Your group insurance benefits

Tree Island Industries Ltd.

Union Employees

Standard Life

TREE ISLAND®

Standard Life

Your Group Insurance Benefits

Tree Island Industries Ltd.

Class: 300 Union Employees

Policy: 33778

Effective Date: April 1, 2013

Modification Date: November 1, 2013

This Booklet Has Been Prepared In Collaboration With

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1. General Provisions — Definitions

For the purposes of this booklet, the masculine pronoun and adjective include the feminine, unless a different meaning is plainly to be taken from the context.

All words have their usual meaning, unless a special meaning is indicated.

1.1. Accidental Injury

Any bodily lesion, sustained while your insurance is in force, directly and solely due to an external, sudden, violent and unintentional cause, independent of any illness and requiring within 30 days of the event the care of a physician or an appropriate specialist.

1.2. Actively At Work

The status of a participant who is physically and mentally capable of doing each and every personal job-related work function and who is actually working full-time or part-time in a permanent manner on the basis of a minimum 20 hour workweek at the policyholder's place of business or at any other place designated for the performance of a specific job-related task.

1.3. Dependents

Your spouse or your children or your spouse's children, whether taken individually or collectively. If dependents are insured under this policy, the words spouse and child have the following meanings.

1.3.1. Spouse

1. Your legal spouse.

2. A person whom you publicly acknowledge as your spouse.

The person you have designated in writing to the insurer as your spouse is recognized as your dependent, until such time as you advise otherwise.

Any dissolution of a marriage through divorce or annulment or, in the case of common-law marriage, actual separation for over 3 months, results in the loss of status as spouse.

1.3.2. Child

Your or your spouse's single, legitimate, natural or adopted child who depends on you for livelihood and who meets at least one of the following conditions:

1. He is under 21 years of age.

2. He is under 26 years of age and attending an educational institution on a full-time basis.

3. He became totally and permanently disabled while still considered to be a dependent under 1. or 2. above.

1.4. Elimination Period

The continuous period during which you must be absent due to disability before you can begin to receive monthly disability income in respect of subsequent months.

1.5. Employee

A person actively working in a permanent manner on full-time or part-time basis for the policyholder and receiving regular income for services rendered.

Temporary and seasonal employees are not eligible for coverage.

Part-time employees who work less than 20 hours per week are not eligible.

1.6. Illness, Disease, Sickness

Any pathological condition resulting from a deviation of health requiring both regular and continuous medical care actually given by a physician or an appropriate specialist and an appropriate therapy, considered satisfactory by the insurer.

1.7. Income

Your remuneration as declared by your employer to the insurer.

1.8. Net Income

Your annual income, less the income tax deducted according to the tax tables established under the Canadian Income Tax Act and by any similar legislation of your province of residence.

1.9. Physician

A person duly authorized by a provincial law to practice medicine and who is a member in good standing of a professional medical body.

1.10. Specialist

A physician practicing a specialty of medicine for which he is certified by the Royal College of Physicians and Surgeons of Canada or by the Corporation professionnelle des médecins du Québec, or both.

2. General Provisions — Insurance

2.1. Employee Eligibility

You must complete an application form supplied by your employer for yourself and your dependents, if any.

You become eligible for insurance on the date that you have satisfied the eligibility period specified in the Summary of Benefits.

2.2. Dependents Eligibility

Your dependents become eligible for insurance at the later of the following dates:

1. The day on which you become eligible.
2. The day on which you have a dependent for the first time.

If your application is received by your employer more than 31 days after your eligibility date, you must provide evidence of your insurability, at no expense to the insurer.

2.3. Effective Date Of Insurance

Your insurance and your dependents' insurance, if any, become effective on one of the following dates:

1. Your eligibility date, if your application card is received by your employer on or prior to that date.
2. Your eligibility date, if your application card is received by your employer within 31 days after such date.
3. The date on which the insurer accepts your required evidence of insurability, in all other cases. Such evidence must be provided at no expense to the insurer.

If you were not actively at work on the date your insurance would have otherwise become effective, the insurance takes effect on the date you return to active work.

If your dependents are already insured, any person who subsequently becomes a dependent is immediately insured.

If this group contract is a replacing contract issued within 31 days following the termination of the previous group contract, all applicable legislation and the guidelines of the Canadian Life and Health Insurance Association, concerning the continuation of insurance following the termination of a preceding group contract, will apply.

However, for any claims, Standard Life will not be responsible for paying benefits if in accordance with the previous contract provisions, the previous insurer remains responsible for paying the benefits.

2.4. Change in Coverage

Your employer must immediately notify the insurer in writing, of any event likely to change your insurance coverage, on forms provided for that purpose. Such change takes effect on the actual date of the event. However, in the case of increased coverage, the change takes effect at the later of the following dates:

1. The actual date of the event, if your employer receives notice prior to that date, provided you are then actively at work.

2. The date on which your employer receives the written notice, if such receipt follows the date of the event, provided you are then actively at work.

However, if you were not actively at work on the date the change would have otherwise become effective, the change takes effect on the day you return to active work.

2.5. Termination of Insurance

Your insurance or your dependents' insurance terminates at the earliest of the following dates:

1. On the date you cease to qualify as an eligible employee.

2. On the date the benefit or contract is terminated.

3. On the last day of the period for which the premium has been paid by your employer.

The termination date for each benefit and the reduction formula for the insurance amounts are specified in the Summary of Benefits.

2.6. Claims

If you submit a claim you must provide satisfactory proof within the time limit specified hereafter. Claims must be submitted either through accepted electronic network or on the appropriate forms, which must be completed in full, dated and signed. Claims must be submitted to Standard Life's Head Office or to a designated regional office at no expense to Standard Life. Claim forms and information necessary to submit a claim are available from your Plan Administrator or from our VIP Room Web site at www.standardlife.ca.

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

In this section, the word « contract » refers to the policy and « Insurance Act » refers to the Insurance Act of British Columbia or the Insurance Act of Alberta depending on law applicable to such action or proceeding.

2.6.1. Health Insurance

Claims must be received by Standard Life not later than 15 months from the date that the expense is incurred. However, if coverage for a participant is terminated, including termination of the benefit or contract, all claims must be received by Standard Life not later than 3 months following the termination date. All claims received by Standard Life following these time periods will be declined.

2.6.2. Expenses incurred out-of-Canada under Health Insurance

Claims for hospitalization and physician services incurred out-of-Canada should be received by Standard Life within 90 days following treatment or hospital discharge.

2.6.3. Travel Assistance - Travel Assistance Plus

The insured person must submit to GESA Assistance, within 5 days of an emergency, a declaration of the circumstances of the accident or sudden illness and its known or presumed causes.

2.6.4. Dental Care

Claims must be received by Standard Life not later than 15 months from the date that the expense is incurred. However, if coverage for a participant is terminated, including termination of the benefit or contract, claims must be received by Standard Life not later than 3 months following the termination date. All claims received by Standard Life following these time periods will be declined.

2.6.5. Disability

In the case of disability, the insured person must provide evidence of disability considered satisfactory by Standard Life within 90 days following the date on which he first became entitled to such benefit and thereafter, as often as Standard Life may reasonably require.

2.6.6. Life Insurance and Accidental Death

A life insurance or accidental death claim must be submitted within the time limit prescribed by law. Standard Life reserves the right to require an autopsy, unless prohibited by law.

2.6.7. Accidental Dismemberment

A claim for a loss specified under the accidental dismemberment benefit must be received by Standard Life within 90 days from the date of loss.

Upon termination of the group insurance contract or a benefit, for any disability that began prior to the termination date, Standard Life must receive a claim for a disability benefit or a waiver of premium payment provided under the Participant's Life Insurance Benefit, within a period of 180 days following the commencement of the disability, or within the time period specified in the contract if longer.

2.7. Beneficiary

You may designate one or several beneficiaries. You must, however, advise your employer in writing of any beneficiary designation or change of beneficiary, on forms supplied for that purpose by your employer.

If you have not designated a beneficiary, or if your beneficiary should predecease you, the benefit will be paid to your estate.

You are the beneficiary of your dependents' life insurance, if your plan covers your dependents.

2.8. Documents

You have the right to receive copies of documents you have completed, as well as a copy of the contract for your plan. Please contact Standard Life for any applicable fees.

3. Participant's Life Insurance Benefit

3.1. Sum Insured

Upon death, the sum insured specified in the Summary Of Benefits will be paid to your beneficiary.

3.2. Conversion Privilege

If your life insurance coverage under this benefit is cancelled, on or prior to your 65th birthday, you may convert all or part of your insurance coverage, with the exception of the waiver of premiums provision, into an individual life insurance contract, within 31 days of such cancellation without having to provide evidence of insurability. Such a contract may be a convertible one year term insurance contract, term insurance coverage to age 65 or any individual contract which Standard Life has designated under the conversion privilege at the time the application for conversion is submitted.

The amount of insurance converted will be limited by the following:

1. If coverage is cancelled because this benefit or group contract is cancelled, the amount of the individual life insurance contract may not exceed the amount of insurance that is terminated less any amount of insurance for which you would be eligible under any other group policy within 31 days after your insurance terminates.

2. If coverage is cancelled because of termination of employment or upon retirement, the amount of the individual life insurance contract may not exceed the amount of insurance that is terminated.

3. If you do not apply for the entire amount of insurance available under the conversion privilege, the individual life insurance amount cannot be less than the minimum amount which Standard Life issues for the plan selected.

4. In all cases the amount of the individual life insurance contract cannot exceed $400,000 for a Québec resident or $200,000 for a resident of any other Canadian province or territory.

   If you are entitled to convert coverage under another benefit provided under this policy, the sum of the amounts available for conversion cannot exceed $400,000 for a Québec resident or $200,000 for a resident of any other Canadian province or territory.

The individual life insurance contract becomes effective at the end of the 31 day conversion period. The premium for the individual contract is that which is then required by the insurer for the type of contract selected, taking into account the amount of insurance and the age and sex of the insured person.

3.3. Extension Of Life Insurance Without Premium Payment

If you are less than 65 years old or you attain age 65 on the date of your termination of employment, your retirement, the termination of the benefit or of the group contract, your life insurance is extended, without premium payment for 31 days following such date.

For a Québec resident, the amount of extended life insurance is the sum insured under the group plan. For a resident of any other Canadian province or territory, the amount of extended life insurance cannot exceed the amount of life insurance that is convertible under the conversion privilege.

3.4. Waiver Of Premiums

If your claim for Long Term Disability Benefit has been approved, the premiums under this benefit will be waived for the period during which you are eligible to receive a monthly disability benefit. The waiver of premiums period commences as of the end of the elimination period and terminates as of the end of the maximum period specified under the section Long Term Disability Benefit of the Summary Of Benefits.

At all times, the amount of insurance for which waiver of premiums is granted will not be greater than that which was in force on the onset of your disability and will be subject to the same reduction and termination as if you were actively at work.

If your claim under the Long Term Disability Benefit has been declined or if you cease to be eligible to receive the monthly disability benefit, you will be eligible for waiver of premiums under this benefit subject to the following terms and conditions.

3.4.1. Eligibility

1. You are acknowledged disabled as defined under Definition Of Disability specified hereinafter.

2. You are less than 65 years of age at the onset of disability.

3. You became disabled prior to termination of employment while insured under this benefit.

3.4.2. Definition Of Disability

A state of complete and continuous incapacity, resulting from illness or accidental injury, which wholly prevents you, during the elimination period specified in the Summary Of Benefits and afterwards, from performing any occupation for which you are or may become reasonably qualified by training, education or experience. Furthermore, you must not be able to earn 60% or more of your gross monthly income determined at the onset of disability, as deemed by the insurer.

3.4.3. Conditions For Acknowledgment Of Disability

Your condition must require both regular and continuous medical care provided by an appropriate physician and appropriate treatment, deemed satisfactory by the insurer, be followed.

3.4.4. Evidence Of Disability

You must provide evidence of disability considered satisfactory by Standard Life within 90 days following the elimination period specified in the Summary Of Benefits. If your premiums are waived you must provide the insurer with a proof of continuance of disability, as often as the insurer may reasonably require. Such proof must be submitted to Standard Life's Head Office or to a designated regional office at no expense to Standard Life.

3.4.5. Amount Of Insurance

At all times, the amount of insurance for which waiver of premiums is granted will not be greater than that which was in force on the onset of your disability and will be subject to the same reduction and termination as if you were actively at work.

3.4.6. Beginning Date

The waiver of premiums commences following the completion of the elimination period specified in the Summary Of Benefits.

3.4.7. Termination Date

The waiver of premiums ceases at the earliest of the following dates:

1. The date on which you cease to be disabled.
2. The date on which you reach:
   a) The age of 65.
   b) The normal retirement age under your employer's pension plan.
3. The date on which you fail:
   a) To provide any evidence of disability required by the insurer.
   b) To submit to an examination or interview required by the insurer.
   c) To follow appropriate treatment deemed satisfactory by the insurer.

3.5. Living Benefit

Should you become terminally ill, an advanced death benefit, hereinafter-called Living Benefit, may be payable, subject to the terms and conditions defined below.

3.5.1. Definition Of Terminally Ill

To be considered terminally ill:

1. You must be suffering from an illness from which death is expected within 12 months of the date the insurer receives the Living Benefit claim.

   and

2. The life insurance benefit premiums must be waived in accordance with the Waiver Of Premiums clause.

3.5.2. Physician's Statement

The claim for a Living Benefit payment must be supported by a statement from your physician that clearly and fully states the nature of the illness and that the life expectancy is less than 12 months.

The insurer reserves the right to request further medical statements and a medical examination by a physician designated by the insurer.

The insurer reserves the right to decline the claim for a Living Benefit payment if, in the opinion of its medical advisors, the evidence submitted is not conclusive.

3.5.3. Benefit

The amount payable will be equal to 50% of the sum insured on the date the insurer receives the Living Benefit claim, subject to a maximum of $50,000.

If the insurer receives the request within the 12 months preceding the date on which the sum insured is reduced, the amount payable will be reduced by the percentage specified in the Summary Of Benefits.

In all cases, the amount of the Living Benefit payable under this benefit and the Participant's Optional Life Insurance Benefit cannot exceed $50,000.

The final death benefit payable to the beneficiary will be equal to the sum insured on the date of death less the Living Benefit paid, less the interest accrued. The interest on the Living Benefit payment will be calculated from the date of payment to the date of death, at a rate determined by Standard Life on the date of the Living Benefit payment.

3.5.4. Exclusions

No Living Benefit payment will be made:

1. If the insurer receives the request within the 12 months preceding the date on which the participant's life insurance terminates, such as specified in the Summary Of Benefits.
2. As a result of an accidental injury.
3. Following the termination of this benefit or policy.

3.5.5. Beneficiary

The beneficiary designation must be irrevocable. Furthermore, the irrevocable beneficiary must sign a statement whereby he accepts that the Living Benefit payment plus any interest, will be deducted from the sum insured on the date of death. The irrevocable beneficiary designation may be submitted with the Living Benefit request.

3.5.6. Other Considerations

The Living Benefit payment is not taxable because it is considered by Canada Customs and Revenue Agency to be part of the death benefit. Notwithstanding this, you should examine all the possible ramifications of obtaining this payment. Examples are the possible elimination or ineligibility to social programs; furthermore the amount paid becomes part of your assets and therefore your creditors could seize the amount whether you have declared bankruptcy or not.

4. Participant's Optional Life Insurance Benefit

4.1. Sum Insured

Upon death, the sum insured specified in the Summary Of Benefits, based on the option previously elected, if applicable, will be paid to your beneficiary.

Any change in option will be subject to approval of evidence of insurability by the insurer.

4.2. Conversion Privilege

If your life insurance coverage under this benefit is cancelled, on or prior to your 65th birthday, you may convert all or part of your insurance coverage, with the exception of the waiver of premiums provision, into an individual life insurance contract, within 31 days of such cancellation without having to provide evidence of insurability. Such a contract may be a convertible one year term insurance contract, term insurance coverage to age 65 or any individual contract which Standard Life has designated under the conversion privilege at the time the application for conversion is submitted.

The amount of insurance converted will be limited by the following:

1. If coverage is cancelled because this benefit or group contract is cancelled, the amount of the individual life insurance contract may not exceed the amount of insurance that is terminated less any amount of insurance for which you would be eligible under any other group policy within 31 days after your insurance terminates.

2. If coverage is cancelled because of termination of employment or upon retirement, the amount of the individual life insurance contract may not exceed the amount of insurance that is terminated.

3. If you do not apply for the entire amount of insurance available under the conversion privilege, the individual life insurance amount cannot be less than the minimum amount which Standard Life issues for the plan selected.

4. In all cases the amount of the individual life insurance contract cannot exceed $400,000 for a Québec resident or $200,000 for a resident of any other Canadian province or territory.

   If you are entitled to convert coverage under another benefit provided under this policy, the sum of the amounts available for conversion cannot exceed $400,000 for a Québec resident or $200,000 for a resident of any other Canadian province or territory.

The individual life insurance contract becomes effective at the end of the 31 day conversion period. The premium for the individual contract is that which is then required by the insurer for the type of contract selected, taking into account the amount of insurance and the age and sex of the insured person.

4.3. Extension Of Life Insurance Without Premium Payment

If you are less than 65 years old or you attain age 65 on the date of your termination of employment, your retirement, the termination of the benefit or of the group contract, your life insurance is extended, without premium payment for 31 days following such date.

For a Québec resident, the amount of extended life insurance is the sum insured under the group plan. For a resident of any other Canadian province or territory, the amount of extended life insurance cannot exceed the amount of life insurance that is convertible under the conversion privilege.

4.4. Waiver Of Premiums

If your premiums are waived under your Life Insurance Benefit you are also entitled to waiver of premiums under the present benefit.

The waiver of premiums benefit does not apply in the case of self-inflicted injury, whether you are sane or insane.

4.5. Non-Smoker Status

To be considered as a non-smoker, you must provide the insurer with a statement indicating that you have not smoked cigarettes or cigarillos during the 12 months preceding the date of signature of the application or the request for acknowledgment as a non-smoker. The insurer may require such proof whenever there is an increase in coverage or a change in classification.

If it is proved that you have made a misrepresentation, the present benefit shall be void and Standard Life will have no liability under this benefit.

4.6. Living Benefit

Should you become terminally ill, an advanced death benefit, hereinafter-called Living Benefit, may be payable, subject to the terms and conditions defined below.

4.6.1. Definition Of Terminally Ill

To be considered terminally ill:

1. You must be suffering from an illness from which death is expected within 12 months of the date the insurer receives the Living Benefit claim.

   and

2. The life insurance benefit premiums must be waived in accordance with the Waiver Of Premiums clause.

4.6.2. Physician's Statement

The claim for a Living Benefit payment must be supported by a statement from your physician that clearly and fully states the nature of the illness and that the life expectancy is less than 12 months.

The insurer reserves the right to request further medical statements and a medical examination by a physician designated by the insurer.

The insurer reserves the right to decline the claim for a Living Benefit payment if, in the opinion of its medical advisors, the evidence submitted is not conclusive.

4.6.3. Benefit

The amount payable will be equal to 50% of the sum insured on the date the insurer receives the Living Benefit claim, subject to a maximum of $50,000.

If the insurer receives the request within the 12 months preceding the date on which the sum insured is reduced, the amount payable will be reduced by the percentage specified in the Summary Of Benefits.

In all cases, the amount of the Living Benefit payable under this benefit and the Participant's Life Insurance Benefit cannot exceed $50,000.

The final death benefit payable to the beneficiary will be equal to the sum insured on the date of death less the Living Benefit paid, less the interest accrued. The interest on the Living Benefit payment will be calculated from the date of payment to the date of death, at a rate determined by Standard Life on the date of the Living Benefit payment.

4.6.4. Exclusions

No Living Benefit payment will be made:

1. If the insurer receives the request within the 12 months preceding the date on which the participant's optional life insurance terminates, such as specified in the Summary Of Benefits.

2. As a result of an accidental injury.

3. Following the termination of this benefit or policy.

4.6.5. Beneficiary

The beneficiary designation must be irrevocable. Furthermore, the irrevocable beneficiary must sign a statement whereby he accepts that the Living Benefit payment plus any interest, will be deducted from the sum insured on the date of death. The irrevocable beneficiary designation may be submitted with the Living Benefit request.

4.6.6. Other Considerations

The Living Benefit payment is not taxable because it is considered by Canada Customs and Revenue Agency to be part of the death benefit. Notwithstanding this, you should examine all the possible ramifications of obtaining this payment. Examples are the possible elimination or ineligibility to social programs; furthermore the amount paid becomes part of your assets and therefore your creditors could seize the amount whether you have declared bankruptcy or not.

4.7. Exclusion

If you commit suicide, while sane or insane, less than 24 months after the beginning of your coverage under this benefit, the insurer will only refund the premiums you have paid and such refund will constitute a full discharge of the insurer's liability under this benefit.

5. Spouse's Optional Life Insurance Benefit

5.1. Sum Insured

Upon death of your insured spouse, the sum insured specified in the Summary Of Benefits, based on the option previously elected, if applicable, will be paid to you.

Any change in option will be subject to approval of evidence of insurability by the insurer.

5.2. Waiver Of Premiums

If your premiums are waived under your Life Insurance Benefit you are also entitled to waiver of premiums under the present benefit.

The waiver of premiums benefit does not apply in the case of self-inflicted injury, whether you are sane or insane.

5.3. Non-Smoker Status

To be considered as a non-smoker, you must provide the insurer with a statement indicating that your spouse has not smoked cigarettes or cigarillos during the 12 months preceding the date of signature of the application or the request for acknowledgment as a non-smoker. The insurer may require such proof whenever there is an increase in coverage or a change in classification.

If it is proved that you have made a misrepresentation, the present benefit shall be void and Standard Life will have no liability under this benefit.

5.4. Exclusion

If your spouse commits suicide, while sane or insane, less than 24 months after the beginning of his coverage under this benefit, the insurer will only refund the premiums you have paid and such refund will constitute a full discharge of the insurer's liability under this benefit.

6. Participant's Accidental Death And Dismemberment, Protection Plus, Benefit

6.1. Insuring Agreement

Should you suffer an accidental loss of a type described in the Schedule Of Losses shown below, and provided such loss results directly from accidental injury and occurs within three hundred and sixty-five days of the accident, the following benefits are payable, subject to the terms and conditions hereinafter specified.

6.2. Benefits

6.2.1. Sum Insured As A Result Of Accidental Death And Dismemberment

The sum insured is specified in the Summary Of Benefits. The benefit is limited to the percentage shown in the Schedule Of Losses.

If the insured person suffers more than one loss as a result of the same accident, only one benefit, the greater, will be paid.

Schedule Of Losses

Accidental Loss Of	Sum Insured
a) Life	100.00%
b) Sight of both eyes	100.00%
c) Both hands or both feet	100.00%
d) One hand or one foot and the sight of one eye	100.00%
e) One hand and one foot	100.00%
f) Speech and hearing in both ears	100.00%
g) Quadriplegia	200.00%
h) Paraplegia	200.00%
i) Hemiplegia	200.00%
j) One leg or one arm	75.00%
k) Speech or hearing in both ears	75.00%
l) One hand or one foot	75.00%
m) Sight of one eye	75.00%
n) Thumb and index finger of the same hand	33.33%
o) Four fingers of the same hand	33.33%
p) Hearing in one ear	25.00%
q) Four toes of one foot	25.00%

1. The loss of one hand or one foot shall mean the total loss of use of such limb or its complete severance at or above the wrist or the ankle.

2. The loss of one arm or one leg shall mean the total loss of use of such limb or its complete severance at or above the elbow or the knee joint.

3. The loss of a finger shall mean the total loss of use or its complete severance at or above the metacarpophalangeal joint.

4. The loss of a toe shall mean its complete severance at or above the metatarsophalangeal joint.

5. The loss of sight with respect to an eye shall mean total and irrecoverable loss of sight of that eye.

6. The loss of speech or hearing shall mean total and irrecoverable loss of speech or hearing.

7. Quadriplegia shall mean the total and irrevocable paralysis of both legs and both arms.

8. Paraplegia shall mean the total and irrevocable paralysis of both legs.

9. Hemiplegia shall mean the total and irrevocable paralysis of one leg and one arm on the same side of the body.

6.2.2. Seat Belt Rider Benefit

The benefits payable under article "Sum Insured As A Result Of Accidental Death And Dismemberment" herein shall be increased by 10% if the insured person's injury or death results while he is a passenger or driver of a private passenger type vehicle and his seat belt is properly fastened. Verification of actual use of the seat belt must be part of the official report or certified by the investigating officer. The driver of the vehicle must hold a current and valid driver’s license of a rating authorizing him to operate such vehicle and neither be intoxicated nor under the influence of drugs, unless such drugs are taken as prescribed by a physician. The terms "Intoxicated" and “Under the influence of drugs” are as defined under provincial or federal legislation.

6.2.3. Home Alteration And Vehicle Modification Benefit

If indemnity becomes payable under article "Sum Insured As A Result Of Accidental Death Or Dismemberment" herein and that the insured person was subsequently required, due to the cause for which payment under the same article was made, to use a wheelchair to be ambulatory, then the insurer will pay, upon presentation of proof of payment:

1. The one-time cost of alterations to the participant’s residence to make it wheelchair accessible and habitable for a person confined to a wheelchair.

2. The one-time cost of modifications necessary to a motor vehicle, owned by the participant to make the vehicle accessible or drivable for a person confined to a wheelchair.

The maximum payable under both Items 1. and 2., above, combined will not exceed $10,000.

Benefit payments herein will not be paid unless:

1. Home alterations are made on behalf of the participant and carried out by a firm specializing in such alterations and recommended by a recognized organization, providing support and assistance to wheelchair users.

2. Vehicle modifications are made on behalf of the participant and carried out by a firm specializing in such matters and modifications are approved by the Provincial vehicle licensing authorities.

6.2.4. Day Care Benefit

If indemnity becomes payable under article "Sum Insured As A Result Of Accidental Death Or Dismemberment" herein for accidental loss of life of the participant, the insurer will pay an amount equal to the lesser of the following amounts:

1. The actual cost charged by such day care center per year.
2. 5% of the sum insured.
3. $5,000 per year.

On behalf of any child who was the participant's dependent at the time of such loss and is under age thirteen and is currently enrolled or subsequently enrolled in an accredited day care center within 90 days following such loss.

The benefit is payable annually for a maximum of 4 consecutive payments, only if the dependent child continues his enrollment in an accredited day care center.

6.2.5. Educational Benefit For Dependent Child

If indemnity becomes payable under article "Sum Insured As A Result Of Accidental Death Or Dismemberment" herein for accidental loss of life of the insured person, the insurer will pay an amount equal to the lesser of the following amounts to or on behalf of any dependent child who, at the date of accident, was enrolled as a full-time student in any institution of higher learning beyond a grade level where education gratuity is not available under provincial or federal legislation, or enrolled as a full-time student in such an institution within 365 days following such loss:

1. The actual annual tuition charged by such institution per school year.
2. 5% of the sum insured.
3. $5,000 per school year.

The benefit is payable annually for a maximum of 4 consecutive annual payments, only if the dependent child continues his education in an institution of higher learning.

No payments will be made for room or board or other living, traveling, or clothing expenses.

"Institution of higher learning" as used herein includes any university, private college, community college, trade school or collège d'enseignement général et professionnel, in accordance with the definition applicable in the participant's province of residence.

6.2.6. Occupational Training Benefit For Spouse

If indemnity becomes payable under article "Sum Insured As A Result Of Accidental Death And Dismemberment" herein for accidental loss of life of the insured person, the insurer will pay to or on behalf of the surviving spouse the actual cost incurred within 3 years from the date of death of the insured person as payment for an approved and mutually agreed upon formal occupational training program specifically qualifying him to gain active employment in an occupation for which he would otherwise not have had sufficient qualifications, up to a maximum of $10,000.

No payments will be made for room or board or other living, traveling, or clothing expenses.

6.3. Exclusions

6.3.1. Suicide, Attempted Suicide Or Self-Inflicted Injury

No benefit shall be payable for any loss resulting from suicide, attempted suicide or self-inflicted injury, while sane or insane.

6.3.2. Other Causes

No benefit shall be payable for any loss resulting directly or indirectly from one of the following causes:

1. Committing, attempting to commit, or provoking an assault or criminal offense.
2. Civil unrest, insurrection or war, whether war be declared or not, or participation in a riot.
3. Service in the armed forces or reserves of any country.
4. Flight or attempted flight on board a plane or other aircraft if the insured person is part of the crew or performs any function relating to the flight, or participates in the flight as a parachutist.
5. Injuries sustained by the participant as the result of driving a vehicle, if the insured person, at the time of sustaining the injuries, had alcohol in his blood in excess of 80 milligrams of alcohol per 100 milliliters of blood.

6.4. Waiver Of Premiums

If your premiums are waived under your Life Insurance Benefit you are also entitled to waiver of premiums under the present benefit.

7. Long Term Disability Benefit

7.1. Insuring Agreement

Should you become disabled as defined hereinafter, the insurer undertakes to pay the monthly disability benefit specified herein for each month or part of a month (one-thirtieth of the monthly benefit amount for each day) during which your disability lasts, subject to the terms and conditions hereinafter specified.

7.2. Definition Of Disability

7.2.1. Participant's Own Occupation And Any Occupation, As Specified In The Summary Of Benefits

1. During The Elimination Period And The Initial Disability Period Specified In The Summary Of Benefits

   A state of complete and continuous incapacity, resulting from illness or accidental injury, which wholly prevents you from performing the substantial duties of your own occupation.

2. Following The Initial Disability Period

   A state of complete and continuous incapacity, resulting from illness or accidental injury, which wholly prevents you from performing the duties of any occupation for which you are or may become reasonably qualified by training, education or experience. Furthermore, you must not be able to earn 60% or more of your gross monthly income determined at the onset of disability, as deemed by the insurer.

7.3. Conditions For Acknowledgment Of Disability

In assessing your eligibility for benefits under "Definition Of Disability", the availability of work will not be a factor.

Your condition must require regular and continuous medical care provided by an appropriate physician and you must also follow treatment deemed appropriate by the insurer.

Disability will only be recognized if you are receiving no remuneration arising either directly or indirectly from any work, except under a rehabilitation program approved by the insurer or a progressive return to work program recognized by the insurer, as described under the Rehabilitation And Progressive Return To Work Programs section, or a part-time return to work recognized by the insurer as described under the Partial Disability section.

7.4. Beginning Of Monthly Disability Benefit Payments

Monthly disability benefit payments commence following completion of the elimination period specified in the Summary Of Benefits.

If a disability occurs during the course of a maternity, adoption, paternity, parental or family matters leave, the elimination period commences on the date of the onset of disability. Monthly disability benefit payments commence at the later of the following dates:

1. The date following the completion of the elimination period.

2. Your scheduled date of return to work.

The benefit is payable provided the coverage has been kept in force for the entire duration of the leave.

7.5. Termination Of Monthly Disability Benefit Payments

Monthly disability benefit payments cease at the earliest of the following dates:

1. The date on which you cease to be disabled.

2. The date on which the maximum benefit period specified in the Summary Of Benefits expires.

3. The date on which you reach:

   a) The age specified in the Summary Of Benefits.

   b) The normal retirement age under your employer's pension plan.

4. The date of your death.

5. The date on which you fail:

   a) To provide any evidence of disability required by the insurer.

   b) To submit to an examination or interview required by the insurer.

   c) To follow appropriate treatment deemed satisfactory by the insurer.

6. The date on which you refuse:

   a) To participate in any rehabilitation or progressive return to work program.

   b) To perform an alternate occupation of comparable income offered by your employer.

   c) An occupation offered following a rehabilitation program and which accommodates the limitations of your disability.

7. The date on which you have been absent from Canada for a period longer than 4 weeks, unless the insurer has given prior approval to pay benefits during a specified period of time following the first 4 weeks.

7.6. Disability Benefit Payments While Serving A Sentence

Monthly disability benefits are not payable for the period that you are serving a sentence and are confined in a prison, penitentiary or similar institution including halfway facilities, or are under house arrest. Upon completion of the sentence, if you still qualify for disability benefits you will continue to receive these benefits effective from the date of release.

While no benefits are payable for the period that you are serving a sentence, either during the period or retroactively at the time of release, the time served will be taken into account in determining the transition date from the initial disability period to the period following the initial disability period.

7.7. Amount Of Monthly Disability Benefit And Reductions

The amount of monthly disability benefit is determined in accordance with the provisions specified hereinafter and subject to the provisions of the sections Subrogation, Rehabilitation And Progressive Return To Work Programs and Partial Disability.

The amount of monthly disability benefit payable is the lesser of the Basic Monthly Benefit and the All Source Maximum as defined hereinafter.

7.7.1. Basic Monthly Benefit

The basic monthly benefit is specified in the Summary Of Benefits.

The basic monthly benefit will be reduced by the gross amount of all disability or retirement benefits which are payable or which would have been payable to you, had a satisfactory application been made under:

1. The Canada/Quebec Pension Plan, excluding benefits payable on behalf of your dependent children, as specified in the Summary Of Benefits.
2. A Workmen's/Workers' Compensation Act, Workplace Safety and Insurance Act or other similar legislation.
3. A provincial auto insurance plan or motor vehicle insurance policy that does not take into account disability benefits payable under the Employment Insurance Program.
4. A Criminal Injury Compensation Act or other similar legislation.
5. Any other government plans.

Furthermore, the basic monthly benefit will be reduced by the gross amount of all income, compensation, indemnity and benefits you would be eligible to receive, due to the same or related disability, from any insurance or retirement plan to which your employer contributes.

7.7.2. All Source Maximum

The all source maximum is equal to the percentage specified in the Summary Of Benefits, applied to your net monthly income determined at the onset of disability and reduced by the gross amount of:

1. All disability or retirement benefits, all income, compensation, indemnity, earnings, payments and benefits deducted under the basic monthly benefit.

2. All disability benefits for which you would be eligible from any association plan where contributions are made on your behalf or any group plan.

Future cost of living adjustments made to amounts received from any of the above-mentioned sources will not bring about further reductions.

Canada/Quebec Pension Plan retirement benefits that you were receiving prior to the beginning of your disability will not be considered in the benefit amount calculation.

Nothing in this contract shall prevent the insurer from adjusting or recovering any overpayment of benefits under the contract which may arise as a result of a lump sum payment from any source on account of disability which, had it been paid in installments, would have resulted in a reduction or cessation of benefits hereunder.

7.8. Subrogation

Standard Life will be subrogated to your rights to any amount which may be recovered from a third party for loss of income through payment, arbitration award, judgment, settlement or otherwise, for injury or other damages caused by any person or organization (a "third party"). The subrogation rights will be limited to the extent of benefits paid or payable to you under this benefit. Any monthly disability benefit paid to you prior to and after a judgment or settlement, shall be considered conditional payments and shall be subject to recovery by Standard Life as set out herein.

Standard Life may require you to sign a subrogation agreement reflecting the particular circumstances of the case, taking into account the nature of the claim against the third party, the expected date of hearing, settlement, payment and other factors. Standard Life has the right to suspend or not initiate payment of benefits until the completed and signed agreement is received. In the event that you do not sign such a subrogation agreement, then Standard Life's subrogation rights shall prevail.

You must notify Standard Life as soon as any action is commenced against any third party for damages for which Standard Life would be subrogated. Your solicitor shall be deemed to represent Standard Life's interests in such action unless Standard Life notifies that another solicitor is to be appointed to act on Standard Life's behalf.

When you receive an amount for damages for loss of income from a third party prior to trial of the action:

1. You must refund to Standard Life the amount recovered for past loss of income, up to the amount of monthly disability benefit paid. Should you fail to reimburse Standard Life within the 2 months following the judgment or settlement, Standard Life will suspend or adjust future monthly disability benefit payments to recover the amount that should have been reimbursed, including interest.

2. Standard Life may, at its option, suspend or adjust future monthly disability benefit payments until the total amount of benefits withheld is equal to the amount that you recovered for future loss of income.

In the event that a lump sum payment is received for general damages without specific allocation for loss of income, the monies received shall be deemed to have been received firstly in compensation for loss of income and secondly for other claims, and Standard Life will be entitled to receive an amount which it considers, acting reasonably, to be a reasonable amount for loss of income.

7.9. Rehabilitation And Progressive Return To Work Programs

The insurer may require that you engage in a rehabilitation and/or progressive return to work program when the insurer considers that participation is reasonable and appropriate. The insurer, in consultation with its medical advisors, may revise, extend or terminate the program, whenever it is considered reasonable and appropriate.

Furthermore, during the initial disability period, the insurer may require that you engage in an alternate occupation of comparable income actually offered by your employer and which is considered reasonable and appropriate by the insurer.

7.10. Partial Disability

Following the commencement of monthly disability benefit payments, if you satisfy the definition of disability but are working on a part-time basis you may receive the monthly disability benefit specified herein, while at the same time receiving remuneration for your work.

However, the sum of the remuneration and of the monthly disability benefit payment may at no time exceed the gross monthly income under a taxable benefit, or the net monthly income under a non-taxable benefit, paid to you at the time disability began. If such sum exceeds the said gross or net income prior to disability, the monthly disability benefit payment will be reduced by the amount of such excess.

7.11. Successive Periods Of Disability

During the elimination period, successive periods of disability from a single cause separated by up to 14 calendar days will be combined.

Following the elimination period, if you have returned to active work, as per your pre-disability work schedule at a minimum, and again become disabled within 6 consecutive months of the termination of benefits and if such disability results from the same cause as the previous disability or from related causes, it is considered to be a continuation of the previous disability. This also applies when no benefits were paid for the previous disability due to the application of the Pre-existing Conditions clause.

This clause will not be applied and benefits will not be payable under this benefit if:

1. The benefits are payable under a replacing contract following the termination of this contract or this benefit.

2. Your coverage was terminated, you are employed by another employer and the benefits are payable under the employer’s salary replacement plan or group insurance contract.

However, if you have returned to active work and again become disabled due to an illness or accidental injury totally unrelated to the previous cause of disability, it is considered as a new disability, and a new elimination period will apply.

7.12. Waiver Of Premiums

No premiums for this benefit will be required as of the date you are entitled to a monthly disability benefit payment.

7.13. Maternity, Adoption, Paternity, Parental And Family Matters Leave

No monthly disability benefits shall be payable for any illness or accidental injury:

1. During a maternity, adoption, paternity, parental or family matters leave taken in accordance with provincial or federal legislation or during any maternity, adoption, paternity, parental or family matters leave taken in agreement with your employer.

2. In the course of any period during which you receive maternity, parental or compassionate care benefits from an Employment Insurance financial assistance program or a provincial program providing similar benefits.

3. During any extension of maternity, adoption, paternity, parental or family matters leave beyond the periods specified above, if you were entitled to and requested such extension.

Maternity leave is deemed to commence on the earlier of the date you elected or the date of delivery. The elected date may also be one required by your employer, where such action is permitted by provincial or federal legislation.

7.14. Pre-existing Conditions

No monthly disability benefits shall be payable if you become insured on or after the commencement date of this contract for any disability beginning within the period, specified in the Summary Of Benefits, that follows your effective date of insurance, if your disability is caused by, partly attributable to or is a consequence of a sickness or injury for which you have:

1. Consulted a physician, a specialist or health care professional within the number of days, specified in the Summary Of Benefits, that precedes your effective date of insurance.

2. Received or been recommended by a physician or specialist to receive medical treatment or services within the number of days, specified in the Summary Of Benefits, that precedes your effective date of insurance.

3. Taken medication within the number of days, specified in the Summary Of Benefits, that precedes your effective date of insurance.

If this contract is a replacing contract, this provision shall not apply if you were insured under the previous contract at the date it terminated. However, if you were insured under the previous contract and you become disabled within the time limits of the previous contract's Pre-existing Conditions clause your claim will be assessed subject to the previous contract's Pre-existing Conditions clause, in the same manner as if the contract had not been replaced.

7.15. Exclusions

No monthly disability benefits shall be payable for any disability resulting in whole or in part from, or as a direct or indirect consequence of, any of the following causes:

7.15.1. Civil unrest and other

Civil unrest, insurrection or war, whether war be declared or not, or participation in a riot.

7.15.2. Self-inflicted injury

Self-inflicted injury, while sane or insane.

7.15.3. Fraud and offence

Committing, attempting to commit, or instigating a fraud or an offence, whether punishable by indictment or on summary conviction.

8. Health Insurance Benefit

8.1. Insuring Agreement

If as a result of accidental injury, illness or pregnancy, you or one of your dependents incur expenses for medically required services, care, treatment and equipment, the insurer will reimburse the eligible expenses, subject to the terms and conditions hereinafter specified.

8.2. Reimbursement

The insurer reimburses these expenses subject to the deductible and the maximum amount specified in the Summary Of Benefits.

8.2.1. Deductible

The deductible is that portion of eligible expenses which must be paid by the insured person before any benefits are payable. The maximum deductible required per calendar year is specified in the Summary Of Benefits.

8.2.2. Carry Over Provision

If the deductible has been satisfied in whole or in part by the payment of expenses incurred in the last three months of a calendar year, the deductible for the following year will be reduced by the amount of expenses thus applied to the deductible.

8.2.3. Maximum Amount

1. Maximum Eligible Amount Per Insured Person

   Maximum eligible expenses incurred by the insured person before applying the reimbursement percentage.

2. Maximum Reimbursable Amount Per Insured Person

   Maximum amount reimbursed by the insurer after applying the reimbursement percentage to the eligible expenses incurred by the insured person.

The maximums specified in the Summary Of Benefits are eligible amounts, unless otherwise specified.

8.2.4. Participant's Coordination And Limitation Of Benefits

If you are insured under other group policies or government programs or where coverage is required by statute, the benefits payable from all sources cannot exceed 100% of expenses incurred; that is, benefits will not be payable with respect to that portion of any eligible expense for which benefits are payable by another plan.

8.2.5. Dependents' Coordination And Limitation Of Benefits

Benefits for eligible expenses incurred by your dependents who are insured under this plan as well as another plan will be determined on the following basis:

1. Spouse

   Where your spouse is insured under the present plan and insured as a participant under another plan, that portion of an expense which is eligible for reimbursement under such plan will not be payable under the present benefit. Your spouse must first file a claim with his insurer.

   Thereafter, you may submit to Standard Life a reimbursement request for the portion of the expenses not reimbursed by your spouse's insurer but eligible under the present benefit.

   You must provide copies of the other insurer claim settlement and of the receipts.

2. Child

   Where your child is insured as a dependent under the present plan and also under your spouse's plan, benefits will first be payable under the present plan if your birthdate occurs earlier in the calendar year in relation to that of your spouse.

   As an example, when your birthdate precedes your spouse's birthdate, you must first submit your request to Standard Life.

   Afterwards, your spouse may submit to his insurer a reimbursement request for the portion of the expenses not reimbursed under the present benefit but eligible under his plan. Copies of the settlement issued by Standard Life and receipts must be provided.

   Should the spouses have the same birthdate, the claims for children must then be filed in the alphabetical order of the spouses' first names.

8.3. Eligible Expenses Incurred In Canada

The following expenses for services, care, treatment and supplies are eligible, provided they are medically required, have been incurred in Canada and are not payable or reimbursable under a provincial medical and hospitalization plan, even if the insured person is not eligible or insured under the provincial plan. The maximum amount reimbursed by the insurer is specified in the Summary Of Benefits.

8.3.1. Hospitalization

The insurer will reimburse that part of hospital expenses which exceeds the amount reimbursed by government plans, in accordance with the conditions specified in the Summary Of Benefits.

8.3.2. Room and Board in a Rehabilitation Institution, Convalescent Home or Chronic Care Institution

Room and board in a rehabilitation institution, convalescent home or chronic care institution designated for such treatment by an appropriate government body, while the insured person is under the care of a physician or registered nurse, provided the stay commences less than fourteen days following a period of hospitalization and has previously been prescribed by a physician, in accordance with the conditions specified in the Summary Of Benefits.

8.3.3. Nursing Care Services Rendered At The Insured Person's Home

Private duty nursing services rendered at the insured person's home by a professional practitioner specified in the Summary Of Benefits, for medical services strictly rendered in his professional capacity, in accordance with the conditions specified in the Summary Of Benefits.

The practitioner must be unrelated to the insured person and must not ordinarily reside in the insured person's home. The services rendered must have been previously prescribed by a physician.

8.3.4. Professional Services

1. Services given by a professional practitioner specified in the Summary Of Benefits, in accordance with the conditions specified therein.

    a) The practitioner must be legally authorized by the appropriate provincial or federal body to practice his profession within the scope of his specialty.

    b) The services rendered must have been previously prescribed by a physician unless specified otherwise in the Summary Of Benefits.

    c) The maximums apply for each specialist, unless specified otherwise in the Summary Of Benefits.

    d) X-ray examinations provided by a professional practitioner are eligible, in accordance with the conditions specified in the Summary Of Benefits, if any.

    e) Eligible expenses are limited to one professional visit per day for each type of specialist.

8.3.5. Laboratory Analysis And X-Rays

Laboratory analysis and x-ray examinations for diagnostic purposes, when prescribed by a physician, obtained in an establishment or a specialized laboratory, duly authorized under provincial regulations, if applicable, in accordance with the conditions specified in the Summary Of Benefits.

8.3.6. Medical Supplies

The following supplies, provided they have been previously prescribed by a physician:

1. Rental or initial purchase, as previously approved by the insurer, of a non-motorized wheelchair, crutches, manual hospital bed, respiratory equipment and any other durable medical equipment, excluding batteries and repairs, required on a temporary basis for therapeutic use.

2. Purchase of dressings, casts, oxygen and rental of equipment necessary for its administration, obtained in a specialized establishment or laboratory, duly authorized under provincial regulations, if applicable.

3. Purchase of prostheses and orthotics such as artificial limb or eye, braces, corsets, hernial supports or other orthopaedic devices, obtained in a specialized establishment or laboratory, provincially licensed where such regulations exist.

   Auditive, breast, capillary, dental or oral prostheses, orthopaedic shoes, podiatric orthotics, podiatric supports, arch supports and corrective devices added to ordinary shoes are not covered herein.

4. Purchase of custom made orthopaedic shoes specially made for the insured person, including repairs and modification to stock item and orthotic devices in accordance with the conditions specified in the Summary Of Benefits. Any such appliances must be obtained from a specialized establishment or laboratory, duly authorized under provincial regulations, if applicable, to provide, manufacture and/or fit such orthopaedic devices. These appliances must be manufactured, dispensed or fitted in conjunction with professionals dealing exclusively with foot or ankle disorders. Such expenses are reimbursed according to the same terms and conditions if the prescription is given by a podiatrist, a chiropodist or a chiropractor.

5. Purchase of hearing aids or any related devices, with the exception of batteries, and professional services provided by a hearing aid acoustician, following the purchase, are reimbursed provided they have been prescribed by an audiologist, speech therapist or physician, in accordance with the conditions specified in the Summary of Benefits.

6. Purchase of elastic support stockings specially designed for the treatment of varicose veins, in accordance with conditions specified in the Summary Of Benefits. These must be obtained from a specialized establishment or laboratory, provincially licensed where such regulation exists. Both compression-type elastic support stockings and surgical stockings are deemed to be elastic support stockings for this purpose.

7. Purchase of breast prosthesis and surgical brassiere required as a result of a mastectomy, in accordance with the conditions specified in the Summary Of Benefits.

8. Purchase of wigs required as a result of a chemotherapy treatment, in accordance with the conditions specified in the Summary Of Benefits.

9. Purchase of intra-uterine contraceptive devices (IUDs), in accordance with the conditions specified in the Summary Of Benefits.

10. Purchase of a blood glucose monitor, when insulin must be taken to control diabetes.

11. Purchase of required supplies following an ileostomy or colostomy.

8.3.7. Ambulance Service

Licensed ambulance service for transportation to the nearest hospital equipped to provide the required treatment, or therefrom, when the physical condition of the insured person precludes the use of any other means of transportation.

8.3.8. Dental Care Required As A Result Of Accidental Injury

Dental care required as a result of injury to natural teeth provided by a dentist or specialist, in accordance with the normal suggested fee for a general practitioner.

Only care received within twelve months of the injury is covered. All other dental expenses are excluded.

8.3.9. Eye Examination

Services of an optometrist or ophthalmologist for eye examinations in accordance with the conditions specified in the Summary Of Benefits.

8.3.10. Eye Glasses, Contact Lenses Or Laser Eye Surgery

Purchase of prescription eye glasses or contact lenses provided they have been prescribed by an ophthalmologist or an optometrist, or laser eye surgery (laser refractive surgery) performed by an ophthalmologist, in accordance with the conditions specified in the Summary Of Benefits.

8.4. Eligible Expenses Incurred Outside Canada In Case Of Emergency

Expenses must have been incurred due to an emergency, following an accident that occurred or a sudden and unexpected illness that started during a stay abroad that was not expected to last for more than the length of time specified in the Summary Of Benefits. Should the person insured come back to Canada for a period of less than 45 consecutive days and then leave Canada for another stay abroad, this stay shall be deemed to be a continuation of the previous stay.

8.4.1. Hospitalization

That part of hospital expenses for room and board accommodation, supplies and ancillary hospital services, in excess of the amount reimbursed by government plans will be reimbursed by the insurer, in accordance with the conditions specified in the Summary Of Benefits.

8.4.2. Medical And Surgical Services

Medical and surgical expenses incurred outside Canada, in excess of the amount payable under the government health insurance plan of the insured person's province of residence will be reimbursed by the insurer, in accordance with the conditions specified in the Summary Of Benefits.

8.4.3. Other Care And Services

Expenses incurred for the following care and services that are eligible in Canada under this benefit, are deemed eligible as if they had been incurred in Canada, including the calculation of the amounts to be reimbursed.

1. Drugs.
2. Professional service.
3. Medical supplies.
4. Ambulance services.
5. Dental care as a result of injury.
6. Eye care.

8.5. Eligible Expenses Incurred Out-Of-Province, But In Canada, In Case Of Emergency

Expenses must have been incurred due to an emergency following an accident that occurred or a sudden and unexpected illness that started during a stay in another province or territory of Canada.

8.5.1. Medical And Surgical Services

Medical and surgical expenses incurred which are in excess of the amount payable under the government health insurance plan of the insured person's province of residence will be reimbursed by the insurer, in accordance with the conditions specified in the Summary Of Benefits.

However, the insurer will not reimburse extra-billing fees that are in excess of the schedule of fees established by the provincial health insurance plan where the services were provided.

8.6. Eligible Expenses Incurred Outside Canada On Referral Of A Physician

Hospitalization, medical and surgical services outside Canada on referral of a physician will be reimbursed by the insurer, in accordance with the conditions specified in the Summary Of Benefits, provided each of the following conditions is satisfied:

1. Hospitalization, medical and surgical services are not available in Canada.
2. Hospitalization, medical and surgical services are recognized by the insured person's government health insurance plan.

3. The insured person's government health insurance plan participates in the reimbursement of such expenses.

8.7. Extension Of Insurance Without Premium Payment Upon Your Death

Upon your death, the present benefit is extended without premium payment to the earliest of the following dates:

1. 12 months following your death.
2. The date on which this benefit would have terminated had you then been living.
3. The termination date of the benefit or contract.

8.8. Exclusions

This policy does not cover:

1. Expenses which are or would normally be payable or reimbursable under a private or public insurance plan.
2. Self-inflicted injury, while sane or insane.
3. Injury or illness resulting from civil unrest, insurrection or war, whether war has been declared or not, or participation in a riot.
4. Any treatment or device related directly or indirectly to the full reconstruction of the mouth, to correct vertical dimensions or temporomandibular joint dysfunction.
5. Any treatment, surgery, care, service examination or device which: is not medically necessary; is provided or required for cosmetic purposes; is provided or required in connection with an operation or a treatment conducted as an experiment; is provided or required for non-curative reasons; exceeds what is ordinarily provided or required by current therapeutic practice.
6. Any portion of the charge for services, care treatment and supplies in excess of the reasonable and customary charge for an illness of the same nature and severity in the area where the services are provided.
7. Care or services rendered free of charge or which would be free of charge were it not for insurance coverage or which are not chargeable to the insured person.
8. Rest cure or travel for health reasons.
9. Eye examinations, unless otherwise indicated in the Summary Of Benefits.
10. Prescription, initial purchase, adjustment or replacement of eye glasses or contact lenses, unless otherwise indicated in the Summary Of Benefits.
11. Drugs, unless otherwise indicated in the Summary Of Benefits.

9. Prescribed Drug Benefit
TELUS Health Solutions Plan 88

9.1. Insuring Agreement

If you and your dependents are insured under the Health Insurance Benefit of the present policy, you and your dependents are covered as well for prescription drugs or medications necessitated by accidental injury, illness or pregnancy, provided the present benefit and contract are in force, and subject to the terms and conditions hereinafter specified.

9.2. Special Definitions

9.2.1. Dentist

A person licensed by the provincial licensing authority to practice dentistry.

9.2.2. Participating Pharmacy

A pharmacy having a contractual agreement with TELUS Health Solutions GP and participating in the direct payment prescription drug program.

9.2.3. Pharmacist

A person legally authorized by the appropriate provincial or federal body to practice within the scope of his specialty.

9.2.4. Prescription Drugs Or Medications

Prescription drugs or medications, ingredient costs and dispensing fees.

9.2.5. Prescription Unit

A prescription number signifies a prescription unit.

9.2.6. TELUS Health Solutions GP

Provider of the electronic network TELUS ¦ Assure Card services.

9.2.1. Prior Authorization Process

Prior Authorization is a process used in conjunction with a drug plan where coverage for certain specific drugs must be pre-approved by the insurer.

9.2.2. Grace Period

A grace period is extra time that is allowed for meeting a specific requirement under the policy.

For the Prior Authorization Process, the grace period will allow extra time for the participants to gather and submit their medical evidence to the insurer in order to establish their eligibility to the drug they were prescribed. The grace period will be granted to participants already taking a prescription drug that wasn't on the prior authorization list of Standard Life, or the prior insurer, at the time it was prescribed but that has now been included on Standard Life's list. The grace period will apply to existing participants on the date that the prior authorization list is updated.

9.2.3. Grandfathered

Grandfathered refers to a situation in which an old rule continues to apply to existing situations, while a new rule will apply to all future situations.

Under the Prior Authorization Process, grandfathered refers to an exemption given based on circumstances previously existing, namely, a participant taking a prescription drug that is included under the prior authorization list of Standard Life that was also on the prior authorization list of the prior insurer and that had been authorized by the prior insurer. This exemption will allow the participant to be able to continue taking the drug and to be covered for a specified period of time as determined by Standard Life. This only applies to participants being transferred from a prior insurer.

9.2.4. Specialty Drug Program

A Specialty Drug Program is a publicly funded drug program that fully or partially covers the cost of certain outpatient drugs used to treat a number of serious conditions.

Coverage and eligibility provisions are specific to each Specialty Drug Program.

9.2.5. Specialty Drug

A drug covered under a Specialty Drug Program which has been identified by the insurer as being subject to the Coordination and Limitation of Benefits with Specialty Drug Programs.

9.2.6. Reasonable And Customary Pharmacist Charges

Usual charges required by the pharmacist for dispensing a drug and related services, up to the prevailing charges in the area where similar services are provided for the same drug.

Such prevailing charges are set by the insurer and are subject to change without notice.

9.3. Calculation Of The Amount Payable

9.3.1. Payment Schedule

Ingredient cost plus dispensing fee.

9.3.2. Exclusion And Limitation Under The Prior Authorization Process

The insurer establishes a list of drugs for which a participant will have to obtain a prior authorization before such drugs can become covered under the policy. Such list and the protocol for prior authorization may be changed from time to time by the insurer to reflect, among other things, changes in prescribing practices as new medications and new information become available.

Claims for these drugs are eligible for reimbursement under this coverage only if the drug is medically required and that other clinical criteria determined by the insurer are met. The participant must have the prior authorization form completed by a physician at the participant's own expense.

A drug under the Prior Authorization Process list will only be reimbursed under this coverage as follows:

1. If it has been pre-authorized by the insurer and the expense for that drug is incurred during the treatment period indicated on the prior authorization form, unless the insurer grants the authorization for a different period in which case it shall be incurred during such period; or

2. During a Grace Period of 90 days from the date of the claim during which time the participant must have the prior authorization form completed by his or her physician and returned to the insurer for adjudication; or

3. If it has been Grandfathered by the insurer, but only for a maximum period of one year in total after which time the participant will have to submit medical evidence to the insurer in order to continue being reimbursed for the drug.

9.3.3. Participant's Coordination And Limitation Of Benefits

If you are insured under other group policies or government programs or where coverage is required by statute, the benefits payable from all sources cannot exceed 100% of expenses incurred; that is, benefits will not be payable with respect to that portion of any eligible expense for which benefits are payable by another plan.

9.3.4. Dependents' Coordination And Limitation Of Benefits

Benefits for eligible expenses incurred by your dependents who are insured under this plan as well as another plan will be determined on the following basis:

1. Spouse

2. Where your spouse is insured under the present plan and insured as a participant under another plan, that portion of an expense which is eligible for reimbursement under such plan will not be payable under the present benefit. Your spouse must first file a claim with his insurer.

   Thereafter, you may submit to Standard Life a reimbursement request for the portion of the expenses not reimbursed by your spouse's insurer but eligible under the present benefit.

You must provide copies of the other insurer claim settlement and of the receipts.

3. Child

4. Where your child is insured as a dependent under the present plan and also under your spouse's plan, benefits will first be payable under the present plan if your birthdate occurs earlier in the calendar year in relation to that of your spouse.

   As an example, when your birthdate precedes your spouse's birthdate, you must first submit your request to Standard Life.

   Afterwards, your spouse may submit to his insurer a reimbursement request for the portion of the expenses not reimbursed under the present benefit but eligible under his plan. Copies of the settlement issued by Standard Life and receipts must be provided.

   Should the spouses have the same birthdate, the claims for children must then be filed in the alphabetical order of the spouses' first names.

9.3.5. Coordination And Limitation Of Benefits With Specialty Drug Programs

The first time a claim is submitted for a Specialty Drug, information on how to apply to the Specialty Drug Program will be provided. Claims for a Specialty Drug must first be submitted to the Specialty Drug Program for reimbursement. Application to the Specialty Drug Program must be done during the period determined by the insurer, as communicated to the participant (referred to as the '"Period of Application" in this provision). If the cost of the drug is not reimbursed entirely under the Specialty Drug Program, a claim for the amount that was not reimbursed can be submitted under this coverage.

An expense incurred for the Specialty Drug can only be reimbursed under this coverage if the following conditions are met:

1. It is an Eligible Expense;

2. The Specialty Drug is:

   a) Not covered under a Specialty Drug Program and the letter confirming that the application to the Program was declined is submitted to the insurer; or

   b) Covered under a Specialty Drug Program and the amount claimed represents the difference between the expense incurred for the Specialty Drug and the amount reimbursed under the Specialty Drug program, and is incurred on or after the date the first reimbursement for that Specialty Drug is made under the Specialty Drug Program;

3. The expense meets all the other applicable requirements under this coverage.

A Specialty Drug that is an Eligible Expense under this coverage will be reimbursed, even though the participant has not yet applied to the Specialty Drug Program, if the following conditions are met:

1. It is the first time a claim is submitted to the insurer for that Specialty Drug; or for subsequent claims, the expense for the Specialty Drug was incurred after the date the first expense for that Special Drug was incurred and within the Period of Application;

2. The Specialty Drug is not subject to the Prior Authorization Process or, if it is, conditions provided for under the Exclusion And Limitation Under The Prior Authorization Process provision are met.

9.3.6. Deductible

The deductible is that portion of an eligible expense which is paid by the insured person. Such deductible is specified in the Summary of Benefits.

9.3.7. Reimbursement

TELUS Health Solutions GP reimburses a percentage of eligible expenses incurred after applying the deductible. Such percentage is specified in the Summary of Benefits.

9.4. Eligible Expenses

Expenses incurred by the insured person for prescription drugs or medications are eligible, provided they are incurred in Canada or incurred due to an emergency during a stay abroad that was not expected to last for more than the length of time specified in the section "Health Insurance" in the Summary Of Benefits. Should the insured person come back to Canada for a period of less than 45 consecutive days and then leave Canada for another stay abroad, this stay shall be deemed to be a continuation of the previous stay.

Some eligible drugs are subject to a maximum amount of reimbursement. When such a maximum applies, it is specified in the Summary of Benefits.

9.5. Eligible Drugs And Medications

9.5.1. Prescription Requiring Drugs

Prescribed drugs and medications bearing a Drug Identification Number (DIN) and listed as prescription requiring in Federal or Provincial Drug Schedules.

9.5.2. Injectable Drugs

Selected injectable drugs, injectable vitamins, insulin, and non patient specific allergy extracts bearing a Drug Identification Number.

9.5.3. Extemporaneous Preparations

Extemporaneous preparations or compounds where one of the ingredients is an eligible benefit.

9.5.4. Disposable Needles

Disposable needles, disposable syringes, lancets and chemical reagent testing materials used for insulin administration and monitoring in diabetes.

9.5.5. Over-The-Counter Drugs

Selected products within the following classes of over-the-counter drugs are eligible on presentation of a prescription.

1. Potassium supplements.
2. Single entity iron salts.
3. Nitroglycerin.

9.5.6. Dispensing Limitations

The quantity of a prescription drug dispensed is the lesser of the quantity prescribed or a 34 day supply. However, the maintenance drugs listed below may be dispensed to a maximum of a 100 day supply, if so prescribed by a physician or a dentist.

1. Antiasthmatics.
2. Antibiotics for acne.
3. Anticoagulants.
4. Anticonvulsants.
5. Antiparkinsons.
6. Cardiac drugs.
7. Female hormone replacement therapy.
8. Oral and transdermal contraceptives.
9. Thyroid agents.
10. Antidepressants.
11. Diabetes drugs.
12. Potassium supplements.
13. Celebrex.

9.6. Exclusions

9.6.1. Smoker's Cessation Devices

All nicotine resin containing products and other smoker's cessation devices, even if a prescription is legally required, whether or not such prescription is given for medical reasons.

9.6.2. Fertility Enhancer

Medications and compounded preparations deemed to be fertility drugs.

9.6.3. Cosmetic Items

Items deemed cosmetic, such as topical Minoxidil or sunscreens, even if a prescription is legally required, whether or not such a prescription is given for medical reasons.

9.6.4. Appliances And Devices

Atomizers, appliances, prosthetic devices, colostomy supplies, first aid kits or equipment, electronic diagnostic monitoring or testing equipment (such as "Glucometer®") non-disposable insulin delivery devices (such as "Novolin Pen®") delivery or extension devices for inhaled medications (such as "Rotohaler®", "Diskhaler®", "Aerochamber®") spring loaded devices used to hold lancets, alcohol, alcohol swabs, disinfectants, cotton, bandages, or supplies and accessories for the aforementioned.

9.6.5. Dietary Supplements

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

9.6.6. Contraceptive Devices

Diaphragms, condoms, contraceptive jellies, foams, sponges, suppositories, non-medical intrauterine devices (IUDs) such as Gyne-T, contraceptive implants or appliances normally used for contraception whether or not such a prescription is given for a medical reason.

9.6.7. Herbal And Homeopathic Preparations

Herbal and homeopathic preparations, even if combined with a prescription requiring medicine or with a product considered to be eligible.

9.6.8. Prescriptions Dispensed Other Than By A Pharmacist

Prescriptions dispensed by a physician, clinic, dentist or in any non-accredited hospital pharmacy, or for treatment as an inpatient or outpatient in a hospital, including investigational status drugs and emergency status drugs, unless otherwise approved by TELUS Health Solutions GP

9.6.9. Vaccines

All preventative immunization vaccines and toxoids.

9.6.10. Allergy Extracts

All patient specific allergy extracts, compounded in a laboratory, and not bearing a Drug Identification Number.

9.6.11. Provincial Drug Benefit Plans And Federal Programs

Any medications or drugs that are reimbursed by either the applicable Provincial Drug Benefit Plan or a Federal Program.

9.6.12. Drugs To Treat Erectile Dysfunction

Oral erectile dysfunction drugs, unless otherwise specified in the Summary of Benefits.

9.6.13. Non-Bearing Valid DIN Products

Products not bearing a valid Health Canada issued Drug Identification Number.

9.6.14. Consultation Charges And Professional Fees

Consultation charges and/or professional fees rendered by a licensed physician, pharmacist, other than dispensing fees, or registered nurse.

9.6.15. Injections Administered In A Hospital

Injections normally administered to patients admitted to hospital for treatment.

9.6.16. Medications On The Prior Authorization Process List

Any medications or drugs that are listed on the Prior Authorization Process list that do not meet the requirements set forth under the Exclusion And Limitation Under The Prior Authorization Process clause.

9.6.17. Specialty Drugs

Any Specialty Drug, up to the amount covered or that could have been covered if application had been properly made, under a Specialty Drug Program except to the extent coverage is available under the Coordination and Limitation Of Benefits With Specialty Drug Programs clause.

9.6.18. Dispensing Fees

Dispensing Fees in excess of Reasonable And Customary Pharmacist Charges, in all provinces where applicable.

9.7. Extension Of Insurance Without Premium Payment Upon Your Death

Upon your death, the present benefit is extended without premium payment to the earliest of the following dates:

1. 12 months following your death.
2. The date on which this benefit would have terminated had you then been living.
3. The termination date of the benefit or contract.

9.8. Claims — Pay-Direct Drug Card

For eligible prescription drugs, you may use the TELUS ¦ Assure Card every time you have a prescription filled in a participating pharmacy that accepts the TELUS ¦ Assure Card.

With the TELUS ¦ Assure Card, your prescription drug claims are settled in the pharmacy. When you or one of your insured dependents incur an eligible expense at a participating pharmacy, the pharmacist will submit the claim electronically to TELUS Health Solutions GP for adjudication. The pharmacist will then immediately inform the insured person of the reimbursement amount to which he is entitled and of the amount he must disburse, if any.

However, when you or one of your insured dependents incur an eligible expense at a non-participating pharmacy or outside Canada, you must submit a completed claim form provided for that purpose along with original receipts directly to TELUS Health Solutions GP, within the time prescribed by law.

10.Travel Assistance Plus Benefit

10.1. Coverage

Through GESA Assistance this benefit provides you and your insured dependents medical assistance in case of emergency, while on a business or personal trip of less than the duration specified in the Summary Of Benefits, for an accident or illness occurring outside the province of residence, subject to the conditions hereafter specified.

10.2. Special Definitions

10.2.1. Accident

Any sudden, violent, and unforeseeable event resulting directly from an external cause beyond the control of the insured person and causing bodily injury which prevents the normal continuation of the trip, while this benefit is in force.

10.2.2. Claims

Any event, accident or illness which may give rise to GESA Assistance's intervention.

10.2.3. General Practitioner Or Specialist

Any person with a medical or surgical specialty who is legally licensed and authorized to practice medicine in the country where the insured person is located.

10.2.4. Hospital

Hospital shall mean an institution providing short term health care.

1. Legally recognized as such in the country in which the institution is located.
2. Designated for the care of bed patients.
3. Equipped with laboratory and operating room facilities.
4. Providing at all times the services of licensed physicians and registered nurses on a twenty-four hour basis.

However, rehabilitation institutions, chronic care institutions, convalescent or rest homes, as well as hospital units serving these purposes, are excluded.

10.2.5. Illness

Any sudden and unforeseeable change in health that has been diagnosed by a competent medical authority and prevents the normal continuation of the trip, while this benefit is in force.

10.3. Travel Assistance

10.3.1. Services Provided By GESA Assistance In Case Of Accident Or Illness

1. Arranging consultations with general practitioners or specialists in order to obtain the best medical care available in the area, at the insured person's request.

2. Arranging admission to the hospital nearest the site of the illness or accident.

3. Arranging for the return of the insured person to his home or to a hospital near his home after initial treatment, as soon as his condition permits, by any appropriate means of transportation, if the insured person can no longer use the means of transportation originally planned for his return to his province of residence.

4. Making the necessary arrangements for the payment of medical and hospitalization expenses eligible under the Health Insurance Benefit of the group insurance policy issued by Standard Life, for hospitalization and medical and surgical treatment outside Canada in case of emergency.

   If necessary, and subject to prior agreement with Standard Life, GESA Assistance will advance the funds, in the lawful currency of Canada, for you and your insured dependents, for the medical and hospitalization expenses specified in the preceding paragraph.

5. Making the necessary arrangements for the payment of expenses required in exceptional situations other than expenses for medical and hospitalization expenses specified in the preceding article.

   If necessary, and subject to prior agreement with Standard Life, GESA Assistance will advance up to a maximum of five thousand dollars in the lawful currency of Canada, for you or for you and your insured dependents.

   All such advances are payable by you in one lump sum within thirty days of receipt of a notice to this effect, to Standard Life. In the event of non-payment within the specified delay, Standard Life will send a notice to the policyholder, and the latter shall immediately pay the specified amount.

6. Upon request, confirming insurance coverage to physicians and hospitals.

10.3.2. Expenses Assumed By GESA Assistance In Case Of Accident Or Illness

1. The transportation or transfer, if necessary, by appropriate means, land or air, recommended by the attending physician in agreement with GESA Assistance to a hospital, near the site of the accident or illness best equipped to provide treatment, given the nature and/or severity of the accident or illness.

2. The return of the insured person to his home or to a hospital near his home, if recommended by the attending physician and in agreement with GESA Assistance, after initial treatment and provided his state of health permits and necessitates it.

   GESA Assistance will assume up to the cost of a first class ticket on a regular airline for the return of an insured person if his original return ticket cannot be used for this purpose.

   Furthermore, GESA Assistance will assume expenses for local ambulance service to the airport and upon return, to the insured person's home or the nearest hospital.

10.3.3. Services Provided And Expenses Assumed By GESA Assistance In Case Of Accident, Illness, Death Or Other Emergency

1. Arranging and paying for the return, to the province of residence, of family members who can no longer use the means of transportation originally planned for their return because of the accident, illness or death of the insured person.

2. Arranging and paying a person to escort any dependent child under sixteen years of age, traveling with the insured person if, following the accident, illness or death of the insured person, no accompanying adult is able to do so.

3. Arranging and paying for the return trip of a family member to enable such a member to visit the insured person whose state of health is such that his return is not possible and requires hospitalization for a period exceeding seven days.

4. Arranging and paying for meals and accommodation of an insured person whose trip is interrupted due to the death or hospitalization of another family member traveling with him, up to one hundred and fifty dollars in the lawful currency of Canada per day for seven days.

5. Arranging and paying for all expenses related to the hiring of a driver to return the vehicle to the insured person's residence or to the nearest rental office if, following the accident, illness or death of the insured person, no other passenger traveling with the insured person can drive the said vehicle.

6. Arranging and paying for all expenses for the communication of emergency messages to the family or to the employer whenever the insured person is unable to do so.

7. Providing legal assistance following legal action taken against the insured person.

   Advancing funds for the payment of legal fees, up to a total combined maximum of five thousand dollars, in the lawful currency of Canada, for you and your insured dependents, subject to prior agreement with Standard Life.

Advancing funds for the payment of bail, up to a total combined maximum of five thousand dollars in the lawful currency of Canada, for you and your insured dependents, subject to prior agreement with Standard Life, to cover instances such as ensuring the release and personal appearance of the insured person having been the driver of a vehicle involved in an accident.

All such advances are payable by you in one lump sum within thirty days of receipt of a notice to this effect, to Standard Life.

In the event of non-payment by the participant within the specified delay, Standard Life will send a notice to the policyholder, and the latter shall immediately pay the specified amount.

8. Providing information in case of a problem such as loss of passport, luggage, money, credit cards, travel tickets, etc., which could interrupt the insured person's trip.

10.3.4. Services Provided And Expenses Assumed By GESA Assistance Following The Death Of The Insured Person Due To An Illness Or Accident

GESA Assistance will handle all necessary local formalities and will assume the payment of expenses for postmortem, coffin and the transfer of the deceased to the burial site in the insured person's province of residence. Funeral expenses are not assumed by GESA Assistance nor Standard Life. However, should the family of the insured person decide that the local burial or cremation be a preferable option, the reasonable expenses for the burial or cremation will be assumed by GESA Assistance. However, such expenses may not exceed the other expenses that would have been assumed by GESA Assistance.

10.4. Deductible

The services provided and the expenses assumed under this benefit are subject to the deductible specified under the Health Insurance Benefit, unless a specific deductible is indicated in the Summary Of Benefits.

10.5. Maximum

The services provided and the expenses assumed under this benefit are subject to the maximums specified under the Health Insurance Benefit.

10.6. Extension Of Insurance Without Premium Payment Upon Your Death

Upon your death, the present benefit is extended without premium payment to the earliest of the following dates:

1. 12 months following your death.
2. The date on which this benefit would have terminated had you then been living.
3. The termination date of the benefit or contract.

10.7. Exclusions

The services provided do not cover:

1. Any expenses payable or reimbursable under a private or government insurance plan or which would normally have been reimbursable or payable.
2. Attempted suicide or self-inflicted injury, while sane or insane.
3. Injury or illness resulting from civil unrest, insurrection or war, whether war be declared or not, or participation in a riot.
4. Surgery or treatment which is not medically required, and which is given for cosmetic purposes or for any reason other than curative, or which exceeds ordinary surgery or treatment given in accordance with current therapeutic practice, and surgery or treatment which is given in relation to an operation or treatment of experimental nature.
5. Any portion of expenses for services in excess of the reasonable and customary charge for an illness of the same nature and severity in the locality where the service is provided.
6. Care or services rendered free of charge or which would be free of charge were it not for insurance coverage or which are not chargeable to the insured person.
7. Rest cure or travel for reasons of health.

10.8. Procedures

10.8.1. Reporting Of Accident Or Illness

As soon as an insured person has an accident or learns of his illness, he must use all possible means to limit the extent of such accident or illness. The insured person must submit to GESA Assistance, within the following five days, a declaration of the circumstances of such accident or illness and its known or presumed causes. Furthermore, at the request of GESA Assistance, the insured person must provide a certificate from the attending physician outlining the probable consequences of the illness or the injuries sustained in the accident.

10.8.2. Prescription

Every claim in respect of a covered event shall be time barred within one year from the date of occurrence of such event.

10.8.3. Refund Of Return Portion Of Ticket

When GESA Assistance pays for the return of the insured person, the insured person is obliged to surrender the return portion of his own original ticket, or any refund thereof, to GESA Assistance. In case of non-compliance and in consideration of the present contract, GESA Assistance subrogates Standard Life of all their rights and recourse necessary to recover such sum from the insured person.

10.9. Liability Of GESA Assistance

GESA Assistance shall not be held responsible for delays or impediments in providing assistance in the following events.

1. Strike.
2. War.
3. Invasion.
4. Act of foreign enemies.
5. Hostilities, whether war be declared or not.
6. Civil war.
7. Rebellion.
8. Insurrection
9. Terrorism or military or usurped power.
10. Riot and civil disturbance.
11. Radioactivity.
12. Any other Act of God.

It is understood that the physicians, hospitals, clinics, lawyers or any professionals or professional institutions to whom the insured person is referred by GESA Assistance are for the most part independent contractors responsible for their own acts and not employees, agents or in the service of GESA Assistance.

Furthermore, GESA Assistance and Standard Life shall not be responsible for any act or failure to act on the part of professionals or professional institutions such as, but not limited to, physicians, hospitals, clinics and lawyers.

11.Dental Care Benefit

(Standard Life Acts As The Administrator Of The Present Benefit)

11.1. Covering Agreement

The administrator undertakes to reimburse dental care expenses, incurred by you or one of your covered dependents, subject to the terms and conditions hereinafter specified.

11.2. Expenses

11.2.1. Eligible Expenses

Eligible expenses incurred by a covered person for services, care and treatment provided by a general practitioner, a specialist or a denturologist must be incurred on or after the date the coverage comes into effect but before the coverage for the covered person expires.

The expenses are considered to be incurred only when the treatment is given during the period the coverage is in effect.

For prostheses, expenses are considered to be incurred only on the date such prosthesis is installed.

If an orthodontist sets a global fee at the beginning of a treatment expected to extend beyond a year, the administrator reserves the right to spread such fee over the entire treatment period and to reimburse expenses periodically throughout the treatment.

11.2.2. Fees

Expenses incurred in Canada may not exceed the reimbursement basis in accordance with the Suggested Fee Guide for Dental Services provided for general practitioners, approved and published by the Dental Surgeon Association of the province where treatment is given, and for the year of reference of publication specified in the Summary of Benefits.

Expenses incurred outside Canada may not exceed the reimbursement basis in accordance with the Suggested Fee Guide for Dental Services provided for general practitioners, approved and published by the Dental Surgeon Association of the covered person's province of residence, and according to the reference year of publication specified in the Summary of Benefits.

11.3. Payment Of Benefits

11.3.1. Required Proof

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

11.3.2. Alternate Treatment Plan

If more than one type of treatment exists for the dental condition of the covered person, the administrator reimburses the lesser fee, provided however that the treatment given is normal and appropriate.

11.4. Treatment Plan

If the total cost of a treatment is expected to exceed the amount specified in the Summary Of Benefits, a treatment plan must be submitted to the administrator, who will determine, before commencement of treatment, the amount of expenses to be covered.

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

Even if a treatment plan has been submitted to, and approved by, the administrator, expenses are considered to be incurred only when treatment has actually been given during the period the coverage is in effect.

11.5. Calculation Of The Amount Reimbursable

The administrator reimburses the eligible expenses subject to the deductible, the percentage of reimbursement and the maximum amount specified in the Summary of Benefits.

11.5.1. Deductible

The deductible is that portion of eligible expenses which must be paid by the covered person before any benefits are payable. The maximum deductible required per calendar year is specified in the Summary of Benefits.

11.5.2. Carry-Over Provision

If the deductible has been satisfied in whole or in part by the payment of expenses incurred in the last three months of a calendar year, the deductible of the following year will be reduced by the amount of expenses thus applied to the deductible.

11.5.3. Reimbursement Percentage

The administrator reimburses a percentage of eligible expenses after applying the deductible. Such percentage is specified in the Summary of Benefits.

11.5.4. Maximum Benefit

The maximum amount reimbursed by the administrator after calculation of the deductible and percentage of reimbursement is specified in the Summary of Benefits.

In the case of any person becoming covered more than 31 days following the eligibility date, the reimbursement is subject to the conditions specified in the Summary Of Benefits.

11.5.5. Coordination And Limitation Of Benefits

If you are covered under other group policies or government programs or where coverage is required by statute, the benefits payable from all sources cannot exceed 100% of expenses incurred, that is, benefits will not be payable with respect to that portion of any eligible expense for which benefits are payable by another plan.

11.5.6. Dependents' Coordination And Limitation Of Benefits

Benefits for eligible expenses incurred by your dependents who are covered under this plan as well as another plan will be determined on the following basis:

1. Spouse

   Where your spouse is covered under the present plan and insured as a participant under another plan, that portion of an expense which is eligible for reimbursement under such plan will not be payable under the present benefit. Your spouse must first file a claim with his insurer.

   Thereafter, you may submit to Standard Life a reimbursement request for the portion of the expenses not reimbursed by your spouse's insurer but eligible under the present benefit.

   You must provide copies of the other administrator claim settlement and of the receipts.

2. Child

   Where your child is covered as a dependent under the present plan and also under your spouse's plan, benefits will first be payable under the present plan if your birthdate occurs earlier in the calendar year in relation to that of your spouse.

   As an example, when your birthdate precedes your spouse's birthdate, you must first submit your request to Standard Life.

   Afterwards, your spouse may submit to his insurer a reimbursement request for the portion of the expenses not reimbursed under the present benefit but eligible under his plan. Copies of the settlement issued by Standard Life and receipts must be provided.

   Should the spouses have the same birthdate, the claims for children must then be filed in the alphabetical order of the spouses' first names.

11.6. Expenses For Preventive Treatments

Expenses for the following preventive treatments are eligible:

11.6.1. Examination And Diagnosis

1. Oral examination, as specified in the Summary Of Benefits
2. Recall oral examination, as specified in the Summary Of Benefits
3. Emergency oral examination
4. Specific oral examination

11.6.2. Radiographs

1. Intraoral — Periapical, one complete series every 24 months
2. Intraoral — Occlusal
3. Intraoral — Bitewing
4. Extraoral
5. Sialography
6. Panoramic, once every 12 months
7. Radiopaque dyes
8. Cephalometric film

11.6.3. Tests And Laboratory Examinations

1. Microbiologic culture
2. Caries susceptibility tests
3. Biopsy of oral tissue — Soft
4. Biopsy of oral tissue — Hard
5. Cytologic smear
6. Pulp vitality tests

11.6.4. Preventive Services

1. Prophylaxis, as specified in the Summary Of Benefits
2. Preventive recall packages, as specified in the Summary Of Benefits
3. Fluoride treatments
4. Initial oral hygiene instruction

11.7. Expenses For Basic Treatments

Expenses for the following basic treatments are eligible:

11.7.1. Other Basic Treatments

1. Finishing restorations
2. Pit and fissure sealant and preventative restorative resins combined 1 per tooth per 24 months
3. Caries, trauma and pain control
4. Interproximal discing

11.7.2. Space Maintainers

Space maintainers for loss of primary teeth, for covered persons under age 18

11.7.3. Control Of Harmful Habits

Appliances to control harmful habits 2 per 5 years

11.7.4. Restorative

1. Amalgam restorations
2. Acrylic or composite resin restorations

11.7.5. Other Restorative Services

1. Restorations prefabricated, metal or plastic
2. Recement inlay or crown
3. Removal of inlay or crown

11.7.6. Endodontics

1. Pulpotomy
2. Pulpectomy
3. Root canal therapy
4. Periapical services
5. Other endodontic procedures

11.7.7. Periodontics

1. Non surgical services
2. Surgical services
3. Periodontal splinting
4. Adjunctive periodontal procedures
5. Scaling/root planing, combined limit of 12 units per calendar year

11.7.8. Prosthodontics —Removable

1. Adjustments, repairs, additions
2. Relining and rebasing

11.7.9. Prosthodontics — Fixed

Repairs

11.7.10. Oral Surgery

1. Uncomplicated removals
2. Surgical removals
3. Alveoplasty
4. Surgical excision
5. Surgical incision and drainage
6. Frenectomy
7. Hemorrhage, control of

11.7.11. Adjunctive General Services

Anaesthesia, only in relation to surgery

11.8. Expenses for Major Treatments

Expenses for the following major treatments are eligible:

11.8.1. Prosthetics — Initial

The initial, complete or partial, fixed or removable prostheses, in the case of teeth extracted.

11.8.2. Prosthetics — Replacement

Replacement of, complete or partial, fixed or removable prostheses, in the case of:

1. Replacement following the extraction of natural teeth.
2. Replacement of a prosthesis that is at least the age specified in the Summary Of Benefits and can no longer be used.
3. Initial replacement of a temporary prosthesis fitted less than 12 months before.

In no event will the coverage cover lost or stolen prostheses.

Whenever laboratory fees are incurred, they shall be limited to 60% of the fixed fee determined for the procedure, unless justified by a receipt furnished by a commercial laboratory.

11.8.3. Restorative

1. Diagnostic casts
2. Gold foil restorations, if other substances are inappropriate
3. Metal inlay restorations
4. Porcelain inlay restorations, if other substances are inappropriate
5. Onlay restorations
6. Pins for inlays, onlays or crowns
7. Post and cast metal cores
8. Crowns
9. Veneers, laboratory processed
10. Overdentures

11.8.4. Prosthetics — Removable

1. Complete dentures
2. Partial dentures

11.8.5. Prosthetics — Fixed

1. Bridge pontics
2. Retainers and abutments
3. Other prosthetic services

11.8.6. Oral Surgery

1. Oral surgery
2. Treatment of fractures
3. Other oral surgery

11.9. Expenses for Orthodontic Treatments

Expenses for the following orthodontic treatments are eligible:

Reasonable expenses incurred for orthodontic treatment given by an orthodontist or a general practitioner to correct the dental irregularities, subject to the age limitation specified in the Summary Of Benefits, if applicable.

11.9.1. Orthodontic Treatments

1. Oral examination
2. Skull and facial bone survey
3. Radiographs hand and wrist
4. Diagnostic casts, unmounted
5. Surgical exposures
6. Removable active appliances for tooth guidance
7. Fixed or cemented appliances
8. Retention appliances
9. Comprehensive treatment
10. Miscellaneous services

11.10. Exclusions

This benefit does not cover:

1. Treatment or appliance, related directly or indirectly to full mouth reconstruction, to correct vertical dimension and temporomandibular joint dysfunction.
2. Dental implants and all treatments related to implants.
3. Services rendered by a dental hygienist and not administered under supervision of a dentist.
4. Dental services covered under the health benefit, if such benefit is part of this group benefits plan, or under any other group insurance contract.
5. Services and supplies relating to any appliance worn in the practice of a sport.
6. Expenses which are or would normally be payable or reimbursable under a private or public insurance plan.
7. Self-inflicted injury, while sane or insane.
8. Injury or illness resulting from civil unrest, insurrection or war, whether war be declared or not, or participation in a riot.
9. Services which are not medically required, which are given for cosmetic purposes or which exceed ordinary services given in accordance with current therapeutic practice.
10. Care or services rendered free of charge or which would be free of charge were it not for insurance coverage or which are not chargeable to the covered person.

12.Notice

At Standard Life, we are committed to maintaining the highest standards of integrity in our business. In the course of our business, it is necessary to collect personal information about you. We will ask for your consent to collect, use and disclose personal information. We will limit collection, use and disclosure of personal information strictly for the purposes of your group coverage.

We will safeguard your personal information. Access to personal information is restricted to Standard Life employees and employees of authorized service providers who need it to determine eligibility, to administer your group coverage, to assess claims and conduct any required investigations. While Standard Life endeavors to protect all your personal information, your medical information will receive the highest level of protection.

You can be assured that not only do we respect applicable laws and regulations, but we also apply generally accepted privacy ethics and standard business practices for the handling of your personal information.

How can you access your personal information and submit a complaint?

You have the right to be informed of the nature and source of personal information that Standard Life has on record concerning you. Personal medical information will be made available only through a physician designated by you.

You also have the right to request the correction of inaccurate, incomplete or obsolete information in your file. If demonstrated to our satisfaction that the information held in our record is inaccurate or incomplete, we will make the necessary changes.

If you are not satisfied as to how we have handled your personal information, you may submit a complaint.

Any request to access or correct information held in our records or to submit a complaint should be made in writing to:

The Manager, Customer Relations and Ombudsman
The Standard Life Assurance Company of Canada
1245 Sherbrooke West
Suite 1000
Montreal, Qc
H3G 1G3

Additional information about Standard Life's privacy protection practices can be obtained on our public Web site and in the VIP Room Web site for Plan Members.

References to "you" and "your" in this Notice include yourself and your dependents.

13. Summary Of Benefits

Please see next page for the detailed coverage of this class.

1 - Eligibility Period

A- Present Employees

Dental Care Benefit:

First of the month next following 4 months

All Other Benefits:

First of the month following hire date

B- Future Employees

Dental Care Benefit:

First of the month next following 4 months

All Other Benefits:

First of the month following hire date

2 - Participant's Life Insurance Benefit

A- Sum Insured

3 times the annual income
Rounded to the next $1,000 if not already a multiple thereof

B- Maximum Amount Of Insurance

$200,000 if the participant is less than 65

C- Reduction Of Sum Insured

50% at age 65 to a maximum of $25,000

D- Waiver Of Premiums — Elimination Period

119 days

E- Termination Of Benefit

At the earlier of the participant's retirement or attainment of age 70

3 - Participant's Optional Life Insurance Benefit

A- Sum Insured

Per unit of $10,000
Maximum of $300,000

B- Evidence Of Insurability

Required in all cases

C- Termination Of Benefit

At the earlier of the participant's retirement or attainment of age 65

4 - Spouse's Optional Life Insurance Benefit

A- Sum Insured

Per unit of $10,000
Maximum of $300,000

B- Evidence Of Insurability

Required in all cases

C- Termination Of Benefit

At the earlier of the participant's retirement or attainment of age 65

5 - Participant's Accidental Death And Dismemberment Protection Plus Benefit

A- Sum Insured

3 times the annual income
Rounded to the next $1,000 if not already a multiple thereof

B- Maximum Amount Of Insurance

$200,000 if the participant is less than 65

C- Reduction Of Benefit

50% at age 65 to a maximum of $25,000

D- Termination Of Benefit

At the earlier of the participant's retirement or attainment of age 70

6 - Long Term Disability Benefit

A- Definition Of Disability

Participant's occupation and any occupation

B- Elimination Period

119 days

C- Initial Disability Period

24 months

D- Maximum Benefit Period And Age Limit

Participant's attainment of age 65

E- Amount Of Monthly Disability Benefit

The amount of monthly benefit, rounded to the next highest dollar, shall be the lesser of the:

1) Basic Monthly Benefit

60% of the gross monthly income determined at the beginning of disability

Subject to a maximum of $5,000

The basic monthly benefit is reduced by all applicable reductions excluding the Canada/Quebec Pension Plan benefits for dependent children

2) All Source Maximum

85% of the net monthly income determined at the beginning of the disability less all applicable reductions

F- Taxability Of Benefits

Benefits are non-taxable

G- Pre-Existing Conditions

1) Period Preceding The Effective Date Of Insurance

90 days

2) Period Following The Effective Date Of Insurance

12 months

H- Termination Of Benefit

At the earlier of the participant's retirement or attainment of age 65

7 - Health Insurance Benefit

A- Deductible, Unless Otherwise Specified

$50 per insured person

Maximum of $50 per family

This deductible is combined with the one of the Prescribed Drug Benefit

B- Reimbursement, Unless Otherwise Specified

80% of the first $1,000 of expenses per calendar year and 100% of the excess

C- Maximum Amount For Expenses Incurred In Canada

Unlimited maximum

The maximum reimbursed amount for all expenses incurred in Canada excludes medical and surgical expenses incurred out of province, but in Canada, in case of emergency

D- Duration Of Stay Outside Canada, Unless Otherwise Specified

2 months

E- Hospitalization

1) Hospitalization In Canada

Private room without limit as to the number of days

Reimbursed at 80 %

2) Hospitalization Outside Canada In Case Of Emergency

Semi-private room without limit as to the number of days

The maximum specified in article "Medical And Surgical Care Outside Canada And Out Of Province In Case Of Emergency" includes expenses for hospitalization outside Canada in case of emergency

Reimbursed at 100%

F- Medical And Surgical Care Outside Canada And Out Of Province In Case Of Emergency

Maximum of $3,000,000 per calendar year, including expenses for hospitalization outside Canada

For a participant who is on leave of absence, the maximum amount is $3,000,000 for a stay abroad that must not exceed 2 months; for a participant who is not actively at work due to a lay-off, strike or lock-out for a period exceeding 3 months, the maximum amount as of the end of such period is $3,000,000 per insured person for a stay abroad that must not exceed 2 months.

Reimbursed at 100%

G- Hospitalization And Medical And Surgical Care Outside Canada On Referral

Lifetime reimbursable maximum of $25,000

Reimbursed at 80%

H- Rehabilitation Institution, Convalescent Home Or Chronic Care Institution

Reimbursable maximum of $20 per day, up to a maximum of 90 days

I- Nursing Services

1) Eligible Expenses

Registered nurse

2) Maximum

Maximum of 720 hours per calendar year with prescription

J- Professional Services

1) Acupuncturist

Reimbursable maximum of $100 per calendar year

Without prescription

2) Chiropractor And Naturopath

Combined reimbursable maximum of $200 per calendar year

Without prescription

3) Masseur And Physiotherapist

Combined reimbursable maximum of $250 per calendar year

Without prescription

4) Speech Therapist

Reimbursable maximum of $100 per calendar year

Without prescription

5) Podiatrist And Chiropodist

Combined reimbursable maximum of $200 per calendar year

Without prescription

6) Psychologist

Reimbursable maximum of $200 per calendar year

Without prescription

K- Laboratory Analysis And X-Rays

Reimbursable maximum of $500 per calendar year

L- Vision Care

1) Eye Examination (only for insured person between age 19 to 64)

Reimbursable maximum of $75 for each consecutive 24-month period

No deductible

Reimbursed at 100%

2) Eye Glasses, Contact Lenses Or Laser Eye Surgery

Reimbursable maximum of $450 per each consecutive 24-month period

No deductible

Reimbursed at 100%

M- Medical Supplies

1) Elastic Support Stockings

Maximum of 2 pairs per calendar year

2) Custom Made Orthopaedic Shoes and Modifications to Stock Item and Orthotic Devices

Reimbursable maximum of $400 per each consecutive 12-month period for over age 19

Reimbursable maximum of $200 per each consecutive 12-month period for under age 19

3) Hearing Aids

Reimbursable maximum of $500 per 5 calendar years

4) Capillary Prostheses

Lifetime reimbursable maximum of $300

5) Breast Prostheses

Reasonable and customary charge per calendar year

6) Intra-Uterine Contraceptive Devices

Maximum of 1 per each consecutive 24-month period

N- Termination Of Benefit

At the participant's retirement. However, Hospitalization Outside Canada In Case Of Emergency, Medical And Surgical Care Outside Canada And Out Of Province In Case Of Emergency and Hospitalization And Medical And Surgical Care Outside Canada On Referral cease at the earlier of the participant’s retirement or attainment of age 75

8 - Prescribed Drug Benefit, TELUS Health Solutions Plan 88

A- Deductible

$50 per insured person

Maximum of $50 per family

This deductible is combined with the one of the Health Insurance Benefit

B- Reimbursement

100% of the ingredient cost and of the dispensing fee

Reimbursement under this benefit is subject to the provisions of the Specialty Drug Program and Prior Authorization Process, where applicable.

The amount reimbursed under this benefit is limited by the reasonable and customary charges set by the insurer on the pharmacist’s dispensing fee, where applicable.

C- Sclerosant Injections

Maximum of $20 per visit

D- Termination Of Benefit

At the participant's retirement

9 - Travel Assistance Plus Benefit

A- Coverage

This benefit provides assistance in case of emergency outside the insured person's province of residence

B- Duration Of Stay Outside The Province Of Residence

2 months

C- Deductible

None

D- Reimbursement

100 %

E- Termination Of Benefit

At the earlier of the participant's retirement or attainment of age 75

10 - Dental Care Benefit

(Standard Life Acts As The Administrator Of The Present Benefit)

A- Eligible Expenses

Preventive treatments

Basic treatments

Major treatments

Orthodontic treatments

B- Frequency Of Treatments

Oral examination, once every 24 months

Recall oral examination, 2 per calendar year

Prophylaxis, 2 per calendar year

Preventive recall packages, 2 per calendar year

Replacement of prostheses, if the prosthesis is at least 5 years old and can no longer be used

C- Treatment Plan

A treatment plan must be submitted to the administrator when the total cost of a treatment is expected to exceed $500

D- Deductible

1) Preventive treatments -Basic treatments -Major treatments -Orthodontic treatments -

No deductible

E- Reimbursement

100% for preventive treatments

100% for basic treatments

75% for major treatments

50% for orthodontic treatments

F- Maximum Amount Reimbursed

1) Preventive treatments -Basic treatments -Major treatments -

Unlimited

2) Orthodontic treatments -

$3,500 lifetime

3) Late Application For Preventive - Basic - Major Treatments

$250 during the first 12 months of coverage for any person becoming covered more than 31 days following the eligibility date

4) Late Application For Orthodontic Treatments

$250 during the first 36 months of coverage for any person becoming covered more than 31 days following the eligibility date

G- Fee Schedule

1) Expenses Incurred In Canada

Expenses incurred are reimbursed according to the current fee schedule for general practitioners of the province where treatment is given

2) Expenses Incurred Outside Canada

Expenses incurred are reimbursed according to the current fee schedule for general practitioners of the province of residence

H- Termination Of Benefit

At the participant's retirement

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GE8444H 06-2012