ATTENTION:

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Attached to and forming part of Group Policy No. H.330706-1 issued to

THE CORPORATION OF THE CITY OF VAUGHAN AND THE VAUGHAN PUBLIC LIBRARY BOARD

This policy has been amended:

1. effective January 1, 2020 in respect of the following provisions:

GENERAL DEFINITIONS
POLICY DETAILS - POLICY ADMINISTRATOR

2. effective November 25, 2022 in respect of the following provisions:

POLICY DETAILS - MEDI-PACK BENEFIT
POLICY DETAILS – DENTAL CARE BENEFIT – 1
PAY DIRECT DRUG BENEFIT
MEDI-PACK BENEFIT

Revision Instructions

Deleted Pages	Replacement Pages
Cover Page	Cover Page (Jan.01.20)
Agreement Page	Agreement Page (Jan.01.20)
4	4 (Jan.01.20)
13 (Jan.30.18)	13 (Nov.25.22)
Prepared: April 24, 2018	
14	14 (Nov.25.22)
16	16 (Jan.01.20))
41b (Jun.28.16)	41b (Nov.25.22)
51 (Apr.01.16)	51 (Nov.25.22)

The payment of any amount of premium due on or after the effective date of this amendment in respect of the insurance provided under this policy shall be considered evidence of the Group Policyholder's acceptance of this amendment.

Signed at The Canada Life Assurance Company, Regina, Saskatchewan, on January 10, 2023.

President and
Chief Executive Officer

President and
Chief Operating Officer, Canada

Accepted and attached to this policy on ____________________________.

____
Signature

____
Title

GROUP INSURANCE POLICY

GROUP POLICYHOLDER:	**THE CORPORATION OF THE CITY OF VAUGHAN**
	AND THE VAUGHAN PUBLIC LIBRARY BOARD
GROUP POLICY NO.:	**H.330706-1**
EFFECTIVE DATE:	**November 1, 2015**
INSURANCE PROVIDED:	**Health, Dental and Disability Income Insurance for Vaughan Professional Firefighters' Association Members**

(Jan.01.20)

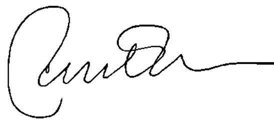
AGREEMENT

Canada Life agrees to pay the benefits provided by this policy to the persons entitled to receive them. This agreement is made in consideration of the Group Policyholder's payment of the required premiums.

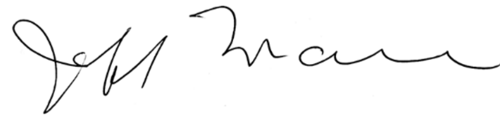
This policy takes effect at 12:01 a.m. on the Effective Date, local time at the Group Policyholder's address.

The following pages and any riders or amendments are a part of this policy.

Signed at The Canada Life Assurance Company, Winnipeg, Manitoba



President and
Chief Executive Officer



President and
Chief Operating Officer, Canada

TABLE OF CONTENTS

NAME OF PROVISION	PAGE NUMBER
REWRITTEN POLICY	3
GENERAL DEFINITIONS	4
POLICY DETAILS	6
EMPLOYER	6
EMPLOYEE	6
ELIGIBILITY DATE	7
TERMINATION DATE	7
ELIGIBLE EMPLOYEE CLASS DESCRIPTIONS	8
BENEFITS	8
EMPLOYEE LONG TERM DISABILITY INCOME BENEFIT	9
HOSPITAL BENEFIT	10
PAY DIRECT DRUG BENEFIT	11
MEDI-PACK BENEFIT	12
DENTAL CARE BENEFIT - 1	14
DENTAL CARE BENEFIT - 2	15
POLICY ADMINISTRATOR	16
PARTICIPATION REQUIREMENTS	16
HOW AND WHEN AN EMPLOYEE'S INSURANCE TAKES EFFECT	17
HOW AND WHEN A DEPENDENT'S INSURANCE TAKES EFFECT	18
CHANGES IN AN EMPLOYEE'S AMOUNT OF INSURANCE	19
CHANGES IN A DEPENDENT'S BENEFITS	19
WHEN AN EMPLOYEE'S INSURANCE TERMINATES	20
WHEN A DEPENDENT'S INSURANCE TERMINATES	21
PROOF OF CLAIM	22
PAYMENT OF CLAIM	23
PHYSICAL EXAMINATION	23
LEGAL ACTIONS	23
SUBROGATION (Third Party Liability)	24
COORDINATION OF BENEFITS	25
PREMIUMS	26
PERIOD OF GRACE	27
CURRENCY	27

TABLE OF CONTENTS

NAME OF PROVISION **PAGE NUMBER**

CONTESTABILITY 27

AGE AND SEX 27

AMENDMENTS TO THE POLICY 28

CONTRACT 28

TERMINATION OF POLICY 28

EMPLOYEE LONG TERM DISABILITY INCOME BENEFIT 29

HOSPITAL BENEFIT 35

PAY DIRECT DRUG BENEFIT 37

MEDI-PACK BENEFIT 42

DENTAL CARE BENEFIT - 1 52

DENTAL CARE BENEFIT - 2 63

REWRITTEN POLICY

This policy replaces the previous policy bearing No. H.330706, issued by us with an effective date of April 1, 2009, including any amendments that were made to such previous policy.

Each Employee, described in the Employee section of the Policy Details for this policy, who was insured under the previous policy immediately prior to the Effective Date of this policy will be insured under this policy on the Effective Date. However, only the terms of the previous policy will apply to him if he is not Actively at Work on the Effective Date of this policy. The terms of this policy will begin to apply to him when he is again Actively at Work subject to the following exceptions:

1. An Employee and his Dependents, if any, will become insured under a Benefit included in this policy that they were not insured for under the previous policy only when any requirements set out in this policy with respect to becoming insured under additional Benefits have been met.

2. If this policy includes any Benefit which provides for the replacement of lost income and the Employee suffers a recurrence of a Disability which commenced while he was insured under the previous policy then the Benefit included in this policy will not apply to him until such Continuous Period of Disability has ended and he is again Actively at Work.

Neither of the following will apply to an Employee who was insured under the previous policy immediately prior to the Effective Date of this policy:

1. The completion of the period of service, if any, that is described in the Eligibility Date section of the Policy Details.

2. The How and When an Employee's Insurance Takes Effect provision of this policy.

A Dependent, of an Employee who becomes insured under this policy as described above, will become insured under this policy at the same time as the Employee if the Dependent was insured under the previous policy immediately prior to the Effective Date of this policy. However, only the terms of the previous policy will apply to the Dependent in either of the situations described below:

1. If the Employee of whom he is a Dependent is not Actively at Work on the Effective Date of this policy, the terms of this policy will begin to apply to the Dependent when the Employee is again Actively at Work.

2. If the Dependent is confined to a hospital on the Effective Date of this policy, the terms of this policy will begin to apply to the Dependent on the day after the day he is discharged from the hospital.

If both situations exist then the terms of this policy will begin to apply to the Dependent at whichever of the times specified in clause 1 and 2 occur the latest.

The terms of the How and When Dependent's Insurance Takes Effect provision will not apply to a Dependent who was insured under the previous policy immediately prior to the Effective Date of this policy.

GENERAL DEFINITIONS

The terms that are defined in this provision are used throughout the policy. Terms that apply to a specific Benefit provision are defined in the Definitions section of that provision. The words he, him and his refer to all genders.

"You" and "your" mean the Policyholder.

"We", "our" and "us" mean The Canada Life Assurance Company.

"Actively at Work" means that an Employee is

(a) actually performing his normal duties, if it is a scheduled work day, or

(b) capable of performing his normal duties, if he is not at work due to a non-scheduled work day, holiday or vacation day,

at his normal place of employment or at some other location where his Employer's business requires him to be.

"Annual Earnings" as used to determine the insurance benefits of an Employee under this policy will be calculated as his annual gross base earnings from the Employer, excluding any income he receives from the Employer such as but not limited to bonuses, dividends, overtime and profit sharing.

However, if an Employee's income includes commissions his Annual Earnings will be calculated as follows:

(a) If he has been employed by the Employer for at least 2 calendar years, his average annual gross earnings during the preceding 2 calendar years as set forth on his T-4 Taxation Form.

(b) If he has been employed by the Employer for less than 2 calendar years, the amount that is estimated by the Employer. The estimate must reflect a reasonable expectation of the income to be earned. We will verify the estimate with the Employer at the time a claim is submitted to us. The benefits of a person will be based on the lesser of (1) his actual earnings and (2) the estimated level of earnings on which premiums were being paid. A premium refund will be made if actual earnings are less than the estimated earnings.

(c) Any change in his Annual Earnings will be deemed to take effect only on April 1st in each year.

"Monthly Earnings" will be the Annual Earnings of the Employee divided by 12.

"Dependent" means the following:

1. Either the spouse or common-law spouse of an Employee. There may be only one such person insured under this policy at a time. An Employee must complete an application for dependent's insurance if he wishes to change or add a legally married or common-law spouse that is to be insured. Benefits will only be paid with respect to the person recorded as being the Employee's spouse or common-law spouse. If a common-law spouse is insured the word "spouse" will mean "common-law spouse" where it is used throughout this policy.

2. Each unmarried child, step-child or common-law child of an Employee provided the child relies fully upon the Employee for support and maintenance and fits one of the following descriptions:

   (a) The child is under 22 years of age.

   (b) The child is at least 22 years of age but under 25 years of age and is attending an accredited educational institute, college or university on a full-time basis.

   The attainment of any maximum age specified above will not terminate the insurance on the life of an insured dependent child if at the time the child is incapable of self-support due to mental or physical handicap and relies upon the Employee for support and maintenance. The Employee may be required to submit proof satisfactory to us of the child's state of incapacity at the time a claim is incurred under this policy.

However, for the purposes of this policy, anyone who is in full-time service in any naval, military or air force will be excluded from this definition.

"Common-law spouse" will mean a person of the same or different gender whom the Employee publicly represents as his spouse and has been living with for the past 24 months.

"Common-law child" will mean a child of the common-law spouse from another relationship who resides with and is in the care and custody of the Employee and his common-law spouse.

POLICY DETAILS

The Policy Details provision describes some of the details of this policy. These details are referred to in the other provisions of this policy and do not detract from the importance of the other provisions. Please refer to the rest of the policy for a full explanation of the insurance benefits including the limitations and exclusions that apply.

EMPLOYER	-	You.
EMPLOYEE (Who May Be Insured)	-	Each person who is a Vaughan Professional Firefighters' Association Member who works at least 42 hours per week on a regular basis for an Employer
		Each person who ceases/ceased to be employed by the Employer due to retirement in accordance with the OMERS Act while insured under this policy or a policy which was replaced by this policy, and who has permanently worked, up to the date of retirement, for at least 5 continuous years for an Employer
		If an Employer is a partnership or sole proprietorship we will consider a partner or proprietor to be an Employee if such person works at least 20 hours per week on a regular basis on behalf of the Employer.
		A resident of a foreign country who is employed outside of Canada or the United States by an Employer may not be insured under this policy.

ELIGIBILITY DATE (The Earliest Date an Employee May Become Insured)	-	The date this policy took effect, if the person is an Employee on such date. The day following completion of 3 months of continuous employment for an Employer, if the person is not an Employee on the date this policy took effect. The earliest first day of the Policy Month following the month in which the Employee's 65th birthday occurs, with respect to a retired Employee. Such other date requested by you that we have agreed to in writing.
TERMINATION DATE	-	None, with respect to a Non-retired Employee who qualifies for post-retirement coverage as a Retired Employee. The end of the month in which a Non-retired Employee's 65th birthday occurs, with respect to a Non-retired Employee who does not qualify for post-retirement coverage as a Retired Employee. The Termination Date shown above will apply to all Employees except as otherwise stated on the Benefit pages of these Policy Details.

POLICY DETAILS

ELIGIBLE EMPLOYEE CLASS DESCRIPTIONS

Class Description

Vaughan Professional Firefighters' Association Members

Retired Vaughan Professional Firefighters' Association Members under age 65

Retired Vaughan Professional Firefighters' Association Members age 65 and over

BENEFITS

The Benefits included in this policy and the classes of Employees that they apply to are shown below:

Benefit Name	Classes
Employee Long Term Disability Income Benefit	Non-retired Employees
Hospital Benefit	All Employees
Pay Direct Drug Benefit	All Employees
Medi-Pack Benefit	All Employees
Dental Care Benefit - 1	Non-retired Employees
Dental Care Benefit - 2	Retired Employees

POLICY DETAILS

EMPLOYEE LONG TERM DISABILITY INCOME BENEFIT

No Benefit payments will be made under this provision for a Continuous Period of Disability that starts after the Employee attains his 65th birthday.

The Monthly Amount of Disability Income Benefit for each insured Employee will be determined from the following Schedule:

Classes	**Monthly Benefit**
Non-retired Employees	75% of Monthly Earnings, maximum Monthly Benefit of $8,000

If a Monthly Benefit calculated above is not a multiple of $1.00, it will be increased to the next higher multiple of $1.00.

The Monthly Benefit is subject to the reductions described in the Benefit provision.

Maximum Benefit Payment Period	-	To the Employee's 65th birthday or, if he has not received at least 12 Monthly Benefit payments in a Continuous Period of Disability, to the date on which he receives such 12th payment.
Elimination Period	-	182 DAYS

POLICY DETAILS

HOSPITAL BENEFIT

Deductible Amount	-	Nil.
Benefit Amount	-	The amount of the difference between the hospital's average semi-private room rate and its room rate for ward accommodation with respect to Non-retired Employees. The amount of the difference between the hospital’s average private room rate and its room rate for ward accommodation with respect to Retired Employees.

POLICY DETAILS

PAY DIRECT DRUG BENEFIT

Benefit Amount	-	100% of the amount of the Eligible Charges that exceed the Deductible Amount, with respect to Non-retired Employees.
	-	90% of the amount of the Eligible Charges that exceed the Deductible Amount, with respect to Retired Employees.
Deductible Amount	-	$3 per prescription, with respect to Non-retired Employees only.
Maximum Benefit Amount	-	$500 lifetime, with respect to all nicotine resin containing products, with respect to Non-retired Employees.
Eligible Charges	-	Are described in the Benefit Provision.

POLICY DETAILS

MEDI-PACK BENEFIT

Deductible Amount	-	Nil, with respect to Non-retired Employees and Retired Employees under age 65.
	-	$100 for an Employee and $100 in total for all of an Employee's insured Dependents, with respect to Retired Employees age 65 and over.
Benefit Amount	-	100% of the amount of the Eligible Charges that exceeds the Deductible Amount.
Eligible Charges	-	Are described in the Benefit provisions.

This Benefit also includes the Medi-Pack Benefit Supplements outlined on the following page. The Eligible Charges described in the Supplements are subject to the Deductible and Benefit Amounts shown above unless otherwise stated in the Supplement.

POLICY DETAILS

MEDI-PACK BENEFIT SUPPLEMENT(S)

Supplement	Benefit Maximum
Vision Care (not applicable to an Insured once laser eye surgery expenses are paid under the Medical Reimbursement Benefits contract)	
Eye Glasses or Contact Lenses	- $450 in any 2 consecutive calendar years, with respect to a Retired Employee - $550 in any 2 consecutive calendar years, with respect to a Non-retired Employee.
Eye Examinations	- Charges for eye examinations, services for training and remedial exercises, and diagnosis and treatment of accidental injury or disease to the eyes are described in the Benefit Supplement and subject to the maximum under Vision Care. Charges up to $10 per half-hour for visual motor therapy to a legally licensed ophthalmologist or optometrist.
Contact Lenses	- $200 lifetime maximum if visual acuity is improved to the 20/40 level which is not possible through eye glasses.
Paramedical Services	- Charges up to $70 per visit for the services of a legally licensed chiropractor, osteopath, naturopath, podiatrist, physiotherapist, speech therapist or massage therapist, with respect to a Non-retired Employee. - Charges up to $50 per visit for the services of a legally licensed chiropractor, osteopath, naturopath, podiatrist, physiotherapist, speech therapist or massage therapist, with respect to a Retired Employee . - X-rays by a licensed chiroprator not to exceed $70 per person per calendar year, with respect to a Non-Retired Employee. - X-rays by a licensed chiroprator not to exceed $50 per person per calendar year, with respect to a Retired Employee. Surgery performed by a podiatrist not to exceed $200 person per calendar year. - $3,500 per calendar year for the services of a legally licensed psychologist, psychotherapist or social worker, with respect to a Non-retired Employee. - $2,500 per calendar year for the services of a legally licensed psychologist, with respect to a Retired Employee. Charges per visit are not to exceed $50 per half-hour for individual psychotherapy and testing, $50 per half-hour for family therapy, $50 per hour for group therapy, and $50 for all other visits, to a maximum of 10 visits in a calendar year for all eligible charges.

POLICY DETAILS

DENTAL CARE BENEFIT - 1

Schedule of Fees	-	Current Ontario Dental Association Fee Guide.
Deductible Amount	-	Nil.

Benefit Amounts

Dental 1 Charges	-	100%
Dental 2 Charges	-	100%
Dental 3 Charges	-	80%
Dental 4 Charges	-	100%

Maximum Benefit Amounts

Dental 1 Charges	-	Unlimited
Dental 2 Charges	-	Unlimited
Dental 3 Charges	-	$1,500 per person in any calendar year.
Dental 4 Charges	-	$1,500 per year for each dependent child.
	-	$3,000 lifetime for adults

POLICY DETAILS

DENTAL CARE BENEFIT - 2

Schedule of Fees	-	Current less 3 years Dental Association Fee Guide.
Deductible Amount	-	Nil.

Benefit Amounts

Dental 1 Charges	-	100%
Dental 2 Charges	-	100%

Maximum Benefit Amounts

Dental 1 Charges	-	Unlimited
Dental 2 Charges	-	Unlimited

POLICY DETAILS

GENERAL

POLICY ADMINISTRATOR	-	The Canada Life Assurance Company.
PARTICIPATION REQUIREMENTS	-	This policy requires that the larger of the Participation Requirements shown below be maintained at all times:

1. At least 75% of all the Employees with no dependents and 50% of those Employees with dependents who qualify under the definition of Employee must be insured.

2. At least 10 Employees must be insured.

Please notify us if the participation of the Employees in this policy changes from an optional basis to a mandatory basis or the reverse. Such a change will affect the Participation level that must be maintained under this policy.

HOW AND WHEN AN EMPLOYEE'S INSURANCE TAKES EFFECT

An Employee will become insured under this policy on whichever of the dates shown below applies to him provided that he is then Actively at Work. If he is not Actively at Work on the date on which he would otherwise become insured he will become insured only when he is again Actively at Work.

1. If his application to become insured is completed on or before his Eligibility Date, his Eligibility Date.

2. If his application to become insured is completed no more than 30 days after his Eligibility Date, his Eligibility Date.

3. If his application to become insured is completed more than 30 days after his Eligibility Date, the date on which we have, in writing, either approved evidence of his insurability or waived such requirement. Any evidence required under this provision must be provided without expense to us.

The Eligibility Date of an Employee is shown in the Policy Details.

The application to become insured must be completed on a form approved for that purpose by us. It must be promptly deposited with the Policy Administrator.

Notwithstanding the above, a retired Employee who was insured under a policy which was replaced by this policy will become insured under this policy on the Effective Date.

HOW AND WHEN A DEPENDENT'S INSURANCE TAKES EFFECT

A Dependent will become insured under this policy on whichever of the following dates is applicable:

1. With respect to an Employee who has a Dependent at the time he becomes insured under the policy:

   (a) If the application for Dependent's insurance is completed on or before the Employee's Eligibility Date, the Employee's Eligibility Date.

   (b) If the application for Dependent's insurance is completed no more than 30 days after the Employee's Eligibility Date, the Employee's Eligibility Date.

   (c) If the application for Dependent's insurance is completed more than 30 days after the Employee's Eligibility Date, the date on which we have, in writing, either approved evidence of the Dependent's insurability or waived such requirement.

2. With respect to an Employee who has no Dependents at the time he becomes insured under this policy and later acquires a Dependent:

   (a) If the application for Dependent's insurance is completed no more than 30 days after he acquires a Dependent, the date on which the Dependent is acquired.

   (b) If the application for Dependent's insurance is completed more than 30 days after acquiring a Dependent, the date on which we have, in writing, either approved evidence of the Dependent's insurability or waived such requirement.

Insurance on any Dependent child of an Employee who is acquired while he has any other Dependents insured under this policy, will take effect on the date on which such Dependent is acquired and an application has been completed on such Dependent.

A Dependent, other than a new-born child, who is confined in a hospital on the date that he would otherwise become insured, will not become insured until the first day after the date of his discharge from the hospital.

An Employee must complete an application for the insurance:

1. on each Dependent including Dependent children, and

2. if he later wishes to change or add a legally married or common-law spouse.

Such application for Dependent's insurance must be on a form approved for that purpose by us and promptly deposited with the Policy Administrator.

Any evidence required under this provision must be provided without expense to us.

CHANGES IN AN EMPLOYEE'S AMOUNT OF INSURANCE

You must deposit written notice with the Policy Administrator of any change in the class or earnings of an Employee which would affect the amount of his insurance.

A decrease in the amount of his insurance will take effect on the date stated in the notice.

An increase in the amount of his insurance other than due to a change to a class with additional Benefits will take effect on whichever of the dates shown below applies to him provided that he is then Actively at Work. If he is not Actively at Work on the date on which the amount of his insurance would otherwise increase, the increase will take effect only when he is again Actively at Work.

1. If we receive the notice from you no more than 30 days after the date of change, the date stated in the notice.

2. If we receive the notice from you more than 30 days after the date of change, the date on which we have, in writing, either approved evidence of his insurability or waived such requirement.

An increase in the amount of his insurance due to a change to a class with additional Benefits will take effect on the date that we have, in writing, either approved evidence of his insurability or waived such requirement.

If we decline evidence of his insurability, the amount of his insurance will be limited to that which applied to him prior to the change in his class or earnings. It may not be increased for any reason until we approve evidence of his insurability.

When we are calculating the amount of a benefit based on earnings that has become payable with respect to an Employee under this policy, we will use whichever of the following amounts was the smaller at the time the Loss was incurred or the Disability commenced:

1. The Employee's actual earnings as defined in the General Definitions provision.

2. The level of earnings on which the premium for the Employee's benefit was being paid.

Any evidence required under this provision must be provided without expense to us.

CHANGES IN A DEPENDENT'S BENEFITS

If an Employee has any Dependents insured under this policy at the time his class changes to one with additional Benefits, such Dependents will become insured for the additional Benefits on the date on which we have, in writing, either approved evidence of the insurability of his Dependents or waived such requirement. Any evidence required under this provision must be provided without expense to us.

If the class of an Employee is changed so that his coverage under one or more Benefits terminates, his Dependents, if any, will cease to be insured under such Benefits at the same time.

WHEN AN EMPLOYEE'S INSURANCE TERMINATES

All of an Employee's insurance under this policy will terminate at the earliest time shown below:

1. On termination of his employment. However, if his Employer has terminated his employment and is required to extend benefits to him during a prescribed notice of termination in accordance with any federal or provincial employment standards legislation, he may continue to be insured under this policy for that period provided his Employer has asked for the continuation in writing. No such continuation will be effective until approved in writing by us and in no event will it extend beyond the date on which this policy terminates.

2. The date on which he ceases to be an Employee as described in this policy. However, if an Employee is absent from work due to injury, disease, illness, pregnancy or mental disorder, his insurance will be continued in force under this policy until the date stated in a written notice deposited with the Policy Administrator that the Employee's insurance is to be terminated.

3. The date on which this policy terminates.

4. If an Employee is absent from work due to a temporary lay-off, the earlier of (a) the date stated in a written notice deposited with the Policy Administrator that the Employee's insurance is to be terminated and (b) the last day of the 6th month that follows the month in which his absence from work began.

5. If an Employee is absent from work due to a leave of absence, the earlier of (a) the date stated in a written notice deposited with the Policy Administrator that the Employee's insurance is to be terminated and (b) the end of the 12th month following the date his absence from work began.

6. On the date of his retirement unless otherwise stated in the Policy Details.

7. The day before he attains the Termination Date shown in the Policy Details.

8. When he goes on strike or is locked-out unless there is a written agreement between you and us that he will continue to be insured under this policy during the strike or lock-out.

9. The day before he enters service in any naval, military or air force.

10. The date that is stated in the notice that an Employee has asked, in writing, to have his insurance terminated. This clause will only apply if participation in this policy is at his option.

If an event that is described above occurs, written notice must be deposited with the Policy Administrator within 31 days. Failure to give notice within such 31 day period will result in insurance not being continued in force beyond the time it would terminate as shown above.

WHEN A DEPENDENT'S INSURANCE TERMINATES

All of a Dependent's insurance under this policy will terminate at the earliest time shown below:

1. When he ceases to be a Dependent as defined in this policy.

2. When the Employee of whom he is a Dependent ceases to be insured under this policy or ceases to be insured under all of the Benefits included in this policy for which his Dependents are eligible.

3. The date that is stated in the notice, that the Employee has asked, in writing, to have his Dependents cease to be insured. This clause will only apply if participation in this policy is at the option of the Employee.

PROOF OF CLAIM

Proof satisfactory to us that a claim has been incurred under any Benefit provision of this policy must be given to us at our Head Office. If such proof is not received by us within the time period shown below we will have no liability for the claim.

- Proof of a Disability under the Employee Long Term Disability Income Benefit must be given to us within 90 days after the last day of the Elimination Period shown in the Policy Details.

- Proof of all claims with respect to the Group Life Advance Plus Benefit must be received no later than 90 days after the end of the Group Life Advance Plus Qualifying period.

- Proof of a charge incurred or proof of the performance of a service insured under any other Benefit provision of this policy must be given to us within 180 days after the end of the year in which the charge was incurred or the service performed.

However, if this policy terminates, any proof that is required with respect to a claim must be given to us within 90 days after the date that this policy terminates.

We may demand proof of the continuance of an Employee's Disability under the Employee Long Term Disability Income Benefit after initial proof is given to us when and as often as we may reasonably require it. If such proof is not given to us by the time requested he will be deemed to have ceased to be Disabled immediately prior to the date that we made such demand.

We may require additional information to aid in the determination of benefits payable under the Dental Care Benefit provision. Such additional information includes, but is not limited to, the following:

1. A complete dental chart showing extractions, missing teeth, fillings, prostheses, periodontal pocket depths, orthodontic relationships and the date of any work previously done.

2. An itemized claim form for all dental care.

3. Preoperative X-rays, study models and laboratory reports.

The Benefits with respect to which a claim was made will only be paid if such additional information is submitted to us as required.

PAYMENT OF CLAIM

All Benefit payments under this policy will be subject to receipt by us of due proof of claim.

Employee Long Term Disability Income Benefit payments will be made monthly in arrears during any period for which we are liable. Any balance remaining unpaid at the end of such period will be paid at that time.

All other Benefit payments under this policy will be made when due.

PHYSICAL EXAMINATION

We will have the right and opportunity, at our own expense, to have a physician of our choice examine anyone in respect of whom a claim is being made when and as often as we may reasonably require. The Benefits with respect to which the claim was made will not be paid if the person fails to submit to the medical examination requested by us.

LEGAL ACTIONS

No action or proceeding against us in respect of a claim made under this policy will be started within 60 days of the date on which initial proof of the claim is given to us. No such action will be taken against us more than one year (or such longer period that is specifically required by law) after the end of the period within which initial proof of claim is required by us.

SUBROGATION (Third Party Liability)

In the event that benefits under this policy are payable with respect to an Employee or any of his Dependents and in the further event that such Employee or Dependent has a right to recover damages from any individual or organization, we will be subrogated in the amount of any benefits paid under this policy to the rights of recovery of the Employee or Dependent against any such individual or organization. The Employee or Dependent will reimburse us in the amount of any benefits paid, out of the damages recovered. Without limiting the generality of the foregoing, the term damages will include any lump sum or periodic payments received on account of (1) past, present or future loss of income, and (2) any other benefits, otherwise payable under this policy.

The Employee shall be required to notify us immediately if he or his Dependent commences an action against a third party which includes a claim for wage loss or for any other benefits, otherwise payable under this policy. The Employee's or Dependent's solicitor shall represent our subrogated rights unless we give notice that we wish to appoint another solicitor to act on our behalf. We reserve our right to commence an action to pursue our subrogated rights against the third party, in which event, the Employee or Dependent agrees to fully co-operate with us in pursuing our claim against the third party.

The Employee or Dependent shall be required to tell us about any judgements or settlements of claims against a third party in the circumstances indicated above. The Employee or Dependent shall also give all records, transcripts, reports and information to us that we may reasonably demand with respect to the calculation or allocation of damages.

If a lump sum payment is made under judgement or settlement for loss of future income or for future periodic or lump sum benefits which would otherwise be payable under this policy, no further benefits will be paid under this policy until such time as the monthly or periodic benefits which would otherwise be payable under this policy equal the amount received in a lump sum.

If a claim for damages against a third party is settled before trial, we shall be reimbursed the amount that reasonably reflects the loss of (1) past, present and future income, and (2) any other periodic or lump sum benefits, that would otherwise be payable under this policy; notwithstanding the actual terms of the settlement.

COORDINATION OF BENEFITS

If a person is covered under any other pre-paid health service contract, insurance policy or plan (hereinafter referred to as plan), benefits will be coordinated and the amount payable under this plan will be pro-rated and limited to the extent that the total amount available under all plans does not exceed 100% of the eligible expenses.

If a person is covered under this plan (i) both as an Employee and as a Dependent or (ii) as a Dependent of more than one Employee, the amount payable under this plan with respect to eligible expenses will be limited to the extent that the total amount available under this plan does not exceed 100% of the eligible expenses.

The manner in which benefits will be coordinated and the order of benefit determination will be as prescribed under the Canadian Life and Health Insurance Association Coordination of Benefits Guidelines. For travel accident insurance plans, benefits will be coordinated on a cost-sharing basis.

We may, subject to the consent of the covered person if so required by law, obtain from or release to any person or corporation any information considered necessary to implement this provision and facilitate the payment of benefits under this plan.

PREMIUMS

Premiums are due in advance on each Premium Due Date. The premium due for each Benefit included in this policy will be calculated on a basis that is established by us.

It is our right to change the basis that is to be used in calculating the premium for any Benefit that is included in this policy as follows:

1. As of any Premium Due Date.

2. At any time that the terms and conditions of this policy are changed.

3. As of the Premium Due Date within the calendar month in which the amount of Benefit for which we are liable is increased due to either of the following reasons:

   (a) A change in a Schedule of Fees that we use to determine the amount of Benefit payable by us.

   (b) A change in any federal or provincial health care legislation or regulation.

If, at any time, we learn that the amount of insurance that should be in force under this policy is not the amount on which the premium was based, an adjustment premium will be paid by you or a refund will be made to you so that the actual premiums for the true amount of insurance will be paid.

If there is any change in the amount of insurance in force under this policy between the dates on which premiums are due, an adjustment premium or a refund will be due. If we do not receive notice of a change due to a decrease in or the termination of an amount of insurance on or prior to the Policy Anniversary that follows the date of the change, we will limit the refund to the amount that is due for the period from such Policy Anniversary to the date on which we receive the notice.

The amount of insurance with respect to an insured person will be decreased or terminated in accordance with the other terms of this policy. The payment of premiums with respect to his insurance after the date of such decrease or termination will not continue to provide insurance of the amount which was in effect with respect to him prior to such decrease or continue insurance in force with respect to him after such termination, whether or not all or part of such premium is refunded.

Refunds will be applied in or toward the payment of any outstanding premiums and adjustment premiums. Any balance will be held at your credit, without interest, and will be applied in or toward payment of succeeding premiums and adjustment premiums as and when they fall due. However, you may, at any time, withdraw in cash any amount so held at your credit.

If this policy is terminated in accordance with the Termination of Policy provision, you will be required to pay to us all adjustment premiums that are due and have not been paid. You will also pay to us a pro rata premium for the period (if any) elapsed from the date on which the last unpaid premium was due to the date on which this policy is terminated.

We will not be required to accept the payment of any premium otherwise than from you.

PERIOD OF GRACE

A period of grace will be allowed for the payment of each premium after the first and each adjustment premium. The period of grace for the payment of each premium will be 45 days after the date on which it is due. The period of grace for the payment of each adjustment premium will be 45 days after the date on which the next premium is due unless we, by written notice to you, limit the days of grace. Such limit will not be less than 45 days after the date the notice is delivered to you. The policy will remain in force during the period of grace unless terminated in accordance with the Termination of Policy provision. In any event, premiums are payable for any period of grace during which the policy continues in force.

CURRENCY

All benefits and premiums payable under this policy will be in Canadian currency.

CONTESTABILITY

If we ask for evidence of insurability an Employee and, if applicable, a Dependent must each disclose to us in the application for insurance, on a medical examination and in any written statements or answers given to us as evidence of insurability, every fact that he knows about that is material to the insurance. We may contest the validity of the insurance coverage of an Employee or Dependent if we learn of a failure to disclose, or a misrepresentation of, such a fact with respect to a claim arising from a Loss or charge incurred, a covered service performed or a Disability that began before such person's insurance has been in force for 2 years.

We may contest the validity of the insurance coverage of an Employee or a Dependent at any time with respect to fraudulent statements or misstatement of age.

In the absence of fraud all statements made will be deemed to be representations and not warranties.

AGE AND SEX

The true date of birth of an insured person will be used to determine:

1. The commencement or termination of his insurance.
2. The amount of his insurance.
3. Any other right or benefit with respect to him.

If we learn that his date of birth or sex has been misstated, a premium will be paid or a refund will be made so that you will pay us the actual premiums for the insurance that applies to him based on his true age and sex.

AMENDMENTS TO THE POLICY

This policy may be amended at any time by written agreement between you and us without the consent of or notice to any other person. This policy can be amended by us at any time with 31 days written notice. Any amendment to this policy must be in writing and attached to the policy. The amendment must bear the signature or a reproduction of the signature of our President and Chief Executive Officer and our President and Chief Operating Officer, Canada.

If an insured Employee is not Actively at Work on the effective date of the amendment, the effective date with respect to that insured Employee will be on the day that he is again Actively at Work. However, if the amendment reduces the amount of insurance to which the Employee is entitled, the effective date will be the effective date of the amendment.

It is understood that, if any income replacement benefit is included in this policy and is amended during an Employee's Continuous Period of Disability, the amendment will have no effect on such income replacement benefit during that same Continuous Period of Disability.

If an insured Dependent (if any) is confined in a hospital on the effective date of the amendment, the effective date with respect to that insured Dependent will be on the first day after the date of his discharge from the hospital. However, if the amendment reduces the amount of insurance to which the Dependent is entitled, the effective date will be the effective date of the amendment.

CONTRACT

The whole contract is made up of this policy, any amendments to this policy and the applications of the insured Employees.

The Policyholder, any other covered Employer or any third party administrator appointed by you will not be considered to be our agent for any purpose under this policy.

Only our President and Chief Executive Officer and President and Chief Operating Officer may modify this policy or waive any of our rights or requirements.

TERMINATION OF POLICY

If you give us written notice that this policy is to be terminated, it will terminate on the later of:

1. The date that is stated in the notice.

2. The date on which we receive the notice at our Head Office.

We may terminate this policy as of any Premium Due Date for any reason including failure to meet the Participation Requirements shown in the Policy Details. We must give you 31 days advance notice in writing. The notice will be sent by pre-paid registered mail to your latest address as shown in our records. The notice period will begin on the third day following the date we mail the notice to you.

This policy will terminate, in any event, at the end of the grace period allowed for the payment of any premium or adjustment premium if such premium is still unpaid at that time.

EMPLOYEE LONG TERM DISABILITY INCOME BENEFIT

Benefit

We will pay to an Employee who begins a Continuous Period of Disability while he is insured under this provision, his Long Term Disability Income Benefit, subject to all of the following conditions:

1. The Benefit will be that which applied to him at the time the Continuous Period of Disability commenced.

2. The amount of the Benefit is described in the Policy Details and it will be subject to the reductions in amount and such other terms that are described in this provision.

3. No Benefit payments will be made for that part of a Continuous Period of Disability that is prior to the later of the following dates:

   (a) The date on which he has completed the Elimination Period.

   (b) The date on which initial proof that the Employee is Disabled is given to us at our Head Office. The proof must be given to us within 90 days after he has completed the Elimination Period and must be satisfactory to us.

4. The payments will be made to him each month in arrears.

5. No Benefit payments will be made if during a Continuous Period of Disability, replacement coverage has been obtained with another insurer, and there is legislation or industry guidelines which stipulates that the new insurer should assume liability for such payments.

The payments to an Employee will continue during the Continuous Period of Disability until the earliest time shown below:

1. The date on which he ceases to be Disabled as defined in this provision. The Employee will cease to be insured under this provision at that time if he does not then return to active work for his Employer.

2. The date of his death.

3. The end of the Maximum Benefit Payment Period that is shown in the Policy Details.

If we cease to make Benefit payments to an Employee because he is no longer Disabled and he becomes Disabled again within 6 months due to the same or a related cause or causes, such Disability will be considered by us to be part of the same Continuous Period of Disability. In such case, (i) a new Elimination Period is not applicable, (ii) the Benefit will be that which applied at the time the Continuous Period of Disability commenced, and (iii) the Benefit is payable in total no longer than the Maximum Benefit Payment Period that was in effect at the time the Continuous Period of Disability commenced.

The Policyholder must give us written notice of any Employee who has been absent from work due to illness for more than 60 days, within 120 days from the commencement of such illness.

If the period during which an Employee is entitled to receive Benefits under this provision is not a complete number of months, the amount of Benefit payable with respect to him for each day that is in excess of a complete number of months will be at the rate of 1/30th of the Monthly Benefit which is applicable to him.

Definitions

"Disabled" and "Disability" mean, with respect to an Employee, that due to injury, disease, illness, pregnancy or mental disorder, he is not able to earn at his own or any other occupation for which he is reasonably fitted by education, training or experience, more than 75% of his Pre-disability Monthly Earnings.

However, an Employee who engages in any business or occupation except as provided in the Rehabilitation section of this provision, will be deemed to no longer be Disabled.

"Continuous Period of Disability" includes all periods of Disability that meet all of the following conditions:

1. They commence while the Employee is insured under this provision.

2. They are due to the same or a related cause or causes.

3. During the Elimination Period, they are not separated by a period of more than 30 days during which the Employee was not Disabled.

4. After the Elimination Period has been satisfied, they are not separated by a period of more than 6 consecutive months during which the Employee was not Disabled.

"Elimination Period" is the period that the Employee must have actually been Disabled during a Continuous Period of Disability before he may receive Benefit payments under this provision. It will not include any period of Disability that is described in the Exclusions section of this provision. The Elimination Period is shown in the Policy Details.

“Pre-disability Monthly Earnings” means an Employee’s Monthly Earnings immediately prior to becoming Disabled.

"Pregnancy" includes childbirth or miscarriage and any disease or infirmity that results from or is aggravated by such pregnancy.

"Pregnancy Leave of Absence" means:

1. any period of pregnancy leave taken by the Employee pursuant to Provincial or Federal statute or pursuant to a mutual agreement between the Employee and the Employer, or

2. any period of pregnancy leave which the Employer requires the Employee to take pursuant to Provincial or Federal statute.

The period of pregnancy will be deemed to commence on the earlier of (a) the elected date of the leave and (b) the date of delivery of the child and will be deemed to end on the earlier of (a) the day before the date on which the Employee is scheduled to return to work and (b) the day before the date the Employee returns to work.

Waiver of Premium

If an Employee begins a Continuous Period of Disability while he is insured under this provision, we will waive the payment of each premium falling due under this provision with respect to him. The premium payments will be waived commencing on the date on which he began the Continuous Period of Disability, provided that he has completed the Elimination Period and his claim has been admitted by us. Premium payments will be waived only while he is actually Disabled during the Continuous Period of Disability.

Rehabilitation

Rehabilitation program as used in this section means a training or work related activity that can be expected to facilitate a Disabled Employee's return to his job or other gainful employment.

We will pay Benefits under this policy while a Disabled Employee is participating in a rehabilitation program provided the program has been approved in advance by us, in writing. The Elimination Period may be satisfied while the Employee is working in an approved rehabilitation program.

If the Employee receives an income under the rehabilitation program the amount of Benefit payable to him under the other terms of this provision will not be reduced unless the total of the monthly income he is receiving from this policy and the sources described in the Integration section plus the gross income he is receiving each month under the rehabilitation program exceeds 100% of his Pre-disability Monthly Earnings. If the total of the monthly income he is receiving exceeds 100% of his Pre-disability Monthly Earnings the amount of Benefit payable to him under the other terms of this provision will be reduced by the amount in excess of 100% of his Pre-disability Monthly Earnings.

We will stop making benefit payments to the Employee at the earliest of the following dates:

1. The date on which he ceases to participate in the program or his 65th birthday if earlier.
2. The date on which he would otherwise cease to be Disabled as defined in this provision.
3. The date on which he would otherwise cease to receive Benefits under this provision.

We will pay expenses incurred by an Employee, other than usual employment expenses, for services and equipment associated with an approved rehabilitation program provided the expenses have been approved in advance by us, in writing. The maximum amount payable for such services and equipment will be a total of $25,000 during the Employee's lifetime.

Integration

We will automatically reduce the Benefit described in the Policy Details by the amount of any benefit payments the Employee is entitled to receive under the Canada/Quebec Pension Plan or a plan in another country for which there is a reciprocal agreement, excluding child benefits to which any member of his family is entitled to apply for and receive as a result of his disability.

If the amount of an Employee's gross income from all sources shown below still exceeds 80% of his Monthly Earnings, we will reduce our Benefit to the extent necessary so that his total monthly amount of gross income from these sources is no more than 80% of such Monthly Earnings. For the purpose of any calculation under this provision, we will consider the full amount of any benefits the Employee is eligible to apply for and receive, before any income tax and/or any other deductions.

1. Any Disability Benefits that are payable to him under this provision.
2. Any Benefits that are payable to him under the Canada/Quebec Pension Plan or a plan in another country for which there is a reciprocal agreement, including child benefits to which any member of his family younger than 18 years of age is entitled to apply for and receive as a result of his disability.
3. Any indemnity for loss of time that is payable to him under any Government Legislated No-Fault Automobile Insurance Plan, unless we are prohibited from taking this indemnity into consideration by government legislation.

4. Any indemnity for loss of time that is payable to him under an insured or uninsured plan which covers the Employee on a group basis.

5. Any continuation of salary from his Employer.

6. Any benefits that are payable under a retirement or pension plan of his Employer.

7. Damages for loss of income recovered from a third party and arising out of the same circumstances that caused his Disability.

8. Income from any employment, other than as described in the other sections of this provision.

We will determine the amount of the payments that an Employee is entitled to receive as described in clauses 2 and 3 above at the later of:

(a) The date such benefit payments commence.

(b) The date on which the payments under this provision commence.

We will not reduce our Benefit by any additional amount payable as described in clause 2 above that an Employee is entitled to receive due to his marital status or number of children.

If an Employee has not applied for a benefit, described above, that he is entitled to apply for, or if he has applied for but has not yet received notice of whether or not he is entitled to such benefit, we will estimate the amount of such benefit. The Benefit payable under this provision will be reduced as described in Integration as if he had received such estimated benefit, until such time as we receive written notice that the application has been declined. If the Employee notifies us that an application or appeal has been declined and we determine that this decision should be subject to appeal, the Employee must file an appeal and we may continue to reduce the Employee's payments until we are notified in writing that such appeal has been declined.

If the Employee receives a lump sum for any of the benefits described in clauses 2 through 8 of Integration, our Benefit under this provision will be reduced by the amount that he would normally receive if the payments were being made on a monthly basis.

Extension of Insurance

If an Employee has begun a Continuous Period of Disability prior to the time his insurance under this policy would otherwise terminate, his Disability Income Benefit will be continued in force under this provision as long as he is entitled to such Benefit with respect to the Continuous Period of Disability. The continuation will be subject to all of the conditions of this provision and in no event will his Disability Income Benefit be continued beyond the Maximum Benefit Payment Period.

Exclusions

1. No amount of Benefit will be payable under this provision with respect to the Disability of an Employee during any of the following periods:

   (a) Any period while the Employee is not under the continuing care of a physician or surgeon legally licensed to practise medicine.

   (b) The period during which the Employee is on leave of absence, including Pregnancy Leave of Absence. If he becomes Disabled while on leave of absence, the leave of absence will be deemed to end on the day before the date on which he is scheduled to return to work.

   (c) Any period while the Employee is either permanently or temporarily outside of Canada or the United States. If he becomes Disabled while he is outside of Canada or the United States his Disability will not be deemed to commence until the date on which he returns to Canada or the United States.

   (d) For any period that an Employee has been paid (in a lump sum or otherwise) a severance allowance due to termination of employment, or for any period for which the Employee has obtained through any legal proceeding damages or other payments representing wage loss or loss of income for the termination of the employment relationship. The period for which benefits will not be paid will be the number of months the severance allowance payments or damages award equates to the employee's pre-disability monthly income, regardless of whether such payments or damages are payable in a lump sum or otherwise.

2. No amount of Benefit will be payable under this provision for any Disability arising from any medical condition(s) unless the Employee is receiving appropriate treatment for such medical condition(s). The appropriateness of such treatment must be agreed upon by us and the Employee's treating physician. If there is a difference in opinion between us and the Employee's treating physician, we reserve the right to seek and accept an independent medical opinion from a physician who is specialized in the treatment of the medical condition(s).

3. No amount of Benefit will be payable under this provision for any Disability that resulted either directly or indirectly from, or was in any manner or degree associated with, or occasioned by, any one or more of:

   (a) Intentionally self-inflicted injury.

   (b) War, insurrection or hostilities of any kind, whether or not the Employee was a participant in such actions.

   (c) Participating in any riot or civil commotion.

   (d) Committing or attempting to commit a criminal offence or provoking an assault.

   (e) A pre-existing condition if a Pre-existing Condition Exclusion is described in the Employee Long Term Disability Income Benefit section of the Policy Details.

HOSPITAL BENEFIT

Benefit

With respect to Non-retired Employees, we will pay to the Employee, for each day that an Insured is confined in a semi-private room in a Licensed Hospital due to injury, disease, illness, mental disorder or pregnancy, an amount equal to the difference between the hospital's average semi-private room rate and its room rate for ward accommodation.

With respect to Retired Employees, we will pay to the Employee, for each day that an Insured is confined in a private room in a Licensed Hospital due to injury, disease, illness, mental disorder or pregnancy, an amount equal to the difference between the hospital's average private room rate and its room rate for ward accommodation.

Definitions

"Insured" means:

1. An Employee, while he is insured under this provision.

2. A Dependent of an Employee, while the Dependent is insured under this provision.

"Licensed Hospital" means a hospital that is licensed to provide active, convalescent or chronic care treatment by the Government that is responsible for the issue of such licenses in the area that it is located. It does not include nursing homes, homes for the aged, rest homes or any other facility that provides similar care.

"Pregnancy" includes childbirth or miscarriage and any disease or infirmity that results from or is aggravated by the pregnancy.

Extension of Insurance

If an Insured is disabled at the time his insurance under this provision would otherwise terminate due to termination of the Employee's employment or because the Employee ceases to qualify under the definition of Employee, he will continue to be insured for any charges that are incurred as a result of the disability until the earliest of the following dates:

1. The date that there are no longer any Employees of his Employer insured under this provision.

2. The date that this policy terminates.

3. The 90th day following the date that the Employee's insurance under this provision would otherwise terminate.

As used in this Extension of Insurance section "disabled" and "disability" mean a state of incapacity resulting from injury, disease, illness, pregnancy or mental infirmity that prevents an Employee from being able to do any work for wages or profit, or for which a Dependent is receiving treatment by a physician or surgeon legally licensed to practise medicine.

Exclusions

No amount of Benefit will be payable under this provision for hospital confinement that resulted either directly or indirectly from, or was in any manner or degree associated with, or occasioned by, any one or more of:

1. Any cause for which the Insured may apply for and receive indemnity or compensation under any Workers' Compensation Act.

2. Intentionally self-inflicted injury.

3. War, insurrection or hostilities of any kind, whether or not the Insured was a participant in such actions.

4. Participating in any riot or civil commotion.

5. Committing or attempting to commit a criminal offence or provoking an assault.

Survivor Benefit

If an Insured who is an Employee dies while he is insured under this provision, the Benefits provided under this provision will be continued in force with respect to a Survivor until the earliest of the following dates:

1. In the case of the spouse of the deceased Employee, or a child, the date on which the spouse remarries.

2. In the case of a child, the date on which the child ceases to be a Dependent as defined in this policy.

3. The date on which this policy or provision is no longer in force.

4. The date on which the second anniversary of the death of the Employee occurs.

No premium payment will be required for the above continuation of insurance.

"Survivor" as used in this section means a Dependent who is insured under this provision on the date of death of the Employee of whom he is a Dependent.

PAY DIRECT DRUG BENEFIT

Benefit Amount

The Benefit Amount is the amount of the incurred Eligible Charges that we or our authorized agent will pay to the dispensing Pharmacy if there is a valid Participating Pharmacy Agreement between the Pharmacy and us or our authorized agent, otherwise to the Employee. The Benefit Amount does not include the Deductible Amount.

We can limit the Eligible Charges for a service or supply to that of the lower cost alternative service or supply that represents Reasonable Treatment.

We can, on such terms as we determine, cover services or supplies not otherwise listed under this Benefit provision where the service or supply represents Reasonable Treatment.

Deductible Amount

The Deductible Amount is the portion of an incurred Eligible Charge which must be paid by an Employee for each prescription and each time an injection is given with respect to an injectable drug for which a charge is made for the drug. The Deductible Amount is shown in the Policy Details.

Conditions

We will pay the Benefit Amount to the Employee for any of the Eligible Charges defined in this provision provided that the Eligible Charge meets all of the following conditions:

1. It is incurred while the Insured is insured under this provision.
2. It is Medically Necessary.
3. It is Reasonable and Customary.
4. It represents Reasonable Treatment.
5. We are not prohibited from paying it by a Government Sponsored plan of the Province or Territory in which the Employee is resident.

Definitions

"Insured" means:

1. An Employee, while he is in insured under this provision.
2. A Dependent of an Employee, while the Dependent is insured under this provision.

"Reasonable and Customary" means a charge which is usually made for an Eligible Charge defined in this provision. Such charges will be considered reasonable and customary if they do not exceed the general level of charges made by other licensed pharmacists in the same geographical area.

"Medically Necessary" means that an Eligible Charge defined in this provision is:

1. recognized by the medical profession as one that is effective, appropriate and essential in the diagnosis or treatment of injury, disease, illness, pregnancy or mental disorder, and

2. based on generally recognized and accepted standards of health care.

"Reasonable Treatment" means treatment that is:

1. accepted by the Canadian medical profession,

2. proven to be effective, and

3. of a form, intensity, frequency, duration essential to diagnosis or management of injury, disease, illness, pregnancy or mental disorder.

"Eligible Charges" means charges for medications prescribed in writing by a physician or other person entitled by law to prescribe them and dispensed by a licensed pharmacist or other person entitled by law to dispense them, bearing a Drug Identification Number (DIN), listed as prescription requiring in Federal or Provincial Drug Schedules and some other non-prescription requiring drugs, including (i) injectable drugs, injectable vitamins, insulins and allergy extracts, (ii) extemporaneous preparations or compounds where at least one of the ingredients is eligible, (iii) disposable needles, syringes, lancets and chemical reagent testing materials used for monitoring diabetes, (iv) contraceptive drugs and products containing a contraceptive drug and (v) drugs in the following categories:

antimalerials
fibrinolytics
fluorides, single entity
iron salts, single entity
nitroglycerine
potassium replacements
thyroid agents
topical enzymatic debriding agents

Eligible Charges will not include charges for any single purchase of drugs or medicines which would not reasonably be consumed or used within a 34 - day period or, with respect to the following maintenance drugs, a 100 - day period:

antiasthmatics
antibiotics for acne
anticoagulants
anticonvulsants
antihypertensives
antiparkinson
antituberculosis
estrogens
glaucoma
hypoglycoemics
oral contraceptives
potassium replacements
thyroid agents
cardiac agents

Charges incurred for the following are not covered whether or not they have been prescribed for medical reasons:

(a) Atomizers, appliances, prosthetic devices, colostomy supplies, first aid kits or equipment, electronic diagnostic monitoring or testing equipment, non-disposable insulin delivery devices, delivery or extension devices for inhaled medications, spring loaded devices used to hold lancets, alcohol, alcohol swabs, disinfectants, cotton, bandages or supplies and accessories for the aforementioned.

(b) Oral vitamins, minerals, dietary supplements, infant formulas or injectable total parenteral nutrition (TPN) solutions, whether or not prescribed for a medical reason, except where Federal or Provincial law requires a prescription for their sale.

(c) Diaphragms, condoms, contraceptive jellies / foams /sponges /suppositories, intrauterine devices (IUD's) or appliances normally used for contraception, whether or not prescribed for a medical reason, unless such contraceptive products contain a contraceptive drug as provided under this provision.

(d) Any drug which does not have a drug identification number as defined by the Food and Drugs Act, Canada.

(e) Homeopathic preparations.

(f) Preventative immunization vaccines and toxoids.

(g) Items deemed cosmetic, such as topical minoxidil or sunscreens (even if a prescription is legally required), whether or not prescribed for a medical reason.

(h) Fertility drugs.

(i) Smoking cessation products, with respect to Retired Employees.

(j) Drugs and medicines administered during treatment in an emergency room of a hospital, or as an in-patient in a hospital.

(k) Any medication which the Insured is entitled to receive, or for which he is entitled to a benefit or reimbursement, by law or under a plan that is legislated, funded, or administered in whole or in part by a government (“government plan”), without regard to whether coverage would have otherwise been available under this plan. In this limitation, government plan does not include a group plan for government employees.

Other Services and Supplies

We can, on such terms as we determine, cover services and supplies under this plan where the service or supply represents reasonable treatment.

Eligible Charge Limitations

Charges incurred for the following shall in no event be considered Eligible Charges:

1. Supplies which are not listed under the definition of Eligible Charges.

2. Supplies which are Medically Necessary for recreation or sports but not for an Insured's regular daily living activities.

3. Delivery and transportation charges.

Charges incurred for supplies outside the Insured's home province shall be considered Eligible Charges only if:

1. the Insured:

   (a) is temporarily out-of-province on business or vacation or for furthering education, and the supplies are necessary as the result of an emergency or unexpected sudden illness, or

   (b) requires reasonable and customary treatment which is not readily available in the Insured's home province and must be obtained elsewhere.

2. in respect only of any such charges which would have been covered under the government hospital or health plan of the Insured's home province had they been incurred in the home province, either:

   (a) some portion of the charge is payable under said plan, or

   (b) the charges are not covered under said plan when incurred out-of-province.

3. the charges would have been considered Eligible Charges had they been incurred in the Insured's home province.

Drug Utilization Review (DUR)

Use of the Drug Card authorizes us, or our authorized agent, to inform pharmacists and physicians on patient safety issues for the Employee and his dependents. We, or our authorized agent, are not legally liable for any such information.

Prior Authorization

In order to determine whether coverage is provided for certain services or supplies, we will maintain a limited list of services or supplies that require prior authorization.

Prior authorization is intended to help ensure that a service or supply represents Reasonable Treatment.

If the use of a lower cost alternative service or supply represents Reasonable Treatment, an Insured may be required to provide medical evidence why the lower cost alternative service or supply cannot be used before coverage may be provided for the service or supply.

Health Case Management

Health Case Management is a program recommended and approved by us that may include but is not limited to:

- consultation with the Insured and his attending physician to gain understanding of the treatment plan recommended by the attending physician;
- comparison with the Insured's attending physician of the recommended treatment plan with alternatives, if any, that represent Reasonable Treatment;
- identification to the Insured's attending physician of opportunities for education and support; and
- monitoring the Insured's adherence to the treatment plan recommended by the person's attending physician.

In determining whether to implement Health Case Management, we may assess such factors as the service or supply, the Insured's medical condition, and the existence of generally accepted medical guidelines for objectively measuring medical effectiveness of the treatment plan recommended by the attending physician.

Health Case Management Limitation

We can, on such terms as we determine, limit the payment of benefits for a service or supply where:

- we have implemented Health Case Management and the Insured does not participate or cooperate; or
- the Insured has not adhered to the treatment plan recommended by his attending physician with respect to the use of the service or supply.

Health Case Management Expense Benefit

Expenses associated with Health Case Management may be paid for by us at our discretion. Expenses claimed under this Benefit provision must be pre-authorized by us.

Designated Provider Limitation

For a service or supply to which prior authorization applies or where we have recommended or approved Health Case Management, we can require that the service or supply be purchased from or administered by a provider designated by us, and

- limit Eligible Charges for a service or supply that was not purchased from or administered by a provider designated by us to the cost of the service or supply had it been purchased from or administered by the provider designated by us, or
- decline a claim for a service or supply that was not purchased from or administered by a provider designated by us.

Patient Assistance Program

A Patient Assistance Program means a program that provides assistance to an Insured with respect to the purchase of services or supplies.

We can require the Insured to apply to and participate in any Patient Assistance Program to which the Insured may be entitled. Further, we can reduce the amount of Eligible Charges for a service or supply by an amount up to the amount of financial assistance the Insured is entitled to receive for that service or supply under a Patient Assistance Program.

Exclusions

No amount of Benefit will be payable under this provision for any Eligible Charge that resulted either directly or indirectly from, or was in any manner or degree associated with, or occasioned by, any one or more of:

1. Any cause for which the Insured may apply for and receive indemnity or compensation under any Workers' Compensation Act.

2. Intentionally self-inflicted injury while sane or insane.

3. War, insurrection or hostilities of any kind, whether or not the Insured was a participant in such actions.

4. Participating in any riot or civil commotion.

5. Committing or attempting to commit a criminal offence or provoking an assault.

Termination of Insurance

If an Insured's insurance under this provision terminates for any reason:

1. No Benefits shall be payable under this provision in respect of any supplies which are purchased by such Insured on or after said termination date.

2. You shall promptly recall the Drug card(s) issued to such Insured.

3. We shall be entitled to a refund from you of the amount of any Benefits paid in respect of any supplies purchased by the use of any Drug card which had not been repossessed by you upon termination of such Insured's coverage under this Benefit provision.

Survivor Benefit

If an Insured who is an Employee dies while he is insured under this provision, the Benefits provided under this provision will be continued in force with respect to a Survivor until the earliest of the following dates:

1. In the case of the spouse of the deceased Employee, or a child, the date on which the spouse remarries.

2. In the case of a child, the date on which the child ceases to be a Dependent as defined in this policy.

3. The date on which this policy or provision is no longer in force.

4. The date on which the second anniversary of the death of the Employee occurs.

No premium payment will be required for the above continuation of insurance.

"Survivor" as used in this section means a Dependent who is insured under this provision on the date of death of the Employee of whom he is a Dependent.

<u>Interchangeable Drug Limitation</u>
(not applicable for Non-retired Employees)

Notwithstanding anything to the contrary in this provision, Eligible Charges for any drug can be limited to that of a lower cost interchangeable drug determined in accordance with our adjudication practices at the time of claim.

An interchangeable drug includes but is not limited to:

(a) a generic equivalent of the brand name drug deemed to be interchangeable by law where the drug is dispensed, or

(b) a subsequent entry biologic drug.

The right to limit Eligible Charges does not apply if medical documentation has been provided that indicates a contraindication to the interchangeable drug.

MEDI-PACK BENEFIT

This provision consists of the following Basic Major Medical Expense Benefit plus the attached Benefit Supplements, if any:

Basic Major Medical Expense Benefit

Benefit Amount

The Benefit Amount is the percentage of the eligible incurred Charges that we will pay to an Employee subject to the other terms of this provision. The Benefit Amount is shown in the Policy Details.

Services or supplies that represent Reasonable Treatment but are not otherwise covered under this policy may be covered by the policy on such terms as determined by us.

Charges for a service or supply may be limited to that of a lower cost alternative service or supply that represents Reasonable Treatment.

Deductible Amount

The Deductible Amount is the portion of the incurred Charges which must be paid by an Employee in each calendar year before we will pay the Benefit Amount under this provision. The Deductible Amount is shown in the Policy Details.

Conditions

We will pay the Benefit Amount to the Employee for any of the Charges defined in this provision provided that the Charge meets all of the following conditions:

1. It is incurred while the Insured is insured under this provision.

2. It is Medically Necessary.

3. It is Reasonable and Customary.

4. It represents Reasonable Treatment.

5. It is recommended and authorized by a physician or surgeon legally licensed to practise medicine.

6. We are not prohibited from paying it by the Government Sponsored plan of the Province or Territory in which the Employee is resident.

Benefit Maximum

The amount payable under this provision is subject to the following limits:

1. It may not be for more than the difference between the actual cost of the Charge and the amount paid under any Government Sponsored plan or would have been paid under the Government Sponsored plan of the Province or Territory in which the Employee is resident if the Insured is eligible but not covered under any such plan.

2. Any Benefit maximum shown in the Policy Details or in the Charges described in this provision.

Any Benefit maximum shown in this policy will be applied separately to each Insured.

Definitions

"Insured" means:

1. An Employee, while he is insured under this provision.

2. A Dependent of an Employee, while the Dependent is insured under this provision.

"Medically Necessary" means that a Charge defined in this provision is:

1. recognized by the medical profession as one that is effective, appropriate and essential in the diagnosis or treatment of injury, disease, illness, pregnancy or mental disorder, and

2. based on generally recognized and accepted standards of health care.

"Reasonable and Customary" means a charge which is usually made for an eligible expense listed in the Charges section. Such charges will be considered reasonable and customary if they do not exceed the general level of charges made by other providers of comparable services in the same geographical area.

"Reasonable Treatment" means treatment that is:

1. accepted by the Canadian medical profession,

2. proven to be effective, and

3. of a form, intensity, frequency, duration essential to diagnosis or management of injury, disease, illness, pregnancy or mental disorder.

"Pregnancy" includes childbirth or miscarriage and any disease or infirmity resulting from or aggravated by the pregnancy.

"Professional Nurse" means:

1. A Registered Nurse or a Licensed Practical Nurse.

2. A Registered Nurse or a Registered Practical Nurse for an Insured who resides in the province of Ontario.

"Licensed Hospital" means a hospital that is licensed to provide active, convalescent and chronic treatment by the Government that is responsible for such licenses in the area that it is located. It does not include nursing homes, homes for the aged, rest homes or any other facility providing similar care.

"Emergency" means any sudden, critical, unforeseen or unexpected occurrence requiring immediate medical attention and takes place outside the Insured's Province or Territory of residence while the coverage is in force.

Charges

1. No charges for drugs, serums and vaccines are covered under this benefit provision.

2. With respect to Non-retired Employees, charges for the services of a Professional Nurse at the Insured's residence provided that such person is not normally resident in the Insured's residence, up to a maximum for each Insured of $25,000 per calendar year. However, the maximum for each Insured will be $25,000 during any period from the first day of a calendar year coincident with or next following an Insured's 65th birthday until his death.

   With respect to Retired Employees, charges for the services of a Professional Nurse at the Insured's residence provided that such person is not normally resident in the Insured's residence, up to a maximum for each Insured of $10,000 per calendar year. However, the maximum for each Insured will be $25,000 during any period from the first day of a calendar year coincident with or next following an Insured's 65th birthday until his death.

   With respect to all Employees, the services will not be considered as eligible Charges under this provision:

   (a) While the Insured is residing in a nursing home, home for the aged, rest home or any other facility providing similar care.

   (b) If in our opinion they are for custodial care and do not require the skill of a Professional Nurse.

   (c) While the Insured is confined in a Licensed Hospital.

3. Charges incurred by an Insured in the Canadian Province or Territory in which he is resident for (i) services furnished by a Licensed Hospital and (ii) supplies prescribed by a physician or surgeon which are obtained from an out-patient department of a Licensed Hospital or a surgical supply company, while the Insured is not confined to the hospital.

4. Charges for the following transportation services:

   (a) Charges for licensed ambulance service or other emergency service when used to transport the Insured (i) from the place where injury, disease, illness, pregnancy or mental disorder is suffered to the nearest hospital where adequate treatment can be rendered, (ii) from one hospital to another hospital, and (iii) from a hospital to the Insured's residence.

   (b) Charges for the fare of one attendant to accompany the Insured if transportation is not provided by a licensed ambulance service.

5. Charges for the following aids, services and supplies:

   (a) Purchase of braces, crutches, artificial limbs or eyes and prosthetic devices approved by us.

   (b) An initial pair of frames and one corrective prosthetic lens for each eye that is prescribed after cataract surgery.

   (c) An initial breast prosthesis following a mastectomy plus a replacement every 2 calendar years and 2 surgical brassieres per calendar year.

   (d) Rental of a wheelchair, hospital bed or other approved durable equipment for temporary therapeutic use. This equipment may be purchased subject to our approval prior to the purchase. If such approval is not obtained, we will pay only the equivalent of the rental cost of the equipment.

   (e) Oxygen.

   (f) Custom-made orthopaedic shoes prescribed by a podiatrist or physician up to a maximum of one pair per calendar year.

   (g) 2 pairs of surgical stockings per calendar year.

   (h) Wigs and hairpieces, up to a lifetime maximum of $100 if necessary as a result of chemotherapy, or up to a lifetime maximum of $250 if necessary as a result of total hair loss from Alopecia Totalis.

   (i) With respect to Non-retired Employees, 2 pairs of custom-made foot orthotics per calendar year. In addition, the maximum amount payable is $400 per pair which shall not exceed $800 per calendar year. To be eligible for payment, the orthotic devices must be medically necessary for the Insured's regular daily living activities and not solely for recreation or sports.

6. Charges by a legally licensed dentist for dental treatment of injuries to natural teeth and the replacement of natural teeth for accidents suffered by an Insured while he is insured under this provision.

   The Charge will be subject to all of the following conditions:

   (a) The treatment is necessitated by a direct accidental blow to the Insured's mouth and not by an object or food placed wittingly or unwittingly in the mouth.

   (b) The accidental blow occurs while the Insured is insured under this provision.

   (c) The treatment is received within 12 months after the accidental blow.

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

   (e) No payment will be made by us for any part of the Charge which exceeds the amount recommended in the current Dental Association Fee Guide for General Practitioners in the Insured's Province or Territory of residence.

   (f) If treatment is to be received more than 90 days after the accidental blow, a treatment plan must be submitted to us within 90 days of the accident.

7. Charges for the following Emergency treatment required by an Insured while he is temporarily absent from the Canadian Province or Territory in which he is resident because of business or vacation and not for health reasons. There is a maximum of $1,000,000 for an Emergency for each Insured under this Eligible Charge. This limitation is not applicable to in-Canada emergency health care benefits. When emergency treatment for a condition is completed, any ongoing treatment related to that condition is not covered.

   We will cover the first 2 weeks of a trip with respect to Retired Employees, and the first 60 days of a trip with respect to all other Employees. This limitation is not applicable to in-Canada emergency health care benefits.

   (a) Room and board in a Hospital up to the Hospital's standard ward rate for each day that the Insured is confined in the Hospital.

   (b) Hospital services and supplies furnished by a Hospital.

   (c) Diagnosis and treatment by a physician or surgeon legally licensed to practise medicine.

In the event of a medical emergency, the insured person or someone on the insured person's behalf must contact the Travel Assistance Centre prior to seeking medical treatment. If it is not reasonably possible for the insured person to contact the Travel Assistance Centre prior to seeking medical treatment due to the nature of the medical emergency, the insured person must contact the Travel Assistance Centre as soon as possible. Failure to contact the Travel Assistance Centre as described will result in a reduction of benefits in the case of hospitalization of 40% of eligible costs. All costs for such emergency will be limited to the insured person's emergency out-of-country coverage maximum or $25,000, whichever is less. This limitation is not applicable to in-Canada emergency health care benefits.

If a physician or the Travel Assistance provider recommends the insured person be moved to a different facility at the destination, and the insured person chooses not to go, eligible costs for emergency coverage will in the case of hospitalization be reduced by 40% of eligible costs. All costs for such emergency will be limited to the insured person's emergency out-of-country coverage maximum or $25,000, whichever is less. This limitation is not applicable to in-Canada emergency health care benefits.

If a physician or the Travel Assistance provider recommends returning to the insured person's home province, and the insured person chooses not to go, emergency coverage will end.

"Hospital" means an institution having diagnostic facilities that provides active emergency treatment with physicians and registered nurses in attendance 24 hours a day and is so licensed by the appropriate governmental authority. It does not include an institution providing convalescent care, a nursing home, home for the aged, a rest home or any other facility providing similar care.

We will not pay for any costs resulting directly or indirectly:

(a) from an accident occurring while the insured person was operating a vehicle, vessel or aircraft, if the insured person:
    i) was impaired by drugs or alcohol, or
    ii) had a blood alcohol level higher than 80 milligrams of alcohol per 100 millilitres of blood.

(b) from the abuse of illegal substances.

Travelling outside Canada while pregnant: We will not cover any pregnancy related costs which are incurred outside of Canada within nine weeks of the expected delivery date. Costs associated with a child born outside Canada within nine weeks of the expected delivery date, or after the expected delivery date, are not covered.

8. Charges for the following hospital or medical services provided outside of an Insured's Canadian Province or Territory of residence if the services are not available in the Province or Territory of residence and are performed on the written referral of a physician or surgeon regularly attending the Insured in his Canadian Province or Territory of residence. The services must be provided in Canada or the United States and the maximum amount payable with respect to an Insured during his lifetime will be $10,000 for all such services.

   (a) Room and board in a Licensed Hospital up to the hospital's standard ward rate for each day that the Insured is confined in the hospital.

   (b) Hospital services and supplies furnished by a Licensed Hospital.

   (c) Diagnosis and treatment by a physician or surgeon legally licensed to practise medicine.

   A written report by the referring physician or surgeon of the services to be provided must be filed with and approved in advance by us.

9. Charges for diagnostic tests, radium treatments and X-ray examinations, excluding dental X-rays, that are incurred by an Insured in the Canadian Province or Territory in which he is a resident if the coverage is not available under the Provincial or Territorial government plan.

10. Charges for the purchase of hearing aids and for repairs, excluding batteries, up to a maximum of $500 in each period of 4 consecutive years for each Insured.

Other Services and Supplies

We can, on such terms as we determine, cover services and supplies under this plan where the service or supply represents reasonable treatment.

Extension of Insurance

If an Insured is disabled at the time his insurance under this provision would otherwise terminate due to termination of the Employee's employment or because the Employee ceases to qualify under the definition of Employee, he will continue to be insured for any Charges that are incurred as a result of the disability until the earliest of the following dates:

1. The date that there are no longer any Employees of his Employer insured under this provision.

2. The date that this policy terminates.

3. The 90th day following the date that the Employee's insurance under this provision would otherwise terminate.

As used in the Extension of Insurance section, "disabled" and "disability" mean a state of incapacity resulting from injury, disease, illness, pregnancy or mental disorder that prevents an Employee from being able to do any work for wages or profit or for which a Dependent is receiving treatment by a physician or surgeon legally licensed to practise medicine.

Exclusions

No amount of Benefit will be payable under this provision for any Charge that resulted either directly or indirectly from, or was in any manner or degree associated with, or occasioned by, any one or more of:

1. Any cause for which the Insured may apply for and receive indemnity or compensation under any Workers' Compensation Act.

2. Intentionally self-inflicted injury.

3. War, insurrection or hostilities of any kind, whether or not the Insured was a participant in such actions.

4. Participating in any riot or civil commotion.

5. Committing or attempting to commit a criminal offence or provoking an assault.

6. An examination by, or the services of, a physician or surgeon if required solely for the use of a third party.

7. Cosmetic Surgery.

8. Any treatment that has as its purpose the correction of temporomandibular joint dysfunction.

Prior Authorization

In order to determine whether coverage is provided for certain services or supplies, we will maintain a limited list of services or supplies that require prior authorization.

Prior authorization is intended to help ensure that a service or supply represents Reasonable Treatment.

If the use of a lower cost alternative service or supply represents Reasonable Treatment, an Insured may be required to provide medical evidence why the lower cost alternative service or supply cannot be used before coverage may be provided for the service or supply.

Health Case Management

Health Case Management is a program recommended and approved by us that may include but is not limited to:

- consultation with the Insured and his attending physician to gain understanding of the treatment plan recommended by the attending physician;
- comparison with the Insured’s attending physician of the recommended treatment plan with alternatives, if any, that represent Reasonable Treatment;
- identification to the Insured’s attending physician of opportunities for education and support; and
- monitoring the Insured’s adherence to the treatment plan recommended by the person’s attending physician.

In determining whether to implement Health Case Management, we may assess such factors as the service or supply, the Insured’s medical condition, and the existence of generally accepted medical guidelines for objectively measuring medical effectiveness of the treatment plan recommended by the attending physician.

Health Case Management Limitation

We can, on such terms as we determine, limit the payment of benefits for a service or supply where:

- we have implemented Health Case Management and the Insured does not participate or cooperate; or
- the Insured has not adhered to the treatment plan recommended by his attending physician with respect to the use of the service or supply.

Health Case Management Expense Benefit

Expenses associated with Health Case Management may be paid for by us at our discretion. Expenses claimed under this Benefit provision must be pre-authorized by us.

Designated Provider Limitation

For a service or supply to which prior authorization applies or where we have recommended or approved Health Case Management, we can require that the service or supply be purchased from or administered by a provider designated by us, and

- limit Eligible Charges for a service or supply that was not purchased from or administered by a provider designated by us to the cost of the service or supply had it been purchased from or administered by the provider designated by us, or
- decline a claim for a service or supply that was not purchased from or administered by a provider designated by us.

Patient Assistance Program

A Patient Assistance Program means a program that provides assistance to an Insured with respect to the purchase of services or supplies.

We can require the Insured to apply to and participate in any Patient Assistance Program to which the Insured may be entitled. Further, we can reduce the amount of Eligible Charges for a service or supply by an amount up to the amount of financial assistance the Insured is entitled to receive for that service or supply under a Patient Assistance Program.

Survivor Benefit

If an Insured who is an Employee dies while he is insured under this provision, the Benefits provided under this provision will be continued in force with respect to a Survivor until the earliest of the following dates:

1. In the case of the spouse of the deceased Employee, or a child, the date on which the spouse remarries.

2. In the case of a child, the date on which the child ceases to be a Dependent as defined in the policy details of this policy.

3. The date on which this policy or provision is no longer in force.

4. The date on which the second anniversary of the death of the Employee occurs.

No premium payment will be required for the above continuation of insurance.

"Survivor" as used in this section means a Dependent who is insured under this provision on the date of death of the Employee of whom he is a Dependent.

MEDI-PACK BENEFIT

Vision Care Supplement

Benefit Amount - 100% of the eligible charges

Deductible Amount - Nil

Charges

1. Charges for eye examinations, including eye refractions, up to a maximum of one such examination in any two consecutive calendar years, and subject to the maximum shown in the Policy Details for each Insured.

2. Charges for eye glasses or contact lenses and the fittings of such eyewear up to the maximum shown in the Policy Details for each Insured.

3. Charges for one pair of contact lenses if visual acuity is improved to at least a 20/40 level and this level of acuity is not possible through wearing eye glasses, up to the maximum shown in the Policy Details for each Insured.

4. Charges for the services of visual training and remedial exercises. The Benefit Maximum will be 50% of the fees charged for such services. The Benefit Amount described in the Policy Details will not apply to this charge.

5. Charges for the diagnosis and treatment of accidental injury or disease to the eyes.

6. Charges for visual motor therapy, up to the maximum shown in the Policy Details for each Insured.

Limitations

1. Charges defined above may be included only to the extent that they are recommended or approved by a legally licensed physician, surgeon, ophthalmologist or optometrist.

2. Charges defined in clauses 4 and 5 above will only be recognized as eligible services if they are received in Canada.

3. Charges defined above are not applicable to an Insured once laser eye surgery expenses are paid under the Medical Reimbursement Benefits contract

MEDI-PACK BENEFIT

Paramedical Services Supplement

Charges

1. X-ray examinations that are recommended or approved by a legally licensed chiropractor.

2. The services that are provided by any of the legally licensed practitioners listed below:

   - Chiropractors
   - Osteopaths
   - Podiatrists or Chiropodists
   - Naturopaths
   - Masseurs
   - Speech Therapists
   - Clinical Psychologists, Psychotherapists or Social Workers
   - Physiotherapists
   - Acupuncturists

Limitations

1. The maximum amount that we will pay with respect to Charges defined above which are incurred by each Insured with respect to each classification of practitioners in a calendar year is shown in the Policy Details.

2. The maximum amount that we will pay for each treatment by a practitioner will be an amount as determined by the applicable Schedule of Fees approved by the Association of which the practitioner is a member. If there is no applicable Schedule of Fees we will determine the maximum amount that is to be paid.

For an Insured who is resident in the Province of Ontario, no payment for expenses will be made under this Supplement for podiatrist services which were performed prior to the date the Insured had satisfied his annual OHIP maximum for such services, subject always to the Limitations contained in this Supplement.

DENTAL CARE BENEFIT - 1

Benefit Amount

The Benefit Amount is the percentage of the eligible incurred charges that we will pay to an Employee subject to the other terms of this provision. The Benefit Amount is shown in the Policy Details.

Deductible Amount

The Deductible Amount is the portion of the incurred charges which must be paid by an Employee in each calendar year before we will pay the Benefit Amount under this provision. The Deductible Amount is shown in the Policy Details.

Conditions

We will pay the Benefit Amount to the Employee for any of the incurred charges defined in this provision provided that the charge meets all of the following conditions:

1. It is necessarily incurred.
2. It is incurred while the Insured is insured under this provision.
3. It is not the result of a service or treatment which the Insured would receive without being charged if he was not insured under this provision.
4. The treatment for it has been performed, recommended or approved by a legally licensed dentist or denturist.
5. We are not prohibited from paying it by any applicable law of the jurisdiction where the Insured resides at the time the charge is incurred.

Assignment of Benefits

We reserve the right to refuse any assignment of benefits under this provision.

Benefit Maximum

The amount payable under this provision is subject to the following limits:

1. Where there are 2 or more courses of treatment available to adequately correct a dental condition, reimbursement may be based on the cost of the least expensive treatment which provides adequate care to the Insured. This Alternate Benefit Clause is in no way an attempt to change a treatment plan. The choice of treatment is a matter of agreement solely between the Insured and the dentist.
2. It may not be more than the amount recommended in the Dental Association Suggested Fee Guide for General Practitioners of the Province or Territory where the services were rendered. The applicable Suggested Fee Guide is shown in the Policy Details. If the provision is based on a current Suggested Fee Guide, the effective date of a change in such Suggested Fee Guide will be deemed to be the first day of the calendar month coincident with or next following the date we receive a copy of the new Suggested Fee Guide.

3. If there is a range of fees shown in the Dental Association Suggested Fee Guide for an eligible charge, or if fees for such charges are subject to individual consideration, or if fees for insured laboratory charges are included, we may determine the amount that will be payable with respect to such charges.

4. Any Benefit maximum shown in the Policy Details.

5. If the charge is for treatment of dental injuries to natural teeth or the replacement of natural teeth that is insured under a Medi-Pack Benefit included in this policy, we will only pay up to the difference between the actual amount of the charge incurred and the amount that is payable under the Medi-Pack Benefit, subject to all of the terms of this provision.

Any Benefit maximum shown in this policy will be applied separately to each Insured.

The actual procedures under the outline of the insured charges are identified by a code system which is used by the Canadian Dental Association. Where a Province or Territory does not employ the Canadian Dental Association procedure codes, the appropriate codes in the fee guide of such Province or Territory for the equivalent procedure will apply.

A change in the Canadian Dental Association codes will not result in a change in the coverage under this provision, payment may be based on the cost of similar services which are eligible expenses.

Definition

"Insured" means:

1. An Employee, while he is insured under this provision.

2. A Dependent of an Employee, while the Dependent is insured under this provision.

Predetermination of Benefits

If the dental expenses in connection with an Insured's treatment will exceed $500, the proposed treatment plan completed by the attending dentist must be filed with and approved by us prior to the date on which the treatment is to start.

Survivor Benefit

If an Insured who is an Employee dies while he is insured under this provision, the Benefits provided under this provision will be continued in force with respect to a Survivor until the earliest of the following dates:

1. In the case of the spouse of the deceased Employee, or a child, the date on which the spouse remarries.

2. In the case of a child, the date on which the child ceases to be a Dependent as defined in this policy.

3. The date on which this policy or provision is no longer in force.

4. The date on which the second anniversary of the death of the Employee occurs.

No premium payment will be required for the above continuation of insurance.

"Survivor" as used in this section means a Dependent who is insured under this provision on the date of death of the Employee on whom he is a Dependent.

Exclusions

No amount of Benefit will be payable under this provision for any charge that resulted either directly or indirectly from, or was in any manner or degree associated with, or occasioned by, any one or more of:

- Any cause for which the Insured may apply for and receive indemnity or compensation under any Workers' Compensation Act.
- Intentionally self-inflicted injury.
- War, insurrection or hostilities of any kind, whether or not the Insured was a participant in such actions.
- Participating in any riot or civil commotion.
- Committing or attempting to commit a criminal offence or provoking an assault.
- Any Group or Policyholder-Sponsored dental care or treatment.
- Any dental care or treatment for which the Insured is not legally obliged to pay.
- Any dental care or treatment which is principally for cosmetic purposes.
- Any appointments not kept or for the completion of claims forms.
- Any dental treatment that has as its purpose the correction of temporomandibular joint dysfunction.
- Any endodontic treatment commencing prior to the date on which the Insured becomes insured under this provision, except as required to be consistent with the terms of the applicable Extension of Insurance on Replacement of this Policy section.
- Replacement of mislaid, lost or stolen appliances.
- Any crowns placed on teeth that are not functionally impaired by incisal or cuspal damage.
- Any crowns, bridges or dentures for which tooth preparations were made prior to the date on which the Insured becomes insured under this provision, except as required to be consistent with the terms of the applicable Extension of Insurance on Replacement of this Policy section.
- Any orthodontic expenses which were incurred prior to the date on which the insured became insured under this provision.

DENTAL CARE BENEFIT - 1

Dental 1 Charges

A. Diagnostic

(1) Initial Examinations (not more than 1 examination in any period of 6 consecutive months)

(2) Recall Examinations (not more than 1 examinations in any period of nine consecutive months)

(3) Specific Examinations (not more than one examination in any period of 6 consecutive months)

(4) Emergency Examination

(5) Full Mouth Series (not more than once in any period of 24 consecutive months)

(6) Periapical

(7) Occlusal

(8) Bitewings (not more than twice in any calendar year)

(9) Extraoral

(10) Sialography

(11) Panorex

(12) Cephalometric

(13) Other X-rays

(14) Tests

(15) Consultations

B. Preventive

(1) Polishing (not more than twice in a calendar year with a maximum of 1 unit per recall visit)

(2) Recall Scaling (not more than twice in a calendar year with a maximum of 1 unit per recall visit)

(3) Preventive Recall Packages (not more than twice in any calendar year)

(4) Fluoride treatment

(5) Oral Hygiene Instruction (not more than once in any period of 6 consecutive months)

(6) Space maintainers (applicable only to the Dependent children of an Employee under 14 years of age)

(7) Occlusal Equilibration (not more than 8 units in any calendar year)

(8) Pit and Fissure Sealants

C. **Minor Restorative**

(1) Caries, Trauma and Pain Control

(2) Amalgam Restorations

(3) Retentive pins

(4) Stainless Steel, Plastic and Polycarbonate (applicable only to the Dependent children of an Employee while they are under 15 years of age)

(5) Tooth Coloured

(6) Veneer Applications

D. **Minor Surgical**

(1) Extractions

(2) Residual Root Removal

E. **Additional Services**

(1) Anaesthesia (used in conjunction with an eligible dental expense)

(2) Professional Visits

(3) Miscellaneous

DENTAL CARE BENEFIT - 1

Dental 2 Charges

A. **Periodontics**

(1) Non-surgical

(2) Surgical (the maximum benefit payable will include charges for packing and post-surgical treatment)

(3) Adjunctive Services

(4) Scaling and/or Root Planing

(5) Periodontal Appliance and Repair

B. **Endodontics**

(1) Pulpotomy

(2) Pulpectomy

(3) Root Canal Therapy

(4) Apexification

(5) Periapical Services

(6) Root Amputation

(7) Surgery

(8) Hemisection

(9) Intentional Removal, Apical Filling and Reimplantation

(10) Endosseous Treatment

(11) Retrofilling

(12) Endodontic Bleaching

(13) Other Procedures

C. Major Surgical

(1) Surgical Exposure

(2) Alveoloplasty, Gingivoplasty, Stomatoplasty, Vestibuloplasty

(3) Surgical Excision

(4) Surgical Incision

(5) Fractures

(6) Frenectomy

(7) Miscellaneous

Dental 2 Extension of Insurance

If an Insured's insurance under this provision terminates due to one of the reasons shown below and he had commenced root canal treatment prior to such termination, he will continue to be insured for any charges incurred for such treatment during the 30 days after such termination:

1. Termination of an Employee's employment.

2. The Employee ceases to qualify under the definition of Employee.

3. Termination of this policy, except when this policy is replaced by a policy issued by another insurer.

Dental 2 Extension of Insurance on Replacement of this Policy

If an Insured is undergoing root canal treatment, the insurer with the policy in force at the date the canal is closed will be responsible for the charges incurred.

DENTAL CARE BENEFIT - 1

Dental 3 Charges

A. **Removable Prosthodontics**

(1) Complete Dentures

(2) Transitional Complete Dentures

(3) Transitional Partial Dentures

(4) Acrylic Partial Dentures

(5) Cast Partial Dentures

(6) Denture Adjustments

(7) Denture Repairs

(8) Denture Relining

(9) Denture Rebasing

(10) Denture Tissue Conditioning

(11) Miscellaneous

B. **Fixed Prosthodontics**

(1) Pontics

(2) Repairs

(3) Retainers and Abutments

(4) Splinting

(5) Retentive Pins in Retainers and Abutments

(6) Other Services

C. **Major Restorative**

(1) Inlay/Onlay Restorations

(2) Retentive Pins in Inlays, Onlays and Crowns

(3) Crowns

(4) Veneer Applications

(5) Posts

(6) Other Services

Dental 3 Extension of Insurance

If an Insured's insurance under this provision terminates due to one of the reasons shown below and he has had a tooth prepared for a crown, bridge or denture prior to such termination, he will continue to be insured for any charges incurred with respect to such crown, bridge or denture during the 90 days after such termination:

1. Termination of an Employee's employment.

2. The Employee ceases to qualify under the definition of Employee.

3. Termination of this policy, except when this policy is replaced by a policy issued by another insurer.

Dental 3 Extension of Insurance on Replacement of this Policy

If an Insured is undergoing crown, bridge or denture work, the insurer with the policy in force at the date the appliance is installed will be responsible for the charges incurred.

Dental 3 Limitations

Charges for replacing an existing denture or bridgework will only be paid if such replacement is for an equivalent denture or bridgework and it meets one of the conditions shown below:

1. The existing denture or bridgework was installed at least 5 years prior to its replacement and cannot be made serviceable.

2. The existing denture or bridgework is an immediate temporary denture or bridgework, for which impressions were taken while the Insured is covered under this provision. The permanent replacement denture or bridgework must be placed within 12 months from the date of installation of the immediate temporary denture or bridgework.

3. The existing denture or bridgework is replaced because additional teeth have been extracted after the denture or bridgework insertion, and while the Insured is covered under this provision.

DENTAL CARE BENEFIT - 1

Dental 4 Charges

Orthodontic Treatment

Charges incurred with respect to an Insured, who is a Dependent child, for all necessary dental services or treatment which has as its objective the correction of malocclusion of the teeth.

Payment of Orthodontic Claims

We will pay for the charges incurred based on one of the following:

(1) If an estimated cost of treatment is used in place of an itemized statement, Benefits for the insured cost of the charge will be payable on a monthly or quarterly basis as billed by the dentist. The average monthly Benefit will be the total estimated cost of treatment, less the initial costs (case diagnosis, initial appliance cost, treatment plan) divided by the number of months in the treatment plan as specified by the dentist.

(2) If a separate estimate of the cost of the initial appliance is included, the first payment will be an amount equal to the insured cost of the appliance. The remainder of the payments will be as calculated in accordance with the terms of clause (1) above.

(3) If a statement is submitted for each treatment as the charge is incurred, payment for the insured cost of the charge will be made as such charge is incurred.

(4) Notwithstanding anything to the contrary in this provision, if an Insured described above incurs charges described in another section of this provision as part of a treatment described in this Dental 4 Charges section, then such charges will be deemed to have been incurred under this Dental 4 Charges section for the purpose of calculating Benefit Amounts and Maximum Benefit Amounts.

DENTAL CARE BENEFIT - 2

Benefit Amount

The Benefit Amount is the percentage of the eligible incurred charges that we will pay to an Employee subject to the other terms of this provision. The Benefit Amount is shown in the Policy Details.

Deductible Amount

The Deductible Amount is the portion of the incurred charges which must be paid by an Employee in each calendar year before we will pay the Benefit Amount under this provision. The Deductible Amount is shown in the Policy Details.

Conditions

We will pay the Benefit Amount to the Employee for any of the incurred charges defined in this provision provided that the charge meets all of the following conditions:

1. It is necessarily incurred.

2. It is incurred while the Insured is insured under this provision.

3. It is not the result of a service or treatment which the Insured would receive without being charged if he was not insured under this provision.

4. The treatment for it has been performed, recommended or approved by a legally licensed dentist or denturist.

5. We are not prohibited from paying it by any applicable law of the jurisdiction where the Insured resides at the time the charge is incurred.

Assignment of Benefits

We reserve the right to refuse any assignment of benefits under this provision.

Benefit Maximum

The amount payable under this provision is subject to the following limits:

1. Where there are 2 or more courses of treatment available to adequately correct a dental condition, reimbursement may be based on the cost of the least expensive treatment which provides adequate care to the Insured. This Alternate Benefit Clause is in no way an attempt to change a treatment plan. The choice of treatment is a matter of agreement solely between the Insured and the dentist.

2. It may not be more than the amount recommended in the Dental Association Suggested Fee Guide for General Practitioners of the Province or Territory where the services were rendered. The applicable Suggested Fee Guide is shown in the Policy Details. If the provision is based on a current Suggested Fee Guide, the effective date of a change in such Suggested Fee Guide will be deemed to be the first day of the calendar month coincident with or next following the date we receive a copy of the new Suggested Fee Guide.

3. If there is a range of fees shown in the Dental Association Suggested Fee Guide for an eligible charge, or if fees for such charges are subject to individual consideration, or if fees for insured laboratory charges are included, we may determine the amount that will be payable with respect to such charges.

4. Any Benefit maximum shown in the Policy Details.

5. If the charge is for treatment of dental injuries to natural teeth or the replacement of natural teeth that is insured under a Medi-Pack Benefit included in this policy, we will only pay up to the difference between the actual amount of the charge incurred and the amount that is payable under the Medi-Pack Benefit, subject to all of the terms of this provision.

Any Benefit maximum shown in this policy will be applied separately to each Insured.

The actual procedures under the outline of the insured charges are identified by a code system which is used by the Canadian Dental Association. Where a Province or Territory does not employ the Canadian Dental Association procedure codes, the appropriate codes in the fee guide of such Province or Territory for the equivalent procedure will apply.

A change in the Canadian Dental Association codes will not result in a change in the coverage under this provision, payment may be based on the cost of similar services which are eligible expenses.

Definition

"Insured" means:

1. An Employee, while he is insured under this provision.

2. A Dependent of an Employee, while the Dependent is insured under this provision.

Predetermination of Benefits

If the dental expenses in connection with an Insured's treatment will exceed $500, the proposed treatment plan completed by the attending dentist must be filed with and approved by us prior to the date on which the treatment is to start.

Survivor Benefit

If an Insured who is an Employee dies while he is insured under this provision, the Benefits provided under this provision will be continued in force with respect to a Survivor until the earliest of the following dates:

1. In the case of the spouse of the deceased Employee, or a child, the date on which the spouse remarries.

2. In the case of a child, the date on which the child ceases to be a Dependent as defined in this policy.

3. The date on which this policy or provision is no longer in force.

4. The date on which the second anniversary of the death of the Employee occurs.

No premium payment will be required for the above continuation of insurance.

"Survivor" as used in this section means a Dependent who is insured under this provision on the date of death of the Employee on whom he is a Dependent.

Exclusions

No amount of Benefit will be payable under this provision for any charge that resulted either directly or indirectly from, or was in any manner or degree associated with, or occasioned by, any one or more of:

- Any cause for which the Insured may apply for and receive indemnity or compensation under any Workers' Compensation Act.
- Intentionally self-inflicted injury.
- War, insurrection or hostilities of any kind, whether or not the Insured was a participant in such actions.
- Participating in any riot or civil commotion.
- Committing or attempting to commit a criminal offence or provoking an assault.
- Any Group or Policyholder-Sponsored dental care or treatment.
- Any dental care or treatment for which the Insured is not legally obliged to pay.
- Any dental care or treatment which is principally for cosmetic purposes.
- Any appointments not kept or for the completion of claims forms.
- Any dental treatment that has as its purpose the correction of temporomandibular joint dysfunction.
- Any endodontic treatment commencing prior to the date on which the Insured becomes insured under this provision, except as required to be consistent with the terms of the applicable Extension of Insurance on Replacement of this Policy section.
- Replacement of mislaid, lost or stolen appliances.

DENTAL CARE BENEFIT - 2

Dental 1 Charges

A. **Diagnostic**

(1) Initial Examinations (not more than 1 examination in any period of 6 consecutive months)

(2) Recall Examinations (not more than one examination every 9 months)

(3) Specific Examinations (not more than one examination in any period of 6 consecutive months)

(4) Emergency Examination

(5) Full Mouth Series (not more than once in any period of 24 consecutive months):

(6) Periapical

(7) Occlusal

(8) Bitewings (not more than twice in any calendar year)

(9) Extraoral

(10) Sialography

(11) Panorex

(12) Cephalometric

(13) Other X-rays

(14) Tests

(15) Consultations

B. **Preventive**

(1) Polishing (not more than twice in a calendar year with a maximum of 1 unit per recall visit)

(2) Recall Scaling (not more than once every 9 months with a maximum of 1 unit per recall visit)

(3) Preventive Recall Packages (not more than one examination every 9 months)

4) Fluoride treatment

(5) Oral Hygiene Instruction (not more than once in any period of 6 consecutive months)

(6) Space maintainers (applicable only to the Dependent children of an Employee under 14 years of age)

(7) Occlusal Equilibration (not more than 8 units in any calendar year)

(8) Pit and Fissure Sealants

C. **Minor Restorative**

(1) Caries, Trauma and Pain Control

(2) Amalgam Restorations

(3) Retentive pins

(4) Stainless Steel, Plastic and Polycarbonate (applicable only to the Dependent children of an Employee while they are under 15 years of age)

(5) Tooth Coloured

(6) Veneer Applications

D. **Minor Surgical**

(1) Extractions

(2) Residual Root Removal

E. **Additional Services**

(1) Anaesthesia (used in conjunction with an eligible dental expense)

(2) Professional Visits

(3) Miscellaneous

DENTAL CARE BENEFIT - 2

Dental 2 Charges

A. **Periodontics**

(1) Non-surgical

(2) Surgical (the maximum benefit payable will include charges for packing and post-surgical treatment)

(3) Adjunctive Services

(4) Scaling and/or Root Planing

(5) Periodontal Appliance and Repair

B. **Endodontics**

(1) Pulpotomy

(2) Pulpectomy

(3) Root Canal Therapy

(4) Apexification

(5) Periapical Services

(6) Root Amputation

(7) Surgery

(8) Hemisection

(9) Intentional Removal, Apical Filling and Reimplantation

(10) Endosseous Treatment

(11) Retrofilling

(12) Endodontic Bleaching

(13) Other Procedures

C. <u>Removable Prosthodontics – Related Services</u>

(1) Denture Adjustments

(2) Denture Repairs

(3) Denture Relining

(4) Denture Rebasing

(5) Denture Tissue Conditioning

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