, by a Professional Counsellor, subject to a maximum of $1,000.

SEAT BELT BENEFIT

If a Participant is injured in a car Accident and suffers a loss for which an amount of insurance is payable under this Benefit, the amount payable will be increased by 10% if the Participant was wearing a Seat Belt, provided that

1) the loss occurs while the Participant 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.

HOME OR VEHICLE CONVERSION

If a Participant 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, the reasonable and necessary expenses incurred within 365 days from the date of the Accident for

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

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

subject to one conversion for each of the eligible expenses described in paragraphs 1) and 2) above and up to a maximum benefit the greater of $15,000 or 10% of the Amount of Insurance indicated in the Benefit Schedule, up to a maximum of $50,000 for all these expenses.

This benefit only applies if

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

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

DISAPPEARANCE

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

EXPOSURE

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

IDENTIFICATION BENEFIT

If a Participant suffers a loss of life, for which an amount of insurance is payable under this Benefit, not less than 150 kilometres from his normal place of residence and identification of the body by a member of his Immediate Family has been requested by the police or a similar governmental authority, the Insurer will pay the reasonable expenses actually incurred by such member for:

1) transportation in a Motor Vehicle or device operated under a license for the conveyance of passengers for hire by the most direct route to the city or town where the body is located; and

2) hotel accommodation in such city or town, subject to a maximum duration of three days.

The reimbursement of such expenses incurred is subject to the Amount of Insurance for loss of life under this Benefit being subsequently payable in accordance with the terms of the policy following the identification of the body as the Insured Person. The Insurer will pay 10% of the Amount of Insurance indicated in the Benefit Schedule, up to a maximum of $10,000 for all such expenses.

Benefits payable under this section are limited to only one policy in the event this benefit is contained in two or more policies issued to the Policyholder by the Insurer.

SERIOUS ILLNESS BENEFIT

If a Participant is under Age 65 and is diagnosed with any one of the covered serious illnesses listed below while coverage is in effect, but only after such coverage has been in effect for a period of 90 days, the Insurer will pay 10% of the Amount of Insurance indicated in the Benefit Schedule, up to a maximum of $10,000, provided the Insured Person has been hospitalized as an In-Patient continuously for at least 48 hours and survives for a period of 30 days thereafter.

Covered Serious Illnesses

Encephalitis	Parkinson's Disease	Tuberculosis
Yersinia Pestis	Acute Poliomyelitis	Typhoid Fever
Necrotizing Fascitis	Acute Rheumatic Fever	Meningitis

The Insurer shall only be obligated to pay the Serious Illness benefit once notwithstanding that an Insured Person may be diagnosed with more than one of the covered serious illnesses.

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

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

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

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

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

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

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

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

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

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

4) For multiple losses to the same limb due to any one Accident, only one loss, corresponding to the most significant loss, will be paid. For all losses due to any one Accident, the aggregate amount payable will not exceed 100% of the Amount of Insurance indicated in the Benefit Schedule, except

   a) for Hemiplegia, Paraplegia and Quadriplegia, where the total amount payable will not exceed 300% of the Amount of Insurance indicated in the Benefit Schedule; and

b) for Loss of Both Arms or Both Hands or Both Feet, where the total amount payable will not exceed 200% of the Amount of Insurance indicated in the Benefit Schedule.

RESTRICTIONS RELATED TO THE WEARING OF A SEAT BELT

To be eligible for the additional amount payable to a Participant who is injured in a car Accident, as specified under the SEAT BELT provision of this Benefit, the driver of the Motor Vehicle must have a valid driver's licence for the type of vehicle he is authorized to drive and must not, at the time of the Accident, be under the influence of drugs, except in the case of medication prescribed by a Physician and taken following the directions for use. Moreover, the driver's blood alcohol level must not exceed the limit set under the Criminal Code of Canada, nor the impaired driving limits established by the local authorities in the area where the Accident occurs.

BENEFIT TERMINATION

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

NOTICE AND PROOF OF CLAIM

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

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

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

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

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.

Dispensing fee means the part of the price of each prescription sold by a drugstore which corresponds to the amount covering the cost of the pharmacist's services.

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

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.

Mark-up means the part of the price of each prescription sold by a drugstore which corresponds to the profit made on the drug.

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 60 consecutive days or less 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 Participant from working in any occupation for which he is suited by education, training and experience.

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

DEFINITIONS FOR DRUGS

Brand Name Drug means the first drug developed, said to be original, and put on the market.

Generic Drug means any reproduction of a Brand Name Drug.

PAYMENT OF BENEFIT

(Not applicable to Dependents of Part Time Members)

Upon receipt of Proof of Claim satisfactory to the Insurer that a Participant, or one of his Dependents, incurred Eligible Expenses while insured under this Benefit, 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 Participant, with Dependents who are already covered, will become insured at birth.

DEDUCTIBLE

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

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 PROVINCE OF RESIDENCE

Part time Members are eligible for Drugs, Ambulance and Hospitalization Expenses coverage only.

Eligible Expenses in the Participant's normal province of residence include charges for the following:

DRUGS

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

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

   cardiac problems;

   pulmonary problems;

   diabetes;

arthritis;

Parkinson's disease;

epilepsy;

cystic fibrosis;

glaucoma.

2) For an Insured Person aged 65 or over, the drugs described in paragraph 1) that are necessary for treatment in respect of an Illness or injury, that are not covered under the Ontario Drug Benefit Program, and that are available only on prescription and dispensed by a pharmacist, or by a Physician, if there is no pharmacist.

   Eligible drug expenses that are used to cover the Deductible under the Ontario Drug Benefit Program are also eligible, subject to the Deductible and Percentage of Reimbursement under this Benefit.

3) Oral contraceptives prescribed by a Physician.

4) 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.

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

6) Anaesthetic administered during surgery that is not performed in a Hospital.

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, subject to the maximum specified in the Benefit Schedule,

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.

HOSPITALIZATION EXPENSES

Hospital: The Insurer will pay, for active Full Time and Part Time Members under Age 70 and eligible Dependents of Full Time Members who are over the Age of 14 days, a daily benefit specified in the Benefit Schedule for the first 120 days the Insured Person is confined to a Hospital for three consecutive days or more and under the care of a licensed Physician. Benefits are retroactive to the first day of Hospital confinement. The total hospital days is equal to the total number of days billed by the Hospital as shown on the discharge papers. The Period of Hospitalization must be necessary because of injury, Illness or childbirth and begin while insurance under the policy is in force.

If an injury of Illness requires more than one period of Hospitalization, then the maximum benefit period of 120 days in a Hospital will be reinstated provided that at least 61 days has elapsed between such periods of Hospitalization.

HEALTH PROFESSIONALS

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

Paramedical Services: Services of the practitioner disciplines specified in the Benefit Schedule and up to the maximum amount specified in the Benefit Schedule, provided that the practitioner is operating within his recognized field. He must be a member in good standing of his professional association that must be recognized by the Insurer. Unless otherwise indicated in the Benefit Schedule, these services do not require prior Medical Recommendation.

Imaging techniques ordered by a chiropractor, a podiatrist, a chiropodist or an osteopath are covered, up to the maximum amount specified in the Benefit Schedule.

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.

MOBILITY AIDS

Wheelchair: Rental or purchase, at the discretion of the Insurer.

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.

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

Orthopaedic shoes: Purchase, up to a payable amount of $350 per Insured Person for any period of 24 months. This maximum is combined with the maximum for Podiatric Orthesis or arch support. 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, in-depth shoes and shoes required for Denis Browne braces. The cost of modifications or adjustments to stock item footwear is also eligible; off-the-shelf shoes that are regular stock are excluded.

ORTHESIS AND PROSTHESIS

Podiatric Orthesis or arch support: Purchase, up to a payable amount of $350 per Insured Person for any period of 24 months. This maximum is combined with the maximum for Orthopaedic shoes.

Artificial limb: Purchase and repair; replacement is included when required due to physiological change.

Artificial eye: Purchase.

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, up to a payable amount of $300 per Insured Person for any period of 5 consecutive years.

Surgical brassieres: Purchase of 2 surgical brassieres per Insured Person each Calendar Year.

Hearing aids: Purchase, repair and replacement (excluding batteries), on the written prescription of a licensed otolaryngologist, up to a payable amount of $400 per Insured Person for any period of 4 consecutive years.

Wigs: Purchase of wigs required as a result of chemotherapy, up to a lifetime maximum of one wig per Insured Person.

THERAPEUTIC EQUIPMENT

Glucometer or reflectant meter: Purchase, or rental, upon medical recommendation, up to a lifetime maximum of one device per Insured Person.

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

Plasma, blood or blood substances: Purchase.

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.

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. 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 support stockings dispensed in a pharmacy or a medical facility, up to a maximum of two pairs per Insured Person each Calendar Year.

Stump socks: Purchase, up to a maximum of two per Insured Person each Calendar Year.

Intra-uterine devices: Purchase.

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

Catheter: Purchase.

Hypodermic needles: 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

X-ray examinations and diagnostic laboratory tests. 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, up to a payable amount of $5,000 per Accident per Insured Person. 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.

EYEGLASSES, LENSES AND EYE SURGERY

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

Eye examinations for adults between the ages of 20 and 64: Including eye refraction, provided they are performed by a qualified ophthalmologist or a licensed optometrist, up to the maximum specified in the Benefit Schedule. Eye examinations for Children are currently covered by the Ontario Health Insurance Plan (OHIP).

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

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

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

The Insured Person may contact HEALTH ASSISTANCE at any time.

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

ELIGIBLE EXPENSES – OUTSIDE PROVINCE OF RESIDENCE

All Eligible Expenses incurred on an emergency basis outside the normal province of residence of the Insured Person are limited to the reasonable and customary charges in the area in which they are incurred and the charges in excess of the amounts reimbursed by the provincial hospital and/or health insurance plan of the normal province of residence of the Insured Person.

TRAVEL INSURANCE

If an Insured Person covered under government health and hospital insurance plans incurs Medical Emergency expenses as a result of an Accident or Illness that occurs while travelling outside his province of residence during the first 45 days of a trip, Eligible Expenses will be reimbursed in accordance with the Benefit Schedule, provided they are eligible under this section and not payable by a government body or under another private insurance plan.

1) Eligible Health Care Expenses

   a) Hospital services and room and board charges in a semi-private room;

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

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

2) Eligible Transportation Expenses

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

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

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

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

e) Cost of returning the personal or rented Vehicle of the Insured Person if the Insured Person suffers from a disability as a result of a Medical Emergency, certified by a Physician, that prevents him from operating this Vehicle and none of the Immediate Family members accompanying him are able to return it. A commercial agency may be hired to return the Vehicle, but the return must be arranged and approved by "Voyage Assistance". The amount reimbursed is limited to $1,000 per Participant.

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

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

3) Eligible Daily Allowance: the cost of meals and accommodations for an Insured Person who must delay his return because of an Illness or bodily injury suffered by the Insured Person himself, an accompanying member of his Immediate Family or a travelling companion, as well as additional child care expenses for Children not accompanying the Insured Person. Eligible Expenses are limited to $150 per day per Participant for a maximum of 7 days and the Illness or injury must be certified by a Physician.

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

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

6) Voyage Assistance service

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

a) 24 hour toll-free telephone assistance;

b) referral to Physicians or health-care facilities;

c) assistance for Hospital admission;

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

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

f) establishing and staying in contact with the Insurer;

g) handling arrangements in the event of death;

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

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

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

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

l) referral to lawyers if legal problems arise;

m) translation services for emergency calls;

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

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

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

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

RESTRICTIONS, EXCLUSIONS AND LIMITATIONS

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

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

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

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

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

   e) services, treatment or supplies provided to the Participant 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) eye examinations, including refraction, except if otherwise mentioned elsewhere in this benefit;

t) 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 as smoking cessation aids;

g) products used in fertility treatment.

h) expenses used to cover the Ontario Drug Benefit Program co-insurance amount for individuals insured under this public plan.

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.

4) Exclusions and limitations applicable to Travel Insurance

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

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

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

b) if the purpose of the trip is to receive medical or paramedical treatment or hospital services, even if the trip was recommended by a Physician; or

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

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

Travel Insurance benefits are limited to the maximum amount and duration specified in the Benefit Schedule.

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 PARTICIPANT ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT, 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 PARTICIPANT ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT, such expenses will be payable under the ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT 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 Participant attains the Age Limit specified in the Benefit Schedule or on the earliest of the dates indicated in the TERMINATION OF PARTICIPANT INSURANCE provision.

DEPENDENT BENEFIT EXTENSION AFTER PARTICIPANT'S DEATH

(Not applicable to Part Time Members)

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

1) 12 months following the death of the Participant;

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

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

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

NOTICE AND PROOF OF CLAIM

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

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

DRUG CLAIMS

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

DENTAL CARE BENEFIT

DEFINITIONS

As used in this Benefit

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

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

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

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

PAYMENT OF BENEFIT

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

To be eligible, the expenses must have been performed

1) by a Dentist; or

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

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

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

COMMENCEMENT OF DEPENDENT INSURANCE

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

DEDUCTIBLE

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

PERCENTAGE OF REIMBURSEMENT

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

ELIGIBLE EXPENSES IN CANADA

PREVENTIVE SERVICES

EXAMINATIONS

- Complete oral examination, once every 36 months
- Recall oral examination, according to the frequency specified in the Benefit Schedule
- Specific oral examination, once every 9 months
- Emergency oral examination

RADIOGRAPHS (X-RAYS)

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

LAB TESTS AND EXAMINATIONS

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

CASE PRESENTATION AND EXPLANATION

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

PREVENTIVE SERVICES

- 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
- Oral hygiene instruction, once every 9 months
- 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 (including root planing) performed by a Dentist limited to a maximum of 10 units per Calendar Year

c) scaling for therapeutic purposes limited to a maximum of 10 units per Calendar Year

d) occlusal equilibration limited to a maximum of 8 units per Calendar Year

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

MAINTENANCE OF REMOVABLE DENTURES

- Repair, once every 24 months
- Structure addition (to an existing removable dentures)
- Relining, once every 24 months
- Rebasing, once every 24 months
- 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.

MAJOR RESTORATIVE SERVICES

PROSTHODONTICS

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

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

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

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

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

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

REMOVABLE DENTURES

- Complete denture
- Immediate complete denture
- Complete or partial overdenture
- Transitional denture
- Partial denture including cast in chrome (but not in gold)

- Partial denture remake
- Remount with occlusal equilibration
- Therapeutic tissue conditioning

FIXED PROSTHODONTICS (bridges)

- Abutments and pontics
- Repairs
- Bridge removal
- Recementation

OTHER SINGLE RESTORATIONS

- Onlays, veneers applications, inlays, crowns
  - a) for a tooth that is fractured due to caries or traumatic injury and cannot be filled by amalgam or composite
  - b) temporary crowns are considered to be part of the final restoration
  - c) replacement of an existing onlay, veneer application, inlay or crown is included if such restoration is at least 5 years old
  - d) only metal crowns on molars are reimbursed
- Porcelain repair
- Retentive pins, pivots, cast posts
- Recementation
- Removal of an inlay or crown

ORTHODONTICS

(Not applicable to Part Time Members)

If a Dependent Child under Age 19, while insured under this Benefit, incurs Eligible Expenses that are for necessary dental treatment, which has as its objective the correction of malocclusion of the teeth, as listed below, the Insurer will reimburse such expenses, in accordance with the provisions of the policy and subject to any maximum specified in the Benefit Schedule.

- services for diagnostic purposes
- preventive orthodontic treatment

- comprehensive orthodontic treatment
- appliances to control harmful oral habits

ELIGIBLE EXPENSES OUTSIDE CANADA

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

RESTRICTIONS, EXCLUSIONS AND LIMITATIONS

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 50% of the suggested fee in the appropriate Fee Guide, as specified in the Benefit Schedule, for the particular dental treatment requiring the lab services.

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

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

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

2) charges for nutritional counselling 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 Participant by the Employer;

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

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

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

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

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

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

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

EXCLUSIONS RELATED TO PROSTHESES AND CROWNS

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

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

2) prosthetics with precision attachments or stress breakers;

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

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

5) transfer coping for crowns.

EXCLUSIONS RELATED TO ORTHODONTIC TREATMENT

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

1) myofunctional therapy;

2) replacement or repair of an orthodontic appliance;

3) patient motivation (psychological evaluation and progress, per visit);

4) procedure requiring the insertion of an adjustable orthodontic appliance before the person is insured under this Benefit.

CO-ORDINATION OF BENEFITS

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

PRE-DETERMINATION OF BENEFIT

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

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

BENEFIT TERMINATION

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

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

DEPENDENT BENEFIT EXTENSION AFTER PARTICIPANT'S DEATH

(Not applicable to Part Time Members)

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

1) 12 months following the death of the Participant;

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

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

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

PROOF OF CLAIM

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

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

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

PAYMENT OF ORTHODONTIC CLAIMS

Notwithstanding anything to the contrary under the CLAIMS provision of the policy, the payment of orthodontic claims will be made on one of the following bases:

1) If a single charge is estimated for the entire course of treatment and the Insured Person pays this charge to the orthodontist in prearranged instalments over an estimated period of treatment or in one lump sum, the Insurer will reimburse the Participant each time he submits a bill, certificate or receipt that specifies the amount of expenses, the date and the nature of the treatment received; or

2) If in lieu of a single charge, a charge is made for each treatment as it is performed, the Insurer will reimburse the Participant as each charge is incurred.

GROUP INSURANCE

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