GROUP INSURANCE PLAN

Policyholder: ***QUÉBEC PROVINCIAL ASSOCIATION OF TEACHERS***

Policy No.: ***97,000-B / 97,001***

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

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

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

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

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

This booklet can also be viewed on our secure website My Client Space accessible via ia.ca, if offered as part of your plan. For any question about coverage options, contact iA Financial Group at 1 877 422-6487.

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INTRODUCTION

Industrial Alliance Insurance and Financial Services Inc. presents this booklet which reflects the benefits insured with our company from which you may benefit as a member of the QPAT.

We suggest that you read this booklet and keep it in a safe place for future reference.

New Participant

To participate in the present plan, you have to fill out the form *Participation Request F54-018A(16)*, indicate the chosen benefits and transmit it to your school board. This form is available at your school board.

Modification to the Coverage

Any modification to the coverage of a participant should be transmitted to your school board on the form *Participation Request F54-018A(16)*. This form is available at your school board.

Claims

Fill out the form *Claim Request F54-326 (16)*, available at your school board or at your school.

All claims should be sent to the following address:

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

For more information, you can communicate with the person designated by your school board, with your local union, with the QPAT or with Industrial Alliance Insurance and Financial Services Inc.

Administration Department

For any information regarding your choice of benefits, plan costs or information related to the administration (modifications such as: name, date of birth, sex, communication language, change of address), you can communicate with our Administration Department at one of the following numbers:

514 499-3800
or
1 800 363-3540

Claims Department

For any question related to eligible expenses or for any claim, you can communicate with our Claims Department at one of the following numbers:

514 499-3800
or
1 800 363-3540

SUMMARY OF BENEFITS

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

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

SPECIAL PROVISIONS

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

Participants are insured under the following classes:

Classes

Teachers Under Full-time Contract
(Members of the Montreal Teachers Association)

Teachers Under Part-time Contract in the Youth Sector
(Members of the Montreal Teachers Association)

GENERAL PROVISIONS

ELIGIBILITY DATE

Subject to all other provisions of the group policy, each member shall become eligible on the latest of the following dates:

a) on the effective date of the plan, if he is then in the employer's service,

or

b) if he is not in the employer's service:

   i) on the scheduled date of the beginning of service if his employment contract takes effect between the first working day and the last working day of the work year; or

   ii) on the date of the first working day of the work year, if his employment contract takes effect before or on the first working day of the work year.

NORMAL RETIREMENT AGE

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

DENTAL CARE INSURANCE

Deductible	none
Reimbursement	
– Preventive treatments:	80%
– Basic treatments:	80%
– Major treatments:	50%
Maximum per insured person	
– Preventive and Basic treatments:	$2,000 per calendar year
– Major treatments:	$2,000 per calendar year

Dependents, if applicable, are covered under this benefit.

Expenses are reimbursed according to the Dental Surgeons Association's Fee Guide for the current year less 2 years, or, if applicable, the Dental Hygienists Association's Fee Guide for the current year less 2 years, subject to any limits which are stated under the Dental Care Insurance benefit. If there is no fee guide for the reference year, the insurer will determine the level of dental expenses to be reimbursed according to the latest fee guide plus an inflationary adjustment.

Termination:

This benefit terminates on the participant's date of retirement.

PARTICIPATION IS <u>MANDATORY</u> FOR THE PARTICIPANTS.

PARTICIPATION IS <u>OPTIONAL</u> FOR THE DEPENDENTS.

DEFINITIONS

Actively at Work: The status of a participant who is performing his or her usual duties on a continuous basis. Wherever there is mention of a number of full-time work days, public holidays are considered full-time work days.

Acceptance of evidence of insurability: The date of acceptance of any evidence of insurability shall mean the first day of the month following the date the insurer receives the last document required for risk assessment.

Association: The *Québec Provincial Association of Teachers* (QPAT).

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

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

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

a) Spouse

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

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

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

b) Child

An unmarried child of the participant or his spouse, or both, or a child living with the participant for whom procedure of adoption is underway, who

wholly depends on the participant for support and maintenance and who meets at least one of the following conditions:

i) He is under 18 years of age; or

ii) He is under 26 years of age and is attending a recognized educational institution on a full-time basis; or

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

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

Employee: A full-time or part-time teacher, covered by a bargaining certificate with a union affiliated with QPAT, as well as any person employed by a school board and accepted for insurance by mutual agreement between CPNCA and QPAT, and arrangements agreed between them.

Employer: A school board covered by a bargaining certificate with a union affiliated with QPAT.

Insured Person: The participant and the dependents of the participant insured under this plan.

The insured person must at all times be covered under a government health plan and live in Canada permanently (at least 182 days a year), in order to be eligible under the present plan and to maintain his or her rights to insurance, unless otherwise agreed previously with the insurer or unless mention to the contrary is made in the present plan.

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

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

School board: A school board covered by a bargaining certificate with a union affiliated with QPAT.

CHANGES IN GOVERNMENT PLANS

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

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

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

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

INCONTESTABILITY

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

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

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

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

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

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

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

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

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

LAWFUL CURRENCY

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

COVERAGE ELSEWHERE

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

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

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

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

ELIGIBILITY

Employee

a) The following persons are eligible for the Dental Care Insurance benefit:

   i) any Full-time Teacher;

   ii) any Part-time Teacher;

b) An employee's eligibility begins:

   i) on the effective date of this plan, if he or she is working for a school board on that date;

   ii) in all other cases, on the date stipulated in the Summary of Benefits, if applicable.

Dependents

Any dependent of a participant is eligible for the insurance, either on the same date as the participant if he or she is already a dependent, or on the date on which he or she becomes a dependent.

When a dependent ceases to be insured under a group insurance plan that includes similar benefits, he or she is eligible for this insurance on the date on which he or she ceases to be insured under the said plan.

PARTICIPATION

a) Participation to this insurance is mandatory for all employees who fulfil the requirements with regard to eligibility described in the ELIGIBILITY provision above.

   However, with prior written notice from his or her employer, a participant may refuse or cease participation to the said benefit as of the end of the premium period stipulated in the notice, provided he or she can provide satisfactory proof that he or she is insured under group insurance coverage with similar benefits.

   A participant under age 65 who refused or ceased participation to the Dental Care Insurance benefit, in accordance with the provisions of the

preceding paragraph, may participate in this insurance under the following conditions:

i) He or she must establish to the insurer's satisfaction that:

- he or she was formerly insured under the said benefit, or under a health insurance component of some other plan containing similar benefits;
- he or she is no longer able to continue participation in the said benefit or plan;
- his or her application is presented within a period of 60 days following termination of his or her insurance. If he or she applies more than 60 days following the termination of his or her insurance, the insurance provided under the Dental Care Insurance benefit will not take effect until the first day of the month following the end of a 60 day period beginning on the date the application is received by the insurer.

ii) For employees who, prior to their application, were not insured under the Dental Care Insurance benefit, the insurer cannot be held responsible for the payment of benefits that may be payable by the previous insurer under an extended coverage or conversion provision.

b) Any employee having one or more dependents may insure himself or herself as an employee without dependents, or as an employee with dependents, as the case may be, by completing a form and sending it to the insurer via the employer.

In the case of part-time teachers, if this form is completed more than 60 days following the date on which his or her dependents become eligible, the employee must, at his or her expense, provide satisfactory evidence of insurability for his or her dependents. Dependents will be eligible for coverage under the drug coverage of this plan on the date of the application, and all additional benefits on the date the evidence of insurability is accepted by the insurer.

c) Any Full-time Teacher may insure his or her dependent children, or his or her spouse and dependent children under the Dental Care Insurance benefit.

d) Any Part-time Teacher may insure his or her dependent children, or his or her spouse and dependent children, under the Dental Care Insurance benefit of this plan.

EFFECTIVE DATE OF INSURANCE

a) The employee's insurance, regardless of his or her insurability status, takes effect on the effective date of this plan, if he or she fulfils the requirements with regard to eligibility at that time, otherwise it takes effect on the day he or she fulfils these requirements.

In accordance with the stipulations of the PARTICIPATION provision, the insurance of an employee who refused or ceased participation in the plan, under the stipulations of the said provision, take effect on the first day of the month during which the insurer receives the application.

b) The dependents' insurance takes effect on the later of the following dates:

i) the date on which the employee's insurance takes effect, or

ii) the date on which they become dependents of the employee;

iii) the date the application is received, if the dependent meets the conditions of the plan.

In the case of Part-time Teachers, if the application for dependents' coverage is received after the 60 days following their eligibility date, evidence of insurability will be required.

Dependents will be eligible for coverage under the drug section of this plan on the date of the application, and all additional benefits on the date the evidence of insurability is accepted by the insurer.

TERMINATION OF INSURANCE

The insurance of any participant automatically terminates at midnight on the earliest of the following dates:

a) The termination date of the benefit or of this plan;

b) The date on which the participant ceases to meet the eligibility requirements;

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

d) The date on which the participant is no longer covered by his or her provincial health plan;

e) The date on which the participant ceases to participate under the terms of the PARTICIPATION provision of this plan;

f) The date the participant is incarcerated after committing a criminal offence for which he or she was found guilty.

- The insurance for all dependents terminates at midnight on the earliest of the following dates:

  a) The termination date of the benefit in question or of this plan;

  b) The termination date of the insurance with respect to the participant of whom he or she is a dependent;

  c) The date on which he or she ceases to be a dependent under the terms of this plan;

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

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

  f) The first day of the month following receipt by the employer of a written notice to the effect that the participant insured with dependents chooses to become insured without dependents.

INTERRUPTION OF A PARTICIPANT'S INSURANCE

a) In the case of a temporary absence without pay as stipulated in the agreement, participation is suspended for the duration of the absence, and resumes automatically upon active return to work with pay. However, the participant may maintain his or her participation in all benefits in force by paying, via his or her employer, the total premium stipulated under this plan in accordance with the situation that prevailed prior to the beginning of this temporary absence without pay.

b) In the case of a temporary absence with pay, participation remains in force for all benefits.

c) In the case where a participant is dismissed and the dismissal is contested by way of a grievance or arbitration under the labour law, the participant may maintain in force the insurance provided under the benefits in which he or she was participating in accordance with the situation prior to the date of the contested dismissal, by paying, via the employer, the total premium stipulated in the plan, until judgment is made.

d) Participants who do not take advantage of the provisions under this clause enabling them to maintain the insurance in force from the beginning of their temporary absence without pay cannot do so later during this absence.

e) If the insurance remains in force, a disability beginning during a temporary interruption in work is considered to have begun on the date on which the participant should normally return to work.

CLAIMS NOTICE

The insurer must receive notice of any claim within 12 months of the date of the event which gives entitlement to the benefit.

However, no delay in the submission of the documents required by the insurer can be withheld against the participant, if he demonstrates that the documents have been delivered as soon as possible.

However, if the group policy terminates, notice of claim must be submitted to the insurer within 90 days following termination of the group plan.

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

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

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

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

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

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

INSURER'S RIGHT TO EXAMINATION OF A CLAIMANT

The insurer, at its own expense, shall have the right and opportunity, whenever it deems necessary, to require a medical examination, by a physician designated by it, of any person for whom a claim is submitted and to make an autopsy in case of death, where it is not forbidden by law. In addition, the insurer reserves the right to obtain the report of any medical practitioner who has examined the person for whom a claim was submitted.

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

BENEFIT PAYMENT

The insurer will pay the insured amounts, in accordance with the terms of the contract, within 30 days of receipt of evidence satisfactory to the insurer. However, in the case of disability claims, the 30 days commence from the expiry of the elimination period if such date is subsequent to submitting evidence satisfactory to the insurer. Payments are made according to the terms and conditions of the contract with retroactive adjustments.

Disability income benefits payable to a participant incapable of managing his or her assets and giving receipt are paid to the guardian or curator. However, after a 6 month period following the date the participant was declared unfit by a physician, the insurer will continue to pay the benefits provided the institution of a protective supervision is undertaken.

SUBROGATION

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

Without limiting the generality of this provision, the term damages will include any lump sum or periodic payments received on account of:

a) Past, present or future loss of income, wages, or earnings; and

b) Any other benefits paid or payable under the group policy.

The participant or dependent shall reimburse the insurer up to the amount of any benefits paid in the past or that are payable in the future under the group policy out of the gross damages recovered whether recovered at trial, or prior to trial by way of any form of settlement, and without regard to whether the participant or dependent has obtained full recovery of his losses.

Where the participant or dependent recovers damages in a lump sum, either by way of settlement or court order, and no allocation has been made in that settlement for the benefits paid or payable by the insurer, the insurer shall be reimbursed, out of the gross damages recovered, the full amount of benefits that have been paid to the participant or dependent. The insurer shall also be entitled to be reimbursed an amount, as determined by the insurer, which reasonably reflects the value of the future benefits payable to the participant or dependent under the group policy. The insurer's recovery in this regard shall not exceed the participant or dependent's gross damages recovered or gross settlement. These rights of reimbursement shall be without regard to the terms of settlement or allocation that may have been agreed to by the participant or dependent and the third party.

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

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

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

The insurer's recovery in this regard shall not exceed the participant or dependent gross damages recovered or gross settlement.

The insurer shall also have the right to seek recovery directly from the participant or dependent, or exercise any other right or remedy it may have under the group policy or under the law, in the event that any overpayment has resulted from the lack of reimbursement.

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

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

LIMITATION ON LEGAL ACTIONS

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

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

DENTAL CARE INSURANCE

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

DEFINITIONS

As used in this benefit:

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

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

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

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

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

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

DENTAL EXPENSES

"Eligible expenses" means fees incurred for treatment given by a general practitioner or by a specialist on the recommendation of a general practitioner or by a dental hygienist. Such expenses must be incurred while this coverage is in force. Expenses incurred in Canada are limited to the normal rate suggested for general practitioners of the province where treatment is given.

Expenses incurred for treatment provided by a denturist are limited to the normal suggested fee for denturists of the province where treatment is provided.

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

These expenses are reimbursed according to the Fee Guide of the year indicated in the Summary of Benefits.

The following expenses are covered if so stated in the Summary of Benefits:

Preventive Treatments

a) Examinations and Diagnoses
   - i) oral examination: once every 3 years
   - ii) recall examination: once every 6 months
   - iii) emergency oral examination
   - iv) specific oral examination

b) X-rays
   - i) intra-oral - periapical: one complete series every 3 years
   - ii) intra-oral - occlusal
   - iii) intra-oral - interproximal
   - iv) extra-oral
   - v) sialography
   - vi) panoramic: once every 3 years
   - vii) radiopaque dyes
   - viii) cephalometric

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

v) pulp vitality tests

vi) caries susceptibility tests

vii) unmounted diagnostic cast

viii) consultation

d) Preventive Services

i) polishing of coronal portion of teeth (prophylaxis): two treatment every 12 months

ii) topical application of fluoride

iii) initial oral hygiene instruction

e) Space maintainers for persons under age 16

Basic Treatments

a) Basic Treatments

i) finishing restorations

ii) pit and fissure sealant

iii) caries control

iv) interproximal disking

v) prophylactic odontotomy

b) Restorative

i) amalgam restorations

ii) composite restorations

iii) retentive pins

iv) preformed stainless steel crowns

v) preformed plastic crowns

c) Endodontics

i) pulp capping

ii) pulpotomy (excluding final restoration)

iii) emergency pulpotomy

iv) endodontic trauma

v) root canal therapy

vi) endodontic surgery

vii) apexification

viii) preparation of tooth for treatment

ix) bleaching (first visit)

x) hemisection

d) Periodontics

i) surgical services

ii) provisional matching

iii) periodontal appliance (to control bruxism)

iv) adjunctive periodontal procedures

Root planing and curettage are covered up to a maximum of 3 sextants or 2 quadrants or up to 14 teeth in any calendar year. These procedures are limited to dentists exclusively and are only covered if testing of periodontal pockets indicates 4 mm or more. In all cases, appropriate x-rays and periodontal chart must be submitted.

e) Dentures - removable

i) adjustments

ii) repairs

iii) rebasing and relining

iv) prophylaxis and polishing

f) Oral Surgery

i) removal of erupted tooth (uncomplicated)

ii) surgical removals (complicated)

iii) removal of tumours or cysts

iv) alveoloplasty

v) osteoplasty
vi) tuberoplasty
vii) removal of hyperplastic tissue
viii) removal of excess mucosa
ix) surgical incision and drainage
x) simple fracture of the mandibule (reduction)
xi) simple fracture of maxilla (reduction)
xii) alveolar fracture
xiii) repair of soft tissue laceration
xiv) repair through and through laceration
xv) frenectomy
xvi) dislocation of mandibule
xvii) treatment of salivary gland
xviii) antrum lavage
xix) closure of oro-antral fistula
xx) hemorrhage control
xxi) post-surgical treatment

g) Adjunctive General Services
i) anaesthesia (in relation to surgery)

Major Treatments

a) Dentures - removable
i) complete dentures
ii) partial dentures

b) Dentures - fixed
i) crown

ii) cast post

iii) pontic

iv) butterfly bridge

v) abutments

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

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

- extraction of one or more additional natural teeth, while the person is insured under this benefit or a similar benefit; or
- the dentures are at least 5 years old and can no longer be used; or
- replacement of temporary dentures fitted less than 12 months before.

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

c) Restorative

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

ii) metal inlay and onlay restorations

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

d) Other Restorative Services

i) prefabricated post (pivot)

ii) recementing of inlays, onlays and crowns

iii) removal of inlays, onlays and crowns

e) Space Maintainers (for loss of primary teeth)

i) stainless steel crown types

f) Implants

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

i) examination and diagnosis

ii) surgical installation of implant

iii) surgical re-entry

iv) placement of attachment

v) post-surgical care

vi) placement of prosthetic post and crown on implant

vii) laboratory fees

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

EXCLUSIONS AND REDUCTIONS

a) This benefit does not cover any expenses:

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

ii) Dental services covered under the health insurance benefit, if such benefit is part of this plan, or under any other group insurance plan;

iii) Services and supplies relating to any appliance worn in the practice of a sport;

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

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

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

vii) For services which are not medically required, which are given for cosmetic purposes, or which exceed the normal services and supplies given in accordance with current therapeutic practice;

viii) For care and 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;

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

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

c) Treatment Plan - If the total cost of a treatment is expected to exceed $600, a treatment plan should be submitted to the insurer who will determine, before commencement of treatment, the amount of eligible expenses.

"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, and specification of the probable date and cost of treatment.

PAYMENT OF BENEFITS

Proof

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

Alternative Treatment Plan

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

CALCULATION OF REIMBURSEMENT

Reimbursement

The insurer reimburses a percentage of eligible expenses incurred in the course of a calendar year, after applying the deductible for that year, if applicable. Such percentage is specified in the Summary of Benefits.

Maximum Benefit Per Insured Person

The global maximum amount reimbursed by the insurer for the present benefit is specified in the Summary of Benefits.

In the case of any person becoming insured more than 31 days following the eligibility date, the reimbursement for dental expenses during the first 12 months of coverage may not exceed $200 per person.

Co-ordination of Benefits

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

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

ii) any government sponsored plan, and

iii) any non-insured employee benefit plan.

SURVIVOR BENEFIT

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

a) 24 months after the participant's death;

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

c) The termination date of this benefit.

EXTENSION OF BENEFITS

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

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

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

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

CONVERSION PRIVILEGE

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

a) his employment; or

b) his group membership,

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

Failure to convert his supplemental health insurance will prevent the participant from converting his dental care insurance.

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

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

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

WAIVER OF PREMIUMS

A participant whose premiums are waived under the article *Waiver of Premiums* of his life insurance benefit is also entitled to waiver of premiums for the present benefit, under the same conditions.

Waiver of premiums of the present benefit terminates automatically on the date of termination of the present benefit.

Moreover, the participant who is not covered under the life insurance benefit is also entitled to waiver of premiums for the present benefit, subject however to all other provisions described under *Waiver of Premiums* of the life insurance benefit.

COPY OF CONTRACT AND ENROLLMENT MATERIAL

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

PROTECTING PERSONAL INFORMATION

Industrial Alliance Insurance and Financial Services Inc. (hereafter "the Company") is committed to protecting the privacy of a participant's (including his or her dependent's) personal information that it collects while providing services under the Group Plan issued to the Policyholder. The Company recognizes and respects a person's right to privacy concerning his or her personal information.

When a participant enrolls under the Group Plan, the Company will establish a confidential file containing the personal information collected. The file will be kept at the Company's offices.

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

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

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

Participant's Right to Access His or Her Personal Information

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

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

To request access to his or her personal information or to have his or her name removed from the list to be shared within the Company, the participant must send a written request to:

Industrial Alliance Insurance and Financial Services Inc.
Access Officer
1080 Grande Allée West
P.O. Box 1907, Station Terminus
Quebec City, Quebec G1K 7M3

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