Q. Please provide copies of the Group Contracts between Medavie Blue Cross or related companies and Newfoundland Power related to the provision of group life, health, extended health and dental benefits to active employees and retirees of Newfoundland Power.

A. Attachment A contains the master Health / Dental Policy between Newfoundland Power and Medavie Blue Cross.

Attachment B contains the master Life Insurance Policy between Newfoundland Power and Medavie Blue Cross.

Health/Dental Policy between Newfoundland Power and Medavie Blue Cross

Medavie Inc., operating under the business name **"Medavie Blue Cross"**, agrees to provide the benefits as specified in this Policy from the effective date until such time as this Policy terminates as provided herein and covers the Employees of:

NEWFOUNDLAND POWER INC.

(herein called the **"Policyholder"**) who are eligible for coverage in accordance with the provisions of this Policy and who make written application for such coverage as herein provided.

POLICY NUMBER: 93489 and Sections (Refer to Master Group Listing)

EFFECTIVE DATE: This Policy takes effect at 12:01 a.m. local time at the Policyholder's address on the 1st day of January 2009.

POLICY YEAR: All Policy years will commence on the 1st day of January of each year.

SUBSCRIBER DUES: Subscriber dues are payable in advance on the effective date of coverage and on the first day of each subsequent month.

BENEFITS:
Hospital Benefit
Worldwide Travel Benefit
Referrals for Services Outside Canada
Extended Health Benefit
Vision Benefit
Drug Benefit
Dental Benefit
Health Spending Account

Signed for Medavie Blue Cross at Moncton, New Brunswick, Canada on this 20th day of February 2009.

Laurier Fecteau
Vice President Marketing

John Diamond
Vice President Finance and Treasurer

Examined by: bckfras

MASTER GROUP LISTING

NEWFOUNDLAND POWER INC.

Policy Number	Group Name	Class Description
93489-001	Newfoundland Power Inc.	A. Newfoundland Power - Executives
93489-002	Newfoundland Power Inc.	B. Permanent Active Employees
93489-003	Newfoundland Power Inc.	C. Short-Term Temporary Active Employees
93489-004	Newfoundland Power Inc.	D. Retired Participants under age 65
93489-005	Newfoundland Power Inc.	E. Retired Participants Age 65 and Over
93489-006	Newfoundland Power Inc.	F. Surviving Spouses of Employees who passed away over the age of 65
93489-009	Newfoundland Power Inc.	I. Long-Term Temporary Employees
93489-015	Newfoundland Power Inc.	O. Surviving Spouses under age 65

AFFILIATED COMPANIES

FORTIS INC. AND AFFILIATED COMPANIES

93489-007	Newfoundland Power Inc.	G. Fortis Executives
93489-008	Newfoundland Power Inc.	H. Fortis Full-time Employees
93489-010	Newfoundland Power Inc.	J. Fortis Retirees Age 65 and Over
93489-011	Newfoundland Power Inc.	K. Fortis Executives
93489-012	Newfoundland Power Inc.	L. Fortis Full-time Employees
93489-013	Newfoundland Power Inc.	M. Fortis Executives
93489-014	Newfoundland Power Inc.	N. Fortis Executives
93489-016	Newfoundland Power Inc.	P. Fortis Executive Retirees under age 65
93489-017	Newfoundland Power Inc.	Q. Fortis Executive Retirees under age 65

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POLICY SUMMARY
(Medavie Blue Cross)

Policyholder: Newfoundland Power Inc.

Policy Number: 93489 and Sections

Effective Date:

The effective date of the following summary of the terms and benefits of this Policy is 01 January 2009.

Employee Eligibility:

Applicable to 93489-001, 002, 007, 008, 009, 011, 012, 013 and 014:
In order to be eligible for all benefits under this Policy, an Employee, as defined in Section 3.1(20), must be required to work at least 30 hours per week.

Applicable to 93489-003:
In order to be eligible for all benefits under this Policy, an Employee, as defined in Section 3.1(20), must be a temporary Employee working at least 20 hours per week.

Applicable to 93489-004:
In order to be eligible for all benefits under this Policy, a Retired Employee must:

i) have attained the age of 55 but under the age of 65 with a completion of 10 years of continuous service with the employer prior to the date of retirement; or
ii) have completed the combination of age + service as outlined by the defined benefit plan and is under the age of 65.

Applicable to 93489-005:
In order to be eligible for all benefits under this Policy, a Retired Employee must be:

i) over the age of 65 and have completed 10 years of continuous service with the employer prior to the date of retirement; or
ii) have completed the combination of age + service as outlined by the defined benefit plan and is over the age of 65.

Applicable to 93489-010:
In order to be eligible for all benefits under this Policy, a Retired Employee must be age 65 or over, completed at least 10 years of services with the employer as a permanent or long-term temporary Employee prior to the date of retirement and have been actively at work the date prior to retirement.

Policyholder: Newfoundland Power Inc.

Policy Number: 93489 and Sections

Effective Date: 01 January 2009

Employee Eligibility (cont'd): **Applicable to 93489-006 and 015:**
In order to be eligible for all benefits under this Policy, the Participant must be a surviving spouse of an insured Employee.

Applicable to 93489-016 and 017:
In order to be eligible for all benefits under this Policy, a Retired Employee must be under age 65, completed at least 10 years of services with the employer as a permanent Employee prior to the date of retirement, receiving a Pension from the employer, and have been actively at work the date prior to retirement.

Applicable to all Policies:
The Policy shall apply to the Employee classes described in the Master Group Listing.

An active Employee will become eligible for coverage at the expiration of the Policy Waiting Period. All Employee applications should be completed and submitted to Medavie Blue Cross within 31 days of the start of this eligibility period.

The term "Employee", used in this contract, shall mean an active Employee and shall be extended to mean a retired Employee, except where reference is made to employment, hours worked per week, or similar references which do not apply to a retired Employee.

Policy Waiting Period: **Applicable to 93489-001, 007, 011, 013 and 014**:
Coverage commences upon the first day of work.

Applicable to 93489-002, 008, 009 and 012:
Coverage commences following three months of active permanent employment.

Applicable to 93489-003:
Coverage commences following 60 continuous days service.

Applicable to 93489-004, 005, 010, 016 and 017:
Coverage commences upon the date of retirement.

POLICY SUMMARY
(Medavie Blue Cross)

Policyholder: Newfoundland Power Inc.

Policy Number: 93489 and Sections

Effective Date: 01 January 2009

Termination of Benefits:

Applicable to 93489-001, 002, 003, 007, 008, 009, 011, 012, 013 and 014:
The benefits provided by this contract terminate at the earlier of retirement or termination of employment.

Applicable to 93489-004:
The benefits provided by this contract terminate at age 65 at which time benefits change with the exception of Dental Care Benefit which terminates at age 65.

Applicable to 93489-005 and 010:
The benefits provided by this contract terminate upon the death of the retired Employee.

Applicable to 93489-006:
The benefits provided by this contract terminate upon the death of the surviving Spouse.

Applicable to 93489-015:
The benefits provided by this contract terminate age 65 at which time benefits change.

Applicable to 93489-016 and 017:
The benefits provided by this contract terminate at age 65 at which time benefits change with the exception of Health Spending Account Benefit which terminates at age 65.

POLICY SUMMARY
(Medavie Blue Cross)

Policyholder: Newfoundland Power Inc.

Policy Number: 93489 and Sections

Effective Date: 01 January 2009

Survivor Benefit:

Applicable to 93489-001, 002, 004, 007, 008, 009, 011, 012, 013, 014, 015, 016 and 017:
In the event of the Employee's death, eligible dependents will continue to be covered for Health Benefits on a premium basis, however, coverage will end on the earliest of the following dates:

- the contract termination date;
- until age 65 at which time benefits change;
- until death of the surviving spouse for Health benefits;
- the effective date of any similar coverage with another insurer;
- whenever they cease to be eligible dependents.

Applicable to 93489-005, 006 and 010:
In the event of the retired Employee's death, eligible dependents will continue to be covered for Health Benefits on a non-premium basis, however, coverage will end on the earliest of the following dates:

- the contract termination date;
- death of the survivor;
- the effective date of any similar coverage with another insurer;
- whenever they cease to be eligible dependents.

Enrolment Requirement:

The minimum enrolment for each line of benefit is three lives.

Participation required under each Non-contributory line of benefit is 100%. For all other benefits, the minimum participation level is as follows:

Number of Eligible Employees	Minimum Enrolment
3 - 9	100%
10 - 24	85%
25 & over	75%

POLICY SUMMARY
(Medavie Blue Cross)

Policyholder: Newfoundland Power Inc.

Policy Number: 93489 and Sections

Effective Date: 01 January 2009

HOSPITAL BENEFIT - IN CANADA ONLY

HOSPITAL ROOM **(Applicable to 93489-001, 002, 003, 004, 007, 008, 009, 011, 012, 013, 014, 015, 016 and 017)**

- semi-private Room Accommodation
- paid directly to the Hospital
- program pays 100% of the Eligible Expense

HOSPITAL ROOM **(Applicable to 93489-005, 006 and 010)**

- semi-private Room Accommodation
- paid directly to the Hospital
- program pays 80% of the Eligible Expense
- maximum of $5,000 in a Calendar Year in combination with Extended Health, Vision and Drug Benefits

WORLDWIDE TRAVEL BENEFIT (Applicable to 93489-001, 002, 004, 005, 006, 007, 008, 009, 010, 011, 012, 013, 014, 015, 016 and 017)

- benefits are provided for an Accident or unexpected illness outside the province of residence
- $2 million per Participant per incidence maximum
- payment assistance through World Assistance
- program pays 100% of the Eligible Expense

REFERRALS FOR SERVICES OUTSIDE CANADA (Applicable to 93489-001, 002, 004, 005, 006, 007, 008, 009, 010, 011, 012, 013, 014, 015, 016 and 017)

- medical services incurred outside of Canada on a referral basis when those services are unavailable in Canada
- program pays 100% of the Eligible Expense up to a lifetime maximum payment of $500,000 per Participant

POLICY SUMMARY
(Medavie Blue Cross)

Policyholder: Newfoundland Power Inc.

Policy Number: 93489 and Sections

Effective Date: 01 January 2009

EXTENDED HEALTH BENEFIT (Applicable to 93489-001, 002, 003, 004, 007, 008, 009, 011, 012, 013, 014, 015, 016 and 017)

- reimbursement to the Employee
- program pays 100% of the Eligible Expense

EXTENDED HEALTH BENEFIT (Applicable to 93489-005, 006 and 010)

- reimbursement to the Employee
- program pays 80% of the Eligible Expense
- maximum of $5,000 in a Calendar Year in combination with Hospital, Vision and Drug Benefits

VISION BENEFIT (Applicable to 93489-001, 002, 003, 004, 007, 008, 009, 011, 012, 013, 014, 015, 016 and 017)

- vision benefits every 24 Consecutive Months; every 12 Consecutive Months for Dependent Children under 18 years of age
- reimbursement to the Employee
- program pays 100% of the Eligible Expense with the exception of visual training which the program pays 50% of the Eligible Expense
- maximum Eligible Expense is $200 for lenses, frames and contact lenses plus one eye exam

VISION BENEFIT (Applicable to 93489-005, 006 and 010)

- vision benefits every 36 Consecutive Months; every 12 Consecutive Months for Dependent Children under 18 years of age
- reimbursement to the Employee
- program pays 100% of the Eligible Expense with the exception of visual training which the program pays 50% of the Eligible Expense
- maximum Eligible Expense is $150 for lenses, frames and contact lenses plus one eye exam
- maximum of $5,000 in a Calendar Year in combination with Hospital, Extended Health and Drug Benefits

POLICY SUMMARY
(Medavie Blue Cross)

Policyholder: Newfoundland Power Inc.

Policy Number: 93489 and Sections

Effective Date: 01 January 2009

DRUG BENEFIT

Includes diabetic supplies, allergy serums and prescription drug items approved by Medavie Blue Cross and certain over-the-counter items which are considered life-saving in nature and which are approved by Medavie Blue Cross.

Certain prescription-requiring drugs on the eligible Drug Benefit list may be subject to quantity maximums, dollar maximums, deductibles, Co-payments or other maximums as approved by Medavie Blue Cross.

- paid directly to the Pharmacy
- Participant pays 20% for each eligible drug on the prescription
- program pays 100% of the remaining Eligible Expense
- No co-payment is required for Insulin
- maximum of $5,000 in a Calendar Year in combination with Hospital, Extended Health and Vision Benefits **(Applicable to 93489-005, 006 and 010)**

POLICY SUMMARY
(Medavie Blue Cross)

Policyholder: Newfoundland Power Inc.

Policy Number: 93489 and Sections

Effective Date: 01 January 2009

DENTAL CARE BENEFIT (Applicable to 93489-002, 004, 008, 009 and 012)

BASIC SERVICES
- reimbursement to the Employee
- program pays 100% of the Eligible Expense
- maximum of $750 in a Calendar Year in combination with Periodontal and Endodontic Services

PERIODONTAL AND ENDODONTIC SERVICES
- reimbursement to the Employee
- program pays 80% of the Eligible Expense
- maximum of $750 in a Calendar Year in combination with Basic Services

FEE SCHEDULE
- current Dental Association Fee Guide for general practitioners in the Employee's province of residence
- If the Employee is referred to a specialist by a general practitioner, the Dental Fee Guide for specialists will be used.

Policyholder: Newfoundland Power Inc.

Policy Number: 93489 and Sections

Effective Date: 01 January 2009

HEALTH SPENDING ACCOUNT BENEFITS (Applicable to 93489-001, 007, 011, 013, 014, 016 and 017)

Refer to SECTION 6 - HEALTH SPENDING ACCOUNT BENEFIT PROVISIONS for a detailed description of the benefit provisions.

SECTION 1 - POLICY PROVISIONS

1.1 THE CONTRACT

The entire contract between Medavie Blue Cross and the Policyholder shall consist of:

a) this Policy and its amendments;
b) the Policyholder's Group Application, a copy of which is attached;
c) the individual applications of the Subscribers; and
d) any document supporting or amending the applications of the Policyholder or Subscribers, provided the document has been signed by the Policyholder or Subscriber.

All statements made by the Policyholder and by any Subscriber shall, in the absence of fraud, be deemed to be representations and not warranties. In the event of a discrepancy between the Policy Summary portion of this Policy and the main portion of this Policy, the provisions of the Policy Summary shall govern.

1.2 NON-WAIVER OF POLICY PROVISIONS

Failure of Medavie Blue Cross to enforce any provision of this Policy at any given time shall not be construed to waive or modify such provision or to render it unenforceable at any other time or occurrence. No agent will have the authority to change or waive any provision of this Policy except as described in Section 1.5, Policy Amendments.

1.3 CONFORMITY WITH EXISTING LAWS

Any provision of this Policy which is in conflict with any applicable federal or provincial law of the Subscriber's place of residence is hereby amended to conform with the minimum requirements of that law.

1.4 CONTRACT ADMINISTRATION

The Policyholder shall furnish Medavie Blue Cross with all information that Medavie Blue Cross will require in order to determine the applicant's eligibility, the effective date of the coverage, the amount of coverage and the dues to be charged. Any changes to this information shall be promptly reported to Medavie Blue Cross. All pertinent records of the Policyholder shall be open to inspection by Medavie Blue Cross at all reasonable times.

Clerical or mechanical errors shall not prejudice the rights of Medavie Blue Cross or of any Person having a beneficial interest in the coverage under this Policy. If a clerical or mechanical error is discovered, the coverage will be that which would have been in force had there been no such error. An equitable adjustment of Subscriber dues between Medavie Blue Cross and the Policyholder shall be made.

The Policyholder shall not be considered to be the agent of Medavie Blue Cross for any purpose under this Policy.

1.5 POLICY AMENDMENTS

This Policy can be modified or amended at any time as may be agreed upon in writing by the Policyholder and Medavie Blue Cross. If the Policy has been amended unilaterally by Medavie Blue Cross, the effective date of the amendment shall not be earlier than 30 days after the date of receipt of the amendment by the Policyholder. The payment of Subscriber dues which are due any time after the effective date of the amendment shall constitute acceptance of the Policy amendment by the Policyholder. No Policy amendment is valid unless it has been authorized by the signatures of two authorized officers of Medavie Blue Cross.

Policy amendments shall not require the consent of any Subscriber or other Person having a beneficial interest in the coverage provided by this Policy.

1.6 POLICY RENEWAL

This Policy may be renewed at the end of each Policy year subject to the payment, within the grace period, of the first Subscriber dues which become due in the new Policy year.

1.7 TERMINATION

a) This Policy will terminate if any dues remain unpaid at the end of the grace period allowed for the payment of dues. The date of termination will be the end of the grace period. If the Policyholder has replaced this group Policy by another insurance Policy covering the same group of Employees, then the termination date of this Policy shall be the earlier of the end of the grace period or the time at which the replacing Policy becomes effective.

b) Either the Policyholder or Medavie Blue Cross may terminate, at the end of any Policy month, the benefits provided by this Policy to a Subscriber by giving to the other at least one calendar month's prior notice in writing. The effective date of termination will be the later of the end of the month in which the notice of termination was received by Medavie Blue Cross or the date requested in the notice of termination.

c) In the event the group Policy terminates or benefits provided to a Subscriber terminate, notice by Medavie Blue Cross to the Policyholder of such termination shall constitute notice to the Subscriber(s).

d) The Subscriber's benefits will be terminated as specified in the Policy Summary.

e) Medavie Blue Cross may terminate this Policy at the end of any Policy month by providing at least one calendar month's prior notice in writing to the Policyholder, if:

   1. the enrolment and participation levels do not meet the minimum enrolment requirements specified in the Policy Summary, or
   2. the Policyholder does not perform, in good faith, its obligations under this Policy.

1.7 TERMINATION (Cont'd)

f) The benefits provided by this Policy shall terminate automatically if the Subscriber's regular employment with the Policyholder is terminated (except that benefits shall be continued during any statutory period of notice of termination where required by law), unless the group has made arrangements through a prior agreement with Medavie Blue Cross to continue coverage.

g) Upon termination of this Policy, Medavie Blue Cross shall be relieved of any liability in providing the benefits of this Policy for any Participant beyond the date of termination, unless otherwise stated in this Policy.

h) Termination of the rights and benefits of the individual Subscriber shall also mean termination of the rights and benefits of his or her Dependents.

i) The rights and benefits of the Subscriber may be terminated or suspended immediately by Medavie Blue Cross when deemed necessary for the following reasons:

1. in the event of a claim abuse investigation by Medavie Blue Cross,
2. in the pursuit of criminal charges or disciplinary action undertaken by Medavie Blue Cross.

j) Both parties agree that the collection, use and disclosure of personal information undertaken in the course of administering this contract will be in accordance with the provisions of applicable privacy legislation.

SECTION 2 - SUBSCRIBER DUES

2.1 CURRENCY

All payments under this Policy, either to or by Medavie Blue Cross, shall be made in the lawful currency of Canada.

2.2 PAYMENTS AND DUE DATES

All Subscriber Dues are due and payable by the Policyholder to Medavie Blue Cross on the effective date of this Policy and at the beginning of each month thereafter. The Subscriber Dues are payable at either Medavie Blue Cross's head office or one of its branch offices.

2.3 GRACE PERIOD

After the first Subscriber Dues are paid, a period of 31 days of grace from the next due date will be allowed for the payment of Subscriber Dues without interest. This Policy shall remain in force during the grace period unless it has been terminated in accordance with Section 1.7, Termination. If any dues remain unpaid at the end of the days of grace, this Policy may be terminated as of the end of the grace period.

2.4 TERMINATION

a) If this Policy is terminated, the Policyholder shall be liable to Medavie Blue Cross for payment of all Subscriber Dues from the due date of the first unpaid dues to the date of termination.

b) In the event that Subscriber Dues are in arrears, Medavie Blue Cross may, at its sole discretion, elect to withhold payment of claims beyond the date to which dues are paid or terminate the Policy without prior notice to the Policyholder.

c) If this Policy is terminated by reason of default in payment of any Subscriber Dues, Medavie Blue Cross may reinstate such Policy at its sole discretion and upon such terms and conditions as it may determine.

d) The acceptance by Medavie Blue Cross of the Subscriber Dues more than 31 days after the date to which dues are paid may not have the effect of reinstating the present Policy. Instead, the Policyholder may be entitled to a refund in the amount of the Subscriber Dues so accepted by Medavie Blue Cross.

e) If Subscriber Dues are paid to Medavie Blue Cross for a Subscriber under more than one Policy, or if Subscriber Dues are paid at the family rate to cover Persons ineligible as Dependents, Medavie Blue Cross may make a refund for such period, up to a maximum of 12 months, as it may decide at its sole discretion. Any such refund shall be in full satisfaction of all liability for repayment.

SECTION 2 - SUBSCRIBER DUES

2.5 DETERMINATION OF DUES

The dues payable by or on behalf of the Subscriber shall be as established from time to time by Medavie Blue Cross. Further, Medavie Blue Cross reserves the right to modify Subscriber Dues as a result of changes in government regulations or legislation, a significant change in the enrolment levels or a change in the method of funding. Medavie Blue Cross will provide the Policyholder with 30 days written notice of any change in the amount of Subscriber Dues.

2.6 ADJUSTMENTS

The dues for any increase or addition of coverage, which become effective on a date other than a due date, will be payable from the next due date following the change in coverage.

The dues for any decrease in coverage or termination of coverage, which becomes effective on a date other than a due date, will cease on the next due date following the change in coverage. Medavie Blue Cross shall not be required to refund Subscriber Dues, as a result of the termination of a Subscriber's coverage, for any period greater than six months prior to the date that the notice of termination is received by Medavie Blue Cross.

2.7 RATE RENEWALS

Under normal circumstances, Medavie Blue Cross will renew all monthly rates annually and all required rate adjustments will be effective on the Policy's anniversary date each year.

SECTION 3 - GENERAL BENEFIT PROVISIONS

3.1 DEFINITIONS

This section contains the definitions of words used in this Policy. Words which have special meanings with respect to a particular benefit line are defined in Section 5 of this Policy. All references to the masculine gender in this Policy shall include the feminine gender unless the context clearly indicates otherwise.

1. Accident: An unintentional, sudden, fortuitous and unforeseeable event due exclusively to an external cause of a violent nature and inflicting directly and independently of all other causes, bodily injury.

2. Actively at Work: A Subscriber shall be considered to be Actively at Work on a specified day if he reports for work at his usual place of employment with the Policyholder and is able to perform a substantial portion of the duties of his occupation on a permanent basis. If a Subscriber is not required to report for work on the specified date, he shall be considered to be Actively at Work if he is not disabled to the degree that he could not have reported for work at his usual place of employment and performed a substantial portion of the usual and customary duties of his occupation.

3. Benefit Maximums: Unless otherwise stated, Benefit Maximums will be the maximum payment available to each Participant for the period specified, prior to the application of the Co-insurance.

4. Calendar Year: A Calendar Year is that period of time commencing with the first day of January in a given year and ending the 31st day of December in the same year.

5. Change in Medication: Any increase or decrease in dose, strength or frequency of medication, as well as the addition or discontinuation of any medication.

6. Co-insurance: The Co-insurance is the percentage of Eligible Expense, which Medavie Blue Cross agrees to reimburse the Subscriber, for health and/or dental care services and supplies.

7. Consecutive Calendar Years: Consecutive Calendar Years means the period of time established by the Calendar Year of the incurred date of the claim and applying claims experience for that Calendar Year and the immediately preceding Calendar Year(s).

8. Consecutive Months: The period of time established by the calendar month of the incurred date of the claim and applying claims experience for that calendar month and the immediately preceding calendar month(s).

9. Consultation: A Consultation refers to the situation where the Health Care Professional requests the opinion of another Health Care Professional, with a level of competence to give appropriate advice in this situation, because of the complexity, obscurity or seriousness of the case.

3.1 DEFINITIONS (Cont'd)

10. Co-payment: If applicable to this Policy, the Co-payment is the percentage or dollar amount of Eligible Expense which must be paid by the Subscriber prior to benefits becoming payable by Medavie Blue Cross.

11. Deductible Amount: If applicable to this Policy, the Deductible Amount shall mean the aggregate dollar amount of Eligible Expense, incurred by the Subscriber and/or his Dependents during a Calendar Year, which must be paid by the Subscriber before benefits will be reimbursed by Medavie Blue Cross. In the event coverage is in effect less than a Calendar Year, the deductible will be calculated on a pro-rata basis.

    If the entire deductible amount, as defined above, is not met during the Calendar Year, Eligible Expenses applied to the Deductible Amount during the last quarter of the year (October, November and December) will be carried forward and applied to the next Consecutive Calendar Year deductible calculation.

12. Dentist: A Dentist is a doctor of dental surgery or a doctor of dental medicine licensed to practice and prescribe in the area where services are rendered.

13. Dependent: Dependent means the Subscriber's Spouse and unmarried Dependent Children as defined below. Dependents defined below shall exclude any Person for whom Evidence of Health, if required, was not approved by Medavie Blue Cross. All Dependents must be residents of Canada and be eligible for benefits under the provincial government health care programs in the province of residence in order to be eligible for coverage.

    1. Spouse shall mean a Person of the opposite or same sex who is legally married to the Subscriber, or has continuously resided with the Subscriber for not less than one full year having been represented as members of a conjugal relationship (common law). In the event of divorce, legal separation, or discontinuance of cohabitation ("common law" Spouse), the Subscriber may elect to continue membership of the former Spouse or to provide notice to Medavie Blue Cross to terminate coverage for the Spouse. Medavie Blue Cross will at no time provide coverage for more than one Spouse under the same Policy.

3.1 DEFINITIONS (Cont'd)

13. Dependent: (Cont'd)

2. Children shall mean the Subscriber's natural, legally adopted or stepchildren who are dependent upon the Subscriber for financial care and support. Such Children must be:

a) unmarried;
b) unemployed (working less than 30 hours per week); and
c) less than 23 years of age; or, if 23 years of age but less than 25 years of age, they must be attending an accredited educational institution, college or university on a full-time basis.

The Children of the Subscriber's common-law Spouse shall be covered provided the Children are living with the Subscriber.

Unmarried, unemployed Children 23 years of age or older shall qualify, if they are dependent upon the Subscriber by reason of a mental or physical disability and became totally disabled prior to attaining age 23, and who have been continuously disabled since that time. Unmarried, unemployed Children who became totally disabled while attending an accredited educational institution, college or university on a full-time basis prior to their attaining age 25 and have been continuously so disabled since that time shall also qualify as a Dependent.

14. Diagnostic Services: Diagnostic Services refer to medically accepted examinations and tests required to identify the nature or extent of illness or injury and rendered to a Participant in the office of a Physician or Dentist, in a Hospital, or in a private facility approved by Medavie Blue Cross, when such services have been ordered by a Physician or Dentist.

15. Diopter: Diopter is the unit used to designate the refractive power of vision care lenses.

16. Direct Payment Policy: A Direct Payment Policy is a Policy under which Medavie Blue Cross is billed by the Provider of services and supplies for its share of the Eligible Expense, and for which Medavie Blue Cross agrees to pay its share directly to the Provider of the services and supplies.

17. Direct Payment Provider: A Direct Payment Provider is a Medavie Blue Cross Approved Provider of health care services and supplies which Medavie Blue Cross recognizes for payment on a direct payment basis. The Direct Payment Provider has entered into an agreement with Medavie Blue Cross to provide eligible health care services and supplies to Medavie Blue Cross Participants and to bill Medavie Blue Cross directly for these eligible benefits, less any Co-payment and/or Deductible Amount to be paid by the Participant.

3.1 DEFINITIONS (Cont'd)

18. Drug Benefits: Drug Benefits means drugs that have been:

    a) approved as benefits by Medavie Blue Cross;
    b) approved by Health Canada, the federal governing body responsible for approval of medications for resale by licensed retail pharmacies;
    c) assigned a drug identification number (DIN) in Canada;
    d) prescribed by a Health Care Professional who is licensed to prescribe under the appropriate provincial legislation and is approved by Medavie Blue Cross; and
    e) dispensed by a Medavie Blue Cross Approved Provider.

19. Eligible Expense: Charges incurred by the Participant for health care services and supplies, defined as benefits in this Policy, and are considered Eligible Expenses to the extent that they are:

    a) Usual, Customary and Reasonable in the opinion of Medavie Blue Cross, as defined in this Policy;
    b) recommended, approved or prescribed by a Health Care Professional as approved by Medavie Blue Cross;
    c) in excess of the charges reimbursed, or entitled to be reimbursed, from all other Providers of health and/or dental coverage;
    d) rendered by a Person who does not normally reside in the Participant's home and is not a member of the Participant's immediate family either by blood or marriage;
    e) rendered by a Medavie Blue Cross Approved Provider; and
    f) rendered after the effective date of this Policy and while this Policy is in effect, unless otherwise specified.

    Eligible Expense is considered to be incurred on the date the service or supply was received. The Benefit Maximums specified identify the maximum Eligible Expense prior to the application of the Co-insurance and after the application of any applicable Usual, Customary and Reasonable limits.

    Where more than one form or alternative form of treatment exists, Medavie Blue Cross, in Consultation with its Health Care Consultants, reserves the right to make payment for eligible services and supplies based on an alternate procedure or supply with a lower cost, when deemed appropriate and consistent with good health management.

(Applicable to 93489-001, 002, 003, 009 and 015)

20. Employee: An Employee is a person who is an active, permanent or temporary, Employee of the Policyholder and is required to work at least the number of hours per week specified in the Benefit Summary. An Employee must belong at all times to the class or classes of employees covered by this policy as specified in the Benefit Summary. All employees must be residents of Canada in order to be eligible for coverage under the provincial government health care programs in the province of residence unless they are specifically mentioned in the Benefit Summary.

3.1 DEFINITIONS (Cont'd)

20. Employee (Cont'd)

(Applicable to 93489-007, 008, 011, 012, 013 and 014)
Employee: An Employee is a person who is an active, permanent Employee of the Policyholder or its affiliated companies and is required to work at least the number of hours per week specified in the Benefit Summary. An Employee must belong at all times to the class or classes of employees covered by this policy as specified in the Benefit Summary. All employees must be residents of Canada in order to be eligible for coverage under the provincial government health care programs in the province of residence unless they are specifically mentioned in the Benefit Summary.

(Applicable to 93489-004, 005 and 006)
Employee: A retired Employee is a person who:

(i) has attained the age of 55 but under the age of 65 with a completion of 10 years of continuous service with the employer prior to the date of retirement; or

(ii) has completed the combination of age + service as outlined by the defined benefit plan and is under the age of 65.

All retired employees must be residents of Canada and be eligible for benefits under the provincial government health care programs in the province of residence in order to be eligible for coverage.

(Applicable to 93489-010, 016 and 017)
Employee: An Employee is a person either under or over age 65 who has completed at least 10 years of services with the employer or its affiliated companies as a permanent or long-term temporary retired employee prior to the date of retirement and has been actively at work the date prior to retirement. All employees must be residents of Canada in order to be eligible for coverage under the provincial government health care programs in the province of residence unless they are specifically mentioned in the Benefit Summary.

3.1 DEFINITIONS (Cont'd)

21. Evidence of Health: Evidence of Health shall mean all statements of health or medical evidence of a Person's health, as well as other information required by Medavie Blue Cross to assess his acceptability for coverage. All Evidence of Health must be submitted on forms approved by Medavie Blue Cross for that purpose.

22. Experimental or Investigative: A service or supply which is Experimental or Investigative in nature means any treatment, procedure, facility, equipment, drug, drug usage, or vitamin therapy, which, in the sole opinion of Medavie Blue Cross after Consultation with its Health Care Consultants, is not Medically Necessary or Proven Effective for the purpose for which it is being provided or prescribed.

23. Group Application: Group Application means the original application for group benefits, executed by the Policyholder, and any subsequent revisions completed and signed by the Policyholder seeking coverage. The Group Application forms part of this master Policy.

24. Health Care Planning Assessment: Health Care Planning Assessment means a combination of the complete detailed history and the physical examination of a Participant, collected in order to determine how a disease or injury has altered a Participant's physical and/or mental status, which may or may not result in a Policy for treatment.

25. Health Care Professional: Means a Person who is legally licensed to practice his or her profession where services are rendered, and includes Physicians, Pharmacists, Dentists, and other professionals as approved by Medavie Blue Cross.

26. Hospital: An institution licensed and operating under any federal or provincial health or insurance act, with facilities to provide the following: active in-patient treatment and care primarily for acute conditions; 24-hour nursing care, on-staff Physician care at all times, and diagnostic and surgical services. The term Hospital, as used in this Policy or as otherwise specified, shall not include a rehabilitation Hospital, a facility operating predominantly for the treatment of drug, alcohol or gambling addictions or mental illness, a maternity home, a nursing home, a health spa or hotel, a place for custodial care, a facility for the blind or deaf, or an institution used primarily for the treatment of a specific illness or disease.

    Hospital includes:

    a) a regional Hospital corporation as defined in the Hospitals Act, R.S.N.B., 1980, c. H-6.1 and any amendments thereto;
    b) a Hospital authority as defined in the Hospitals Act, R.S.Nfld., 1990, c. H-9 and any amendments thereto;
    c) a board as defined in the Hospitals Act, R.S.N.S., 1989, c. 208 and any amendments thereto;
    d) a commission as defined in the Hospitals Act, R.S.P.E.I., 1988, c. H-10 and any amendments thereto; and
    e) any other regional Hospital corporation, Hospital authority, board, commission or other authority as defined in any other Provincial Hospital Acts or similar legislation not specifically referred to herein.

3.1 DEFINITIONS (Cont'd)

27. Identification Card: The latest Identification Card issued by Medavie Blue Cross to the Participant indicates that the Participant is eligible for specific benefits as long as the Policy remains in good standing.

28. Interchangeable Drug(s): Interchangeable Drugs are drugs containing the same active ingredient(s), in the same amount(s) and in the same dosage form as that directed by a prescription and approved by provincial legislation.

29. Late Applicant: A Late Applicant is an Employee or Dependent who applies for coverage under this Policy more than 31 days after becoming eligible for benefits. However, for an Employee who was covered for similar benefits under a Spouse's Policy, an applicant is considered late when the Employee applies for coverage more than 31 days after the termination date of the Spouse's Policy.

30. Medavie Blue Cross Approved Provider: A Medavie Blue Cross Approved Provider is a Provider of health care services and supplies recognized and approved by Medavie Blue Cross for payment on a Direct Payment Policy and/or Reimbursement Policy basis. Medavie Blue Cross will make payment for eligible health care services and supplies provided to Medavie Blue Cross Participants by such Medavie Blue Cross Approved Providers.

31. Medically Necessary: A health care service or supply provided or prescribed by a Health Care Professional to prevent or treat an injury, disease or disability will be considered Medically Necessary if, in the sole opinion of Medavie Blue Cross after Consultation with its Health Care Consultants, it is:

    a) consistent with the treatment of symptom(s) or diagnosed injury, disease, or disability;
    b) not primarily provided or prescribed for convenience;
    c) the most appropriate, safe and cost effective service or supply; and
    d) generally recognized as accepted medical practice.

32. Non-contributory: A benefit under this Policy is Non-contributory if the Subscriber is not required to pay any portion of the Subscriber dues for the benefit.

33. Notices: Any Notice under this Policy shall be sufficiently given:

    a) if it is a Notice to Medavie Blue Cross, provided it is mailed with postage prepaid, or delivered to Medavie Blue Cross at its head office in Moncton, New Brunswick;
    b) if it is a Notice to the Policyholder, provided it is mailed with postage prepaid, or delivered to the Policyholder at its address as it appears on the records of Medavie Blue Cross

34. Orthodontics: Orthodontics is the branch of dentistry that endeavours to correct the abnormal arrangement of teeth and/or jaws and keep them in the correct position.

3.1 DEFINITIONS (Cont'd)

35. Participant: A Participant includes the Subscriber, the Subscriber's Spouse or Dependent Children as defined in this Policy.

36. Person: Person means an individual, corporation, limited partnership, general partnership, syndicate, joint venture, association, trust, an unincorporated organization, trustee or other legal representative.

37. Pharmacist: Pharmacist means a Person who is legally licensed to practice the profession of Pharmacy.

38. Pharmacy: Pharmacy means an establishment which is licensed as a Pharmacy and approved by the appropriate provincial pharmaceutical licensing body.

39. Physician: A Physician is a doctor of medicine, who is legally licensed to prescribe prescription drugs, administer medical treatment, and to perform surgery within the scope of the license.

40. Policy Waiting Period: The Policy Waiting Period is the period of continuous active permanent (or temporary) employment that must be completed by Employees in order to be eligible for coverage under this Policy. The Policy Waiting Period is shown in the Policy Summary. The Policy Waiting Period may be waived for any applicant at the written request of the Policyholder and only with the approval of Medavie Blue Cross.

41. Policy: The Policy refers to this document and its amendments.

42. Policyholder: Policyholder means the company, employer or organization which has entered into this contract with Medavie Blue Cross.

43. Private Duty Nurse: Private Duty Nurse must be a Registered Nurse, Registered Nursing Assistant or Licensed Practical Nurse and must be currently registered with the appropriate nurses' association, and must not be a resident of the Participant's home or related to a member of the Participant's family by blood or marriage.

44. Proven Effective: A service or supply will be considered Proven Effective if, in the sole opinion of Medavie Blue Cross after Consultation with its Health Care Consultants, there is sufficient published data as to the medical effectiveness and safety of the supply or service for the purpose for which it is being provided or prescribed.

45. Provider: A Provider means a Person providing a service or supply and includes a Health Care Professional.

46. Related Medical Condition/Illness/Injury: Any medical condition/illness/injury precipitated or caused by; resulting or arising from; directly or indirectly attributed to another medical condition/illness/injury.

3.1 DEFINITIONS (Cont'd)

47. Reimbursement Policy: A Reimbursement Policy is a benefit Policy whereby the Subscriber or Participant must pay for all expenses and submit paid-in-full receipts from a Medavie Blue Cross Approved Provider to Medavie Blue Cross, in a format acceptable to Medavie Blue Cross, including the Medavie Blue Cross assigned Provider identification number, for reimbursement in accordance with the terms of this Policy.

48. Room Accommodation: For the purposes of this Policy, the various levels of Room Accommodation charged by a Hospital for a room normally used by the Hospital as a patient's room shall be as follows:

    a) Private Room Accommodation means a room with one bed;
    b) Semi-private Room Accommodation means a room with two beds; and
    c) Ward Room Accommodation means a room with three or more beds.

49. Stabilized: Stabilized means any sickness or injury which has remained stable for six months prior to the date of departure from the Participant's province of residence. When adjudicating claims, a medical consultant or health professional at Medavie Blue Cross will review six months of medical history which includes tests, changes in medication, medical Consultation, diagnosis, and/or Hospitalization to determine if the medical event was unexpected. No information is to be looked at alone, stability is defined by the overall medical condition, not just one component.

50. Subscriber: A Subscriber is the individual who has made application and has been accepted by Medavie Blue Cross for coverage.

51. Usual, Customary and Reasonable: Usual, Customary and Reasonable means the normal charges for similar services made by other Providers of the same standing in the locality or geographical area where the charge is incurred, as determined by Medavie Blue Cross, or in accordance with a payment schedule established by Medavie Blue Cross.

3.2 APPLICATION FOR COVERAGE

Eligible Employees must apply for coverage in a form which has been approved by Medavie Blue Cross. The application shall be applicable to all benefits of this Policy for which the applicant is eligible.

When a Subscriber with single coverage acquires a Dependent(s), he may apply for family coverage. If Medavie Blue Cross receives application within 31 days of the date the Subscriber acquires the Dependent(s), benefits will begin on the date of acquisition. When application is received after 31 days of the date the Subscriber acquires the Dependent(s), Medavie Blue Cross may request Evidence of Health on the Dependent(s) at the Subscriber's own expense. Medavie Blue Cross may, at its sole discretion, either refuse coverage to the Dependent(s) or permit membership with an effective date established by Medavie Blue Cross.

3.3 COMMENCEMENT OF COVERAGE

The coverage on an Employee or Dependent shall become effective on the date of eligibility except when:

a) the Employee is not Actively at Work on the day that the coverage would otherwise become effective or,
b) the Employee or Dependent is a Late Applicant.

Employee eligibility is described in the Policy Summary. A Dependent becomes eligible upon satisfying the definition of a Dependent specified in Section 3.1, Definitions.

If the Employee is not Actively at Work at the time the coverage would otherwise be effective, then the coverage will take effect only when he returns to work and satisfies the Actively at Work definition.

If the Employee or Dependent is a Late Applicant, then all coverage shall be subject to the submission and approval of Evidence of Health. The effective date of approved coverage shall be the date established by Medavie Blue Cross and agreed upon by the Policyholder. The Evidence of Health required for Late Applicants is to be provided at the Subscriber's own expense.

3.4 BENEFIT CONDITIONS

The benefits under this Policy supplement, and are not intended to replace government health care Policy. As a condition to providing the benefits under this Policy, only Participants eligible for benefits under government Hospital and provincial health care Policy are entitled to the benefits of this Policy. Medavie Blue Cross will make payment for eligible benefits obtained from a Medavie Blue Cross Approved Provider only in excess of the government health care allowances and only where permitted by the provincial legislation. Medavie Blue Cross will not make payment for any health care services or supplies administered by government funded Hospitals, agencies or Providers, unless otherwise specified in this Policy.

The benefits of this Policy will be provided for only those services recommended by a Health Care Professional as approved by Medavie Blue Cross and will be continued only while the Participant is under active treatment and receiving the care of the Health Care Professional.

Benefits provided by this Policy shall be based upon the Usual, Customary and Reasonable charges as defined in Section 3.1, Definitions.

3.5 TERMINATION OF COVERAGE

Except as provided in Section 3.6, Extension of Coverage, a Subscriber will cease to be covered under this Policy on the earliest of the following dates:

1. the date of termination of this Policy;
2. the date that he ceases to be an Employee as defined in Section 3.1, Definitions;
3. the end of the grace period for which any dues have not been paid in full; or
4. the date that he reaches the termination age specified in the Policy Summary.

Except as provided in Section 3.6, Extension of Coverage, the coverage on any Dependent will cease on the earliest of the following dates:

1. the date of termination of this Policy;
2. the date the Subscriber ceases to be covered under this Policy;
3. the date that the Dependent ceases to be an eligible Dependent;
4. the end of the grace period for which any dues have not been paid in full; or
5. the date that he reaches the termination age specified in Section 3.1, Definitions.

3.6 EXTENSION OF COVERAGE

If an Employee ceases to be Actively at Work due to sickness or injury, the Employee shall be considered to be still employed and eligible for continued coverage until:

1. he recovers from the sickness or injury; or
2. such time as his employment with the Policyholder is terminated;

whichever occurs first.

If an Employee ceases to be Actively at Work due to a leave of absence, strike, lock-out or temporary lay-off, the Policyholder may elect, on a basis that precludes individual selection, to continue coverage for up to six months from the end of the month in which employment was interrupted.

If an Employee ceases to be Actively at Work due to an approved maternity or parental leave, the Employee shall be considered to be still employed and eligible for continued coverage to the end of the maternity or parental leave.

In the event of divorce or legal separation, the Employee may elect to either continue the membership of the Spouse or provide notice in writing to Medavie Blue Cross to terminate coverage for the Spouse.

3.7 REINSTATEMENT OF COVERAGE

If an Employee's coverage has been terminated because of a leave of absence, strike, lock-out, or temporary lay-off, it can be reinstated immediately upon return to work provided that application is made within 31 days of the date the Employee returned to work.

If an Employee, who was eligible for coverage under this Policy but, for any reason, was not covered under this Policy, should have his employment with the Policyholder terminated and be subsequently re-employed, then he shall be considered to be a Late Applicant. The commencement of any coverage shall be in accordance with the terms of Section 3.3, Commencement of Coverage, of this Policy. This provision shall be applied separately for each benefit in this Policy.

3.8 ASSIGNMENT

Medavie Blue Cross may, at its option, pay the amount of benefits provided by this Policy either to the Provider of services and supplies or to the Employee.

Only the Employee and his eligible Dependents are entitled to any of the benefits or rights provided by this Policy.

Should the Employee or Dependent attempt to assign, aid, or attempt to aid, any other Person to obtain benefits under this Policy, the Employee's membership under this Policy may be cancelled immediately without notice.

3.9 CONVERSION OPTION

If an Employee's coverage ceases because of termination of employment, or termination of membership in the class of Employees eligible for coverage under this Policy, then the Employee may apply within 31 days of the termination date of this Policy to convert to one of the programs available to individuals through the local Blue Cross at that time.

The conversion option is also extended to Dependents. In the event of loss of coverage due to a change in status, or the Employee's death, a Spouse or Dependent child may apply within 31 days of the change to convert to one of the programs available to individuals through the local Blue Cross at that time.

If the rights and benefits of the Employee are terminated or suspended by Medavie Blue Cross as specified in Section 1.7, Termination (paragraph i) the conversion option does not apply.

If an employer terminates an Employee's coverage under this Policy which, in the opinion of Medavie Blue Cross, is solely for the purpose of eliminating the Employee's claims and there Dependents from the group's experience, the conversion option will not be available for the Employee or there Dependents.

3.10 COORDINATION OF BENEFITS AND REIMBURSEMENT

Should similar benefits be provided by more than one section of this Policy, any claim for these benefits will be assessed by Medavie Blue Cross in a manner which provides the greatest benefit to the Participant.

Where compensation for benefits covered under this Policy is available to a Participant under any other prepaid health service contract or insurance Policy, the amount payable under this Policy shall be co-ordinated with such other coverages to the extent that the total compensation available from all coverages shall not exceed 100% of the actual cost.

If a Participant is entitled to receive benefits under this Policy and is entitled simultaneously to receive benefits under any other Policy which provides similar benefits, payment of benefits shall be determined in the following manner:

1. If any other Policy does not contain a coordination of benefits provision, then that Policy shall be considered first payer.

2. If any other Policy does contain a coordination of benefits provision, the benefits of such Policy shall be coordinated with the benefits of this Policy.

Coordination of Benefits shall be executed in accordance with the guidelines established by the Canadian Life and Health Insurance Association (CLHIA).

3.11 GENERAL EXCLUSIONS

The following are benefit exclusions under this Policy:

a) medical examinations or routine general check-ups required for use by a third party;

b) charges for rest cures, convalescent care, custodial care, rehabilitation services in a Hospital for the chronically ill or a chronic care unit of a general Hospital, or charges incurred by the Participant when, in the opinion of Medavie Blue Cross, proper treatment should be in a chronic care unit or institution for the chronically ill;

c) charges relating to elective services obtained by a Participant outside his province of residence when his provincial government health care programs have not accepted liability for those items normally covered in the Participant's province of residence;

d) any services and supplies to which the Participant is entitled under any Workers' Compensation statute or any other legislation;

e) charges which normally would not be made if the Participant were not covered by this Policy;

f) services for cosmetic purposes or conditions not detrimental to one's health;

3.11 GENERAL EXCLUSIONS (Cont'd)

g) any services and supplies normally available without cost, or at nominal cost, under any government statute on the effective date of this Policy, whether or not such services or supplies continue to be eligible under a government program;

h) delivery charges to or from a Hospital or Health Care Professional;

i) services in connection with an injury or disease resulting from riot, insurrection or war, whether war be declared or not. This includes any condition caused directly or indirectly by any armed forces;

j) any item or service not listed as a benefit in this Policy;

k) medications restricted under federal or provincial legislation which are prescribed and/or dispensed despite such regulations;

l) registration charges or non-resident surcharges in any Hospital;

m) services required as a result of attempting to commit a criminal act;

n) services performed by an unqualified practitioner;

o) charges for missed appointments or the completion of forms;

p) services which are normally paid for directly or indirectly by the employer;

q) any health care services and supplies which are not provided by a Medavie Blue Cross Approved Provider;

r) charges for Experimental or Investigative health care services or supplies;

s) any health care service or supplies which are not Medically Necessary nor Proven Effective;

t) charges for Health Care Planning Assessments including, but not limited to physiotherapy assessments. Health Care Planning Assessments will be excluded as eligible benefits, unless otherwise specified in this Policy;

u) any health care services and supplies administered in a Hospital or by any agency or Provider controlled by a Hospital or by any agency or Provider funded, in whole or in part, by government of any level, is not eligible for reimbursement under this Policy, unless otherwise specified in this Policy.

SECTION 4 - CLAIM PROVISIONS

4.1 NOTICE OF CLAIM

Notice and proof of claim shall be given to Medavie Blue Cross within 24 months of the date of the service.

If the Policy terminates and proof of a claim incurred prior to contract termination is not given to Medavie Blue Cross within four months of the date of the Policy termination then the claim shall be invalid.

4.2 PROOF OF CLAIM

Medavie Blue Cross has agreements with a number of Providers of health care services and supplies. These Providers are termed as "Direct Payment Providers". The Subscriber's Identification Card should always be presented to the Direct Payment Provider rendering service to the Participant. The Direct Payment Provider will bill Medavie Blue Cross for the eligible benefits.

When services are rendered by a Medavie Blue Cross Approved Provider which has not entered into a direct payment agreement with Medavie Blue Cross, or to claim benefits under a Reimbursement Policy, the Subscriber or Participant must pay for the services rendered and obtain an official paid-in-full receipt and/or statement which provides complete details of the services and/or supplies received. The Subscriber or Participant must submit this paid-in-full receipt from a Medavie Blue Cross Approved Provider, in a format acceptable to Medavie Blue Cross, including his Policy and identification numbers, the Medavie Blue Cross assigned Provider identification number, and details of the service to Medavie Blue Cross to be reimbursed for eligible benefits.

All medical claims incurred outside the Participant's province of residence, which involve a Health Care Professional or Hospital, must be submitted to the Participant's provincial government health care programs in the province of residence prior to submission of the claim(s) to Medavie Blue Cross.

It shall be the responsibility of the Participant to provide evidence of provincial government health care program allowances at the time of submitting such claims to Medavie Blue Cross.

4.3 RELEASE OF MEDICAL INFORMATION TO MEDAVIE BLUE CROSS

In accepting to receive the benefits under this Policy, each Participant is deemed to expressly authorize any Hospital, Physician, Dentist, Pharmacist, nurse, or any other party having made a diagnosis, treated or attended or rendered service to any Participant, to release to Medavie Blue Cross all information or opinions that Medavie Blue Cross may request regarding the Participant's medical condition, medical history and treatment of each Participant, and to allow Medavie Blue Cross to see and to copy reports of Consultations, specialists' reports, X-rays, charts, observations, diagnoses and prognoses, prescriptions, orders for treatment, medical and Hospital records, or other documents regarding the medical condition, history or treatment of each Participant for which a claim is made.

4.4 WAIVER OF LEGAL ACTION

In accepting to receive the benefits under this Policy, each Participant renounces and waives any right of action or claim he or she may have against Medavie Blue Cross arising out of or in any manner connected with the release by Medavie Blue Cross, for the purposes authorized and described in the Policy, of any medical records and information with respect to his or her medical condition and that of any Dependent to be covered under the Policy, which Medavie Blue Cross may obtain from Hospitals, Physicians, Dentists, Pharmacists, nurses, or any other party having made a diagnosis, treated or rendered service to any Participant covered under the Policy.

4.5 LIMITATION OF LEGAL ACTION

No legal action may be brought against Medavie Blue Cross to claim benefits under this Policy until 60 days have elapsed from the date written proof of loss has been furnished to Medavie Blue Cross. Any such action must be brought within one year after filing such proof of loss. The time limitations expressed above shall be deemed extended to agree with the minimum limitation period for such claims in the jurisdiction in which a Subscriber resides.

4.6 RIGHT OF RECOVERY

If benefit payments made under this Policy are later determined to be in excess of the amount of payment necessary to satisfy the intent of this Policy, Medavie Blue Cross reserves the right to recover any such excess. If the excess amount cannot be recovered, Medavie Blue Cross reserves the right to reduce future benefit payments to that claimant until such excess amount is fully recovered.

4.7 SUBROGATION

a) When the Participant receives services as the result of injuries, suffered in whole or in part, due to the fault or neglect of another party, Medavie Blue Cross agrees to make payment for the eligible benefits of this Policy.

b) Medavie Blue Cross shall, upon making any payment or assuming liability for benefits under this Policy, be subrogated to all rights of recovery of the Participant in respect of such benefits and may commence or assume legal proceedings in the name of the Participant to enforce its rights of subrogation.

c) The Participant shall sign any further documentation, as reasonably requested by Medavie Blue Cross from time to time, to give effect to the provisions of this section of the Policy and to secure its rights of subrogation.

d) The Participant will make no representations nor take any actions which might jeopardize Medavie Blue Cross' rights of subrogation or possible recovery.

e) Where the Participant receives reimbursement, in whole or in part, in respect of benefits or payments made or provided or liability assumed by Medavie Blue Cross from a third party or other coverage(s), Medavie Blue Cross has the right to recover payment for such reimbursement from the Participant. Where the net amount recovered, whether by legal proceeding, settlement, subrogated action, or reimbursement from a third party or other coverage(s) is not sufficient to provide complete indemnity for the loss or damage suffered by the Participant, the amount so recovered shall, after deduction for the cost of recovery, be divided between Medavie Blue Cross and the Participant in the proportion in which the loss or damage has been borne by them.

f) The Participant must reimburse Medavie Blue Cross for the amount received from Medavie Blue Cross which is later deemed to be an ineligible expense following a claim audit or review.

4.8 RIGHT OF INSPECTION AND AUDIT

Medavie Blue Cross shall have the right to inspect or audit, or cause to be inspected or audited, the health records of the Participant held in the files of Providers.

SECTION 5A - HOSPITAL BENEFIT PROVISIONS

SECTION 5A.1 - HOSPITAL BENEFIT - IN CANADA

Medavie Blue Cross will pay the Usual, Customary and Reasonable charges for the following Eligible Expenses incurred in Medavie Blue Cross approved Hospitals in Canada. These benefits are subject to any Deductible, Co-insurance or maximum amount shown in the Policy Summary.

1. HOSPITAL ROOM - Medavie Blue Cross will pay the charges of a Hospital in Canada for Room Accommodation specified in the Policy Summary. In computing the number of days of benefits, the day of admission shall be counted as one day, but the day of discharge shall not be counted unless it is also the day of admission.

   The hospital benefit includes semi-private room accommodation for convalescent care if the care is primarily for rehabilitation or convalescent care.

SECTION 5B - WORLDWIDE TRAVEL BENEFIT PROVISIONS

SECTION 5B.1 - WORLDWIDE TRAVEL BENEFITS

The following benefits are provided as a result of an accident or unexpected illness incurred outside the Participant's province of residence in Canada or outside Canada while this plan is in effect.

Coverage shall become effective on the latter of:

- the time of crossing the Participant's provincial border, or
- the effective date of the Subscriber's Worldwide Travel Benefits.

The coverage shall terminate:

- at the Participant's provincial border on the return trip home, or
- at 12:00 midnight on the Subscriber's termination date.

Medavie Blue Cross will pay the Usual, Customary and Reasonable charges for the following Eligible Expenses. These benefits are subject to any Deductible, Co-insurance or maximum amount shown in the Policy Summary, and the Benefit Maximums specified below.

1. ACCIDENTAL DENTAL - Charges for dental treatment to a maximum amount of $1,000 Canadian when, as the result of accidental injury (direct accidental blow to the mouth), natural teeth have been damaged, or a fractured or dislocated jaw requires setting. Such dental treatment must be rendered or reported and approved for payment by Medavie Blue Cross within 180 days of the accident and be supported by proper certification.

   When such dental treatment must be deferred because of the age of the patient, or other factors which are justified, in the opinion of Medavie Blue Cross, the claim may be approved for later payment. To meet our payment criteria, the Participant must have been covered by Medavie Blue Cross for Accidental Dental at the time the accident occurred, and must still be covered by Medavie Blue Cross at the time the services are rendered. The only exception to this criteria is when the Participant is uninsured for Dental benefits at the time the service is rendered, in which case the claim may be approved. The Subscriber must submit to Medavie Blue Cross within 180 days of the accident complete details of the required services from the Dentist and reason for deferment.

2. AMBULANCE - Normal charges for licensed ambulance service, including air ambulance and evacuation, to and from the nearest qualified medical facility.

3. COMING HOME - Extra costs of return economy fare by the most direct route (air, bus, train) when an illness is such that the patient must return home and be accompanied by a qualified medical attendant (not a relative). Written authorization is required from the attending Physician. If returning on a commercial aircraft, this coverage is included:

   - two economy seats by most direct route to the patient's home city in Canada, one for the covered patient and one round trip fare for a medical attendant;
   - the number of economy seats required to accommodate the covered person if on a stretcher and one round trip for a medical attendant.

SECTION 5B.1 - WORLDWIDE TRAVEL BENEFITS (Cont'd)

4. DIAGNOSTIC SERVICES - The cost of diagnostic laboratory and X-ray services, less the amount allowed under the provincial government health plan, when ordered by the attending Physician.

5. DRUG BENEFIT - Charges for Drug Benefits as defined in Section 2.1, in a quantity sufficient for the period of travel. Payment of eligible drugs will be made only when proof of purchase and payment is supplied in the form of an account from a Medavie Blue Cross Approved Provider located outside the Participant's province of residence and showing the name of the preparation, date of purchase, quantity, strength and total cost.

6. EMERGENCY AND PAYMENT ASSISTANCE - The services of a 24-hour emergency hotline are available to Participants who need assistance while travelling. By telephoning the appropriate number on your "World Assistance Card" when a medical emergency occurs, coverage will be confirmed to the hospital or physician. Payment of medical expenses will be arranged or co-ordinated on behalf of the Participant. In addition, the following services are offered:

   Medical Assistance - The patient may call for a list of hospitals or medical facilities and arrangements will be made for:

   - advice from a qualified Physician
   - medical follow-up of the patient's condition and communication with the subscriber and family
   - return home or transfer of patient if medically permissible
   - transport of a family member to the patient's bedside or to identify the deceased.

   Non-Medical Assistance - The patient may call to obtain:

   - an emergency response in any major language
   - emergency assistance in contacting the family or business
   - referral to legal counsel.

7. HOSPITAL ACCOMMODATION - Charges of a public general hospital, less the amount allowed under the provincial government health plan, for (a) room accommodation (not a suite of rooms), and (b) Medically Necessary inpatient and outpatient services.

8. MEALS AND ACCOMMODATIONS - Up to $1,200 Canadian ($150 per day for eight days) per trip for extra costs of commercial accommodation and meals incurred by the Subscriber, or by a covered dependent remaining with a travelling companion when the trip is delayed due to illness or accident to a travelling companion or a covered person. This must be verified by the attending Physician and supported with receipts from commercial organizations.

9. MEDICAL APPLIANCES - The cost of casts, crutches, canes, slings, splints, trusses, braces and/or temporary rental of a wheelchair when required as a result of sickness or accident. This benefit will be payable only when the sickness or accident occurs outside the Participant's province of residence and when ordered by a Physician.

SECTION 5B.1 - WORLDWIDE TRAVEL BENEFITS (Cont'd)

10. NURSE - Private duty nursing, including Registered Nurse, Registered Nursing Assistant or Certified Nursing Assistant, when ordered by a Physician at the Usual, Customary and Reasonable fee. Nurses providing the service must not be a relative of the patient or an employee of the hospital.

11. PARAMEDICAL SERVICES - The cost of services made by chiropractors, osteopaths, chiropodist/podiatrists and physiotherapists (not a relative), in excess of payment by a provincial government health plan, excluding charges for X-rays.

12. PHYSICIANS AND SURGEONS - Customary charges of Physicians and surgeons for services rendered, less the amount allowed under the provincial government health plan.

13. RETURN OF DECEASED - Up to $3,000 Canadian towards the cost of preparation (including cremation) and homeward transportation of a deceased covered person (excluding the cost of a coffin) to the point of departure in Canada by the most direct route.

14. TRANSPORTATION TO VISIT THE COVERED PERSON - One return economy fare by the most direct route for transportation costs (air, bus, train), when the covered person has been confined to hospital or has died and the attending physician advised the necessary attendance of a family member or close friend of the covered person.

15. VEHICLE RETURN - An allowance of up to $500 Canadian for the cost of driving the patient's vehicle, either private or rental, by commercial agency to the patient's residence or nearest appropriate vehicle rental agency when the patient is unable to return it due to sickness or accident.

SECTION 5B - WORLDWIDE TRAVEL BENEFIT PROVISIONS

SECTION 5B.2 - WORLDWIDE TRAVEL - LIMITATIONS AND EXCLUSIONS

1. No benefits are available under this Policy for residents travelling outside their province of residence primarily or incidentally to seek medical advice or treatment, even if such a trip is on the recommendation of a Physician.

2. No benefits are available under this Policy for elective (non-emergency) treatment or surgery. This is defined as treatment or surgery (a) not required for the immediate relief of acute pain and suffering, or (b) which reasonably could be delayed until the covered person has returned to Canada or (c) which the covered person elects to have rendered or performed outside Canada following emergency treatment for, or diagnosis of, a medical condition which (on medical evidence) would not prevent the covered person from returning to Canada prior to such treatment or surgery.

3. Benefits under this Policy shall not be paid if the covered person receives the same from a third party.

4. No benefits will be paid for expenses incurred as the result of abuse of medications; suicide or attempted suicide; criminal acts, or injuries suffered as a result of operating a motor vehicle while alcohol levels are in excess of the legal limit in the jurisdiction where the accident occurred.

5. Medavie Blue Cross, in consultation with the attending Physician, reserves the right to return the patient to Canada. If any Participant is (on medical evidence) able to return to Canada following the diagnosis of, or the emergency treatment for, a medical condition which requires continuing medical services, treatment or surgery, and the Participant elects to have such treatment or services rendered or surgery performed outside Canada, the expense of such continuing medical services, treatment or surgery will not be covered by this plan.

   Medavie Blue Cross accepts no responsibility in the event of the deterioration of the Participant's medical condition during or after the transfer back to Canada.

6.a. **Applicable to Active Employees and Retirees less than 65 years** - Coverage is limited to expenses incurred as a result of a sudden illness or accident which occurs outside the participant's province of residence. Pre-existing conditions will be covered as a benefit, provided the condition is stabilized prior to travel, and medical attention is not anticipated during the travel period.

   b. **Applicable to Retired Employees over 65 years** - Coverage is limited to expenses incurred as a result of a sudden illness or Accident which occurs outside the Participant's province of residence during the term of this Policy.

SECTION 5B.2 - WORLDWIDE TRAVEL - LIMITATIONS AND EXCLUSIONS

7. **Applicable to Retired Employees over age 65 -** Medavie Blue Cross will not pay any benefit or accept any liability for claims relating to a medical condition/illness/injury or Related Medical Condition/Illness/Injury which has:

   - deteriorated; or
   - been diagnosed; or
   - required medical consultation; or
   - required hospitalization; or
   - required a Change in Medication:

   at any time within the six month period immediately prior to the date of departure from the Participant's province of residence.

8. Medavie Blue Cross will not cover expenses in excess of $2 million Canadian per covered Participant, per incidence outside the province of residence.

   All claims and required government forms must be submitted within four (4) months of the date of service.

SECTION 5C - REFERRALS FOR SERVICES OUTSIDE CANADA BENEFIT PROVISIONS

SECTION 5C.1 - REFERRALS OUTSIDE CANADA - BENEFITS

When participants are referred outside Canada by the attending physician for medical services not available in Canada, Medavie Blue Cross will pay for the following eligible benefits. Payment will be made at the Usual, Customary and Reasonable amount for charges in excess of provincial government health care allowances up to a lifetime maximum of $500,000 per Participant.

1. HOSPITAL - All hospital charges for Medically Necessary services, less the amount allowed under the provincial government health care plan, such as:

   - hospital room accommodation
   - intensive care rooms
   - nursing services
   - operating and recovery rooms
   - diagnostic and laboratory services including X-ray
   - oxygen and blood
   - prescription drugs including intravenous solutions
   - physiotherapy.

2. PHYSICIANS AND SURGEONS - Customary charges of physicians and surgeons for services rendered, less the amount allowed under the provincial government health care plan.

3. AMBULANCE - Charges for licensed ambulance services required to transport a stretcher patient to and from the nearest hospital able to provide essential care. Charges for air transport are included to the maximum deemed appropriate by the airline on a regularly scheduled flight.

4. AMBULANCE ATTENDANT - Charges for travel expenses of an accompanying Registered Nurse or qualified medical attendant (not a relative) when Medically Necessary and approved by Medavie Blue Cross.

SECTION 5C - REFERRALS FOR SERVICES OUTSIDE CANADA
BENEFIT PROVISIONS

SECTION 5C.2 - REFERRALS OUTSIDE CANADA - LIMITATIONS AND EXCLUSIONS

1. The referral outside Canada must be Medically Necessary and must not be for services available in Canada, as determined by Medavie Blue Cross.

2. The claim must have prior approval for payment from Medavie Blue Cross.

3. Payment will be made for the reasonable and customary charges of the provider of the services or supplies in the area in which the services are rendered.

4. Payment will only be made for services and supplies rendered while the patient was under the active treatment of a licensed Physician.

5. Payment will not be made for treatment of any illness commencing within 12 months after the Participant's effective date of group coverage for which the Participant has received medical treatment or has been prescribed drugs 12 months prior to the effective date of this coverage.

6. The services to be provided outside Canada must not be Experimental or Investigative in nature.

7. Referrals outside of Canada exclude, but are not limited to, services not available due to waiting lists and/or treatment which has been refused by a physician in Canada.

SECTION 5D - EXTENDED HEALTH BENEFIT PROVISIONS
(Applicable to 93489-001, 002, 003, 004, 007, 008, 009, 011, 012, 013, 014, 015, 016 and 017)

SECTION 5D.1 - EXTENDED HEALTH BENEFIT - IN CANADA

Medavie Blue Cross will pay the Usual, Customary and Reasonable charges for the following Eligible Expenses, when they are incurred in Canada. These benefits are subject to any Deductible, Co-insurance or maximum amount shown in the Policy Summary, and the Benefit Maximums specified below.

1. PHYSICIAN SERVICES - The Usual, Customary and Reasonable charges of a Physician licensed to practice where the services are rendered, within Canada, to the extent that charges are not eligible for payment from a government program, such as a reciprocal agreement under a provincial health care Policy. The services obtained must have been provided outside the Participant's province of residence.

2. PROFESSIONAL AMBULANCE - Charges for licensed ambulance services required to transport a stretcher patient to and from the nearest hospital able to provide essential care. Charges for air transport are included to the maximum deemed appropriate by the airline on a regularly scheduled flight.

   In the event professional ambulance service is not available, Medavie Blue Cross may, at its option, allow payment for those forms of transportation normally used in the area where the sickness or Accident occurred when authorized in writing by a Physician.

3. SPECIAL AMBULANCE ATTENDANT - Charges for travel expenses of an accompanying Registered Nurse (not a relative) when Medically Necessary and approved by Medavie Blue Cross. Such charges are limited to a maximum payable of $500 in a Calendar Year.

4. PRIVATE DUTY NURSING - Charges for Medically Necessary home nursing care performed by a registered nurse, registered nursing assistant or certified nursing assistant at the Participant's residence (other than a convalescent or nursing home) on the written authorization of the attending Physician.

   In addition, services provided by an approved personal care worker are eligible under this benefit for up to four hours per day. Personal care workers offer essential services such as bathing, dressing, toileting, feeding and mobilization. The Participant may be eligible for services in his/her home if under the active care of a nurse or if requiring home care during the recuperation period after a discharge from the Hospital and requires temporary home care during the recuperation period.

   Services that are not eligible under this benefit include custodial care, light housekeeping, meal preparation, shopping, transportation and respite care (patient care provided in the home intermittently in order to provide temporary relief to the family home caregiver).

   The maximum payable will be limited to $10,000 in a Calendar Year. All nursing services must be pre-approved by Medavie Blue Cross in order to be considered for reimbursement. Payment for Eligible Expenses will be based on the payment schedule for Private Duty Nurses established by Medavie Blue Cross for the Participant's province of residence.

   Only those services pre-approved by Medavie Blue Cross and provided by an approved Medavie Blue Cross Provider will be considered for reimbursement.

SECTION 5D.1 - EXTENDED HEALTH BENEFIT - IN CANADA (Cont'd)

5. DIAGNOSTIC AND X-RAY SERVICES - Charges for diagnostic and X-ray services, when carried out by a Medavie Blue Cross approved laboratory which, in the opinion of Medavie Blue Cross, is qualified to render such services. These services will include laboratory services and X-ray examinations.

6. OXYGEN - Charges for oxygen.

7. SPECIAL TRANSPORTATION BENEFIT - Non-emergency transportation services by railroad, boat, airline, private automobile to and from the nearest center where the medical treatment by a specialist or hospital is available. Non-emergency treatment must be through written referral by the attending physician, except for appointments to a specialist, where written confirmation from the specialist or hospital must be provided.

   Transportation for physiotherapy services in or out of hospital is eligible.

   If a private vehicle is used and the distance travelled is at least 50 Kilometres one way or 100 Kilometres round trip by the most direct route, Medavie Blue Cross will pay the lesser of,

   - the actual expenses incurred (receipts must be submitted)
   - $0.28 per Kilometre based from the city/town of residence to the city/town where treatment is received.

   The maximum benefit payable per person for all transportation in one calendar year is:

   (a) For in-province transportation services, $500.
   (b) For out-of-province transportation service, $1,000.

   The maximums for transportation in (a) and (b) above are independent of each other.

Note:
- **Meals and accommodations are not eligible for reimbursement**
- **Transportation services rendered for cosmetic services are not eligible for reimbursement.**
- **Escorts may be eligible under the escort benefit.**

SECTION 5D.1 - EXTENDED HEALTH BENEFIT - IN CANADA (Cont'd)

8. NON-EMERGENCY TRANSPORTATION ESCORT BENEFIT - If the Non-emergency Transportation services are eligible then the escort benefit is eligible based on the following.

    - Expenses incurred specifically for transportation of the escort are eligible.
    - Confirmation from attending physician confirming that an escort is medically required for the patient.
    - If the patient is a dependent child under age 18 then a parent may be considered an escort.

    The maximum benefit payable for an escort per person for all transportation in one calendar year is:

    (a) For in-province transportation services, $500.
    (b) For out-of-province transportation service, $1,000.

    The maximums for escort transportation in (a) and (b) above are independent of each other.

    Note:
    - **Meals and accommodations are not eligible for Reimbursement**
    - **Escorts for Transportation services rendered for cosmetic services are not eligible for reimbursement.**
    - **Escorts are not eligible when transportation was by private vehicle.**

SECTION 5D - EXTENDED HEALTH BENEFIT PROVISIONS
(Applicable to 93489-001, 002, 003, 004, 007, 008, 009, 011, 012, 013, 014, 015, 016 and 017)

SECTION 5D.2 - EXTENDED HEALTH BENEFIT - WORLDWIDE

Medavie Blue Cross will pay the Usual, Customary and Reasonable charges for the following Eligible Expenses. These benefits are subject to any Deductible, Co-insurance or maximum amount shown in the Policy Summary, and the Benefit Maximums specified below.

1. ACCIDENTAL DENTAL - Charges for dental treatment, when natural teeth have been damaged by a direct, accidental blow to the mouth, or a fractured or dislocated jaw requiring setting. This dental treatment must be rendered or reported and approved for payment by Medavie Blue Cross within six months of the Accident. Eligible Expense will be the dentist's usual and customary fee up to the "dental fee guide" for general practitioners in effect where services are rendered.

   When such dental treatment must be deferred because of the age of the patient, or other factors which are justified, in the opinion of Medavie Blue Cross, the claim may be approved for later payment. To meet our payment criteria, the Participant must have been covered by Medavie Blue Cross for accidental dental at the time the Accident occurred, and must still be covered by Medavie Blue Cross at the time the services are rendered. The only exception to this criteria is when the Participant is uninsured for Dental benefits at the time the service is rendered, in which case the claim may be approved. The Subscriber must submit to Medavie Blue Cross within 180 days of the Accident complete details of the required services from the Dentist and reason for deferment.

2. DIABETIC EQUIPMENT - Charges for the following equipment used for the treatment and control of diabetes:
   - Blood glucose machine to a maximum payable of $300 in a lifetime;
   - Blood glucose machine supplies to a maximum payable of $700 in a Calendar Year;
   - Infusion pumps to a maximum payable of $800 in a lifetime;
   - Infusion pump supplies to a maximum payable of $50 in a Calendar Year.

3. OSTOMY SUPPLIES - Charges for essential ostomy supplies.

4. PARAMEDICAL PRACTITIONERS - Charges for treatment, except when performed in a Hospital, by a licensed: speech therapist*, massage therapist*, clinical psychologist (requires a written referral (valid for one year) provided by a physician, surgeon or Newfoundland Power Inc.'s EFAP provider), osteopath, chiropodist/podiatrist or naturopath. The maximum payable for each type of practitioner is $250 in a Calendar Year up to the usual and customary and reasonable fee established by Blue Cross per visit. In addition, the maximum payable for X-rays is $35 per practitioner in a Calendar Year. The maximum payable for a physiotherapist is $500 in a Calendar Year. The maximum payable for a chiropractor is $500 in a Calendar Year and $25 in a Calendar Year for X-rays.

   * Requires a Physician's written referral (valid for one year). The Claim must be accompanied by a claim form completed by a Medavie Blue Cross approved massage therapist or speech therapist.

SECTION 5D.2 - EXTENDED HEALTH BENEFIT - WORLDWIDE (Cont'd)

5. PROSTHETIC APPLIANCES - Charges for the following remedial prosthetic appliances when authorized by the attending Physician:

   - artificial limbs (limited to one prosthetic appliance to each limb in a lifetime);
   - breasts (limited to a left and a right prosthesis every two Consecutive Calendar Years);
   - eyes (limited to one left and one right prosthesis in a lifetime);
   - canes or crutches (limited to two in a lifetime);
   - splints;
   - casts;
   - trusses (limited to one truss every five Consecutive Calendar Years); and
   - braces (limited to one cervical collar in a Calendar Year and all other braces are limited to one in a lifetime).

   Replacement of these items will not be a benefit unless replacement is required due to pathological or physiological change.

   - hair, when hair loss is due to an underlying pathology or its treatment, limited to two occurrences in a Calendar Year. Hair prosthetics, replacement therapy and other procedures for physiological hair loss are excluded (i.e., male pattern baldness).

   Only those appliances pre-approved by Medavie Blue Cross and provided by an approved Medavie Blue Cross Provider will be considered for reimbursement.

   Repairs and/or adjustments are provided to a maximum payable of $300 in a Calendar Year.

6. MEDICAL SUPPLIES AND EQUIPMENT - Charges for the purchase of burn pressure garments to a maximum payable of $500 in a Calendar Year and charges for rental of a wheelchair (excluding electric wheelchairs except for quadriplegics and repairs unless due to physical or pathological change), Hospital-type bed (including mattress and safety side rails and excluding electric hospital beds), equipment for the administration of oxygen, surgical brassieres limited to two occurrences in a Calendar Year to a maximum payable of $250, compression and surgical garments to a combined maximum payable of $500 in a Calendar Year, and jobst sleeves for lymphoedema, when prescribed by a licensed Physician. If, due to extended illness or disability, it is felt that the need for these items will be long term, Medavie Blue Cross, at its sole discretion, may approve the purchase of these items. The TENS machine is limited to a maximum payable of $300 every five Consecutive Calendar Years.

   Once the original equipment purchase is approved, the rental or approved purchase of another piece of similar equipment will be limited to once in five Consecutive Calendar Years.

SECTION 5D.2 - EXTENDED HEALTH BENEFIT - WORLDWIDE (Cont'd)

7. MOLDED ARCH SUPPORTS - Charges for molded arch supports to accommodate, relieve, or remedy some mechanical foot defect or abnormality, excluding their replacement (except for pathological change), when prescribed by an orthopedic surgeon, physiatrist, rheumatologist, podiatrist/chiropodist or the attending Physician.

8. ORTHOPEDIC FOOTWEAR & SUPPLIES - Charges for orthopedic footwear, once in a Calendar Year when the footwear has been customized with special features to accommodate relieve or remedy some mechanical foot defect or abnormality. A prescription from an orthopedic surgeon, physiatrist, rheumatologist, chiropodist/podiatrist or the attending Physician is required. Also, charges for shoe modification and/or adjustment supplies when prescribed by one of the Health Care Professionals noted above to accommodate, relieve, or remedy some mechanical foot defect or abnormality.

   The combined maximum payable for Orthopedic Supplies is $75 in a Calendar Year.

9. HEARING AIDS - Charges for hearing aids (excluding batteries and exams), up to a total maximum payable of $600 (per ear) every 36 Consecutive Months, when prescribed by an otolaryngologist, otologist and/or recommended by a registered audiologist.

SECTION 5D - EXTENDED HEALTH BENEFIT PROVISIONS
(Applicable to 93489-005, 006 and 010)

SECTION 5D.1 - EXTENDED HEALTH BENEFIT - IN CANADA

Medavie Blue Cross will pay the Usual, Customary and Reasonable charges for the following Eligible Expenses, when they are incurred in Canada. These benefits are subject to any Deductible, Co-insurance or maximum amount shown in the Policy Summary, and the Benefit Maximums specified below.

1. PHYSICIAN SERVICES - The Usual, Customary and Reasonable charges of a Physician licensed to practice where the services are rendered, within Canada, to the extent that charges are not eligible for payment from a government program, such as a reciprocal agreement under a provincial health care Policy. The services obtained must have been provided outside the Participant's province of residence.

2. PROFESSIONAL AMBULANCE - Charges for licensed ambulance services required to transport a stretcher patient to and from the nearest hospital able to provide essential care. Charges for air transport are included to the maximum deemed appropriate by the airline on a regularly scheduled flight.

   In the event professional ambulance service is not available, Medavie Blue Cross may, at its option, allow payment for those forms of transportation normally used in the area where the sickness or Accident occurred when authorized in writing by a Physician.

3. SPECIAL AMBULANCE ATTENDANT - Charges for travel expenses of an accompanying Registered Nurse (not a relative) when Medically Necessary and approved by Medavie Blue Cross. Such charges are limited to a maximum payable of $500 in a Calendar Year.

4. PRIVATE DUTY NURSING - Charges for Medically Necessary home nursing care performed by a registered nurse, registered nursing assistant or certified nursing assistant at the Participant's residence (other than a convalescent or nursing home) on the written authorization of the attending Physician.

   In addition, services provided by an approved personal care worker are eligible under this benefit for up to four hours per day. Personal care workers offer essential services such as bathing, dressing, toileting, feeding and mobilization. The Participant may be eligible for services in his/her home if under the active care of a nurse or if requiring home care during the recuperation period after a discharge from the Hospital and requires temporary home care during the recuperation period.

   Services that are not eligible under this benefit include custodial care, light housekeeping, meal preparation, shopping, transportation and respite care (patient care provided in the home intermittently in order to provide temporary relief to the family home caregiver).

   The maximum payable will be limited to $5,000 in a Calendar Year. All nursing services must be pre-approved by Medavie Blue Cross in order to be considered for reimbursement. Payment for Eligible Expenses will be based on the payment schedule for Private Duty Nurses established by Medavie Blue Cross for the Participant's province of residence.

   Only those services pre-approved by Medavie Blue Cross and provided by an approved Medavie Blue Cross Provider will be considered for reimbursement.

SECTION 5D.1 - EXTENDED HEALTH BENEFIT - IN CANADA (Cont'd)

5. DIAGNOSTIC AND X-RAY SERVICES - Charges for diagnostic and X-ray services, when carried out by a Medavie Blue Cross approved laboratory which, in the opinion of Medavie Blue Cross, is qualified to render such services. These services will include laboratory services and X-ray examinations.

6. OXYGEN - Charges for oxygen.

7. SPECIAL TRANSPORTATION BENEFIT - Non-emergency transportation services by railroad, boat, airline, private automobile to and from the nearest center where the medical treatment by a specialist or hospital is available. Non-emergency treatment must be through written referral by the attending physician, except for appointments to a specialist, where written confirmation from the specialist or hospital must be provided.

   Transportation for physiotherapy services in or out of hospital is eligible.

   If a private vehicle is used and the distance travelled is at least 50 Kilometres one way or 100 Kilometres round trip by the most direct route, Medavie Blue Cross will pay the lesser of,

   - the actual expenses incurred (receipts must be submitted)
   - $0.28 per Kilometre based from the city/town of residence to the city/town where treatment is received.

   The maximum benefit payable per person for all transportation in one calendar year is:

   (a) For in-province transportation services, $500.
   (b) For out-of-province transportation service, $1,000.

   The maximums for transportation in (a) and (b) above are independent of each other.

Note:
- **Meals and accommodations are not eligible for reimbursement**
- **Transportation services rendered for cosmetic services are not eligible for reimbursement.**
- **Escorts may be eligible under the escort benefit.**

SECTION 5D.1 - EXTENDED HEALTH BENEFIT - IN CANADA (Cont'd)

8. NON-EMERGENCY TRANSPORTATION ESCORT BENEFIT - If the Non-emergency Transportation services are eligible then the escort benefit is eligible based on the following.

   - Expenses incurred specifically for transportation of the escort are eligible.
   - Confirmation from attending physician confirming that an escort is medically required for the patient.
   - If the patient is a dependent child under age 18 then a parent may be considered an escort.

   The maximum benefit payable for an escort per person for all transportation in one calendar year is:

   (a) For in-province transportation services, $500.
   (b) For out-of-province transportation service, $1,000.

   The maximums for escort transportation in (a) and (b) above are independent of each other.

   Note:
   - **Meals and accommodations are not eligible for Reimbursement**
   - **Escorts for Transportation services rendered for cosmetic services are not eligible for reimbursement.**
   - **Escorts are not eligible when transportation was by private vehicle.**

SECTION 5D - EXTENDED HEALTH BENEFIT PROVISIONS
(Applicable to 93489-005, 006 and 010)

SECTION 5D.2 - EXTENDED HEALTH BENEFIT - WORLDWIDE

Medavie Blue Cross will pay the Usual, Customary and Reasonable charges for the following Eligible Expenses. These benefits are subject to any Deductible, Co-insurance or maximum amount shown in the Policy Summary, and the Benefit Maximums specified below.

1. ACCIDENTAL DENTAL - Charges for dental treatment, when natural teeth have been damaged by a direct, accidental blow to the mouth, or a fractured or dislocated jaw requiring setting. This dental treatment must be rendered or reported and approved for payment by Medavie Blue Cross within six months of the Accident. Eligible Expense will be the dentist's usual and customary fee up to the "dental fee guide" for general practitioners in effect where services are rendered.

   When such dental treatment must be deferred because of the age of the patient, or other factors which are justified, in the opinion of Medavie Blue Cross, the claim may be approved for later payment. To meet our payment criteria, the Participant must have been covered by Medavie Blue Cross for accidental dental at the time the Accident occurred, and must still be covered by Medavie Blue Cross at the time the services are rendered. The only exception to this criteria is when the Participant is uninsured for Dental benefits at the time the service is rendered, in which case the claim may be approved. The Subscriber must submit to Medavie Blue Cross within 180 days of the Accident complete details of the required services from the Dentist and reason for deferment.

2. DIABETIC EQUIPMENT - Charges for the following equipment used for the treatment and control of diabetes:
   - Blood glucose machine to a maximum payable of $300 in a lifetime;
   - Blood glucose machine supplies to a maximum payable of $700 in a Calendar Year;
   - Infusion pumps to a maximum payable of $800 in a lifetime;
   - Infusion pump supplies to a maximum payable of $50 in a Calendar Year.

3. OSTOMY SUPPLIES - Charges for essential ostomy supplies.

4. PARAMEDICAL PRACTITIONERS - Charges for treatment, except when performed in a Hospital, by a licensed: speech therapist*, massage therapist*, clinical psychologist (requires a written referral (valid for one year) provided by a physician, surgeon or Newfoundland Power Inc.'s EFAP provider), osteopath, chiropodist/podiatrist or naturopath. The maximum payable for each type of practitioner is $250 in a Calendar Year including an x-ray, up to the usual and customary and reasonable fee established by Blue Cross per visit. The maximum payable for a physiotherapist is $500 in a Calendar Year. The maximum payable for a chiropractor is $250 in a Calendar Year and $25 payable in a Calendar Year for X-rays.

   * Requires a Physician's written referral (valid for one year). The Claim must be accompanied by a claim form completed by a Medavie Blue Cross approved massage therapist and speech therapist.

SECTION 5D.2 - EXTENDED HEALTH BENEFIT - WORLDWIDE (Cont'd)

5. PROSTHETIC APPLIANCES - Charges for the following remedial prosthetic appliances when authorized by the attending Physician:

   - artificial limbs (limited to one prosthetic appliance to each limb in a lifetime);
   - breasts (limited to a left and a right prosthesis every two Consecutive Calendar Years);
   - eyes (limited to one left and one right prosthesis in a lifetime);
   - canes or crutches (limited to two in a lifetime);
   - splints;
   - casts;
   - trusses (limited to one truss every five Consecutive Calendar Years); and
   - braces (limited to one cervical collar in a Calendar Year and all other braces are limited to one in a lifetime).

   Replacement of these items will not be a benefit unless replacement is required due to pathological or physiological change.

   - hair, when hair loss is due to an underlying pathology or its treatment, limited to two occurrences in a Calendar Year. Hair prosthetics, replacement therapy and other procedures for physiological hair loss are excluded (i.e., male pattern baldness).

   Only those appliances pre-approved by Medavie Blue Cross and provided by an approved Medavie Blue Cross Provider will be considered for reimbursement.

   Repairs and/or adjustments are provided to a maximum payable of $300 in a Calendar Year.

6. MEDICAL SUPPLIES AND EQUIPMENT - Charges for the purchase of burn pressure garments to a maximum payable of $500 in a Calendar Year and charges for rental of a wheelchair (excluding electric wheelchairs except for quadriplegics and repairs unless due to physical or pathological change), Hospital-type bed (including mattress and safety side rails and excluding electric hospital beds), equipment for the administration of oxygen, surgical brassieres which are limited to two occurrences in a Calendar Year to a maximum of $250, compression and surgical garments to a combined maximum payable of $500 in a Calendar Year, and jobst sleeves for lymphoedema, when prescribed by a licensed Physician. If, due to extended illness or disability, it is felt that the need for these items will be long term, Medavie Blue Cross, at its sole discretion, may approve the purchase of these items. The TENS machine is limited to a maximum payable of $300 every five Consecutive Calendar Years.

   Once the original equipment purchase is approved, the rental or approved purchase of another piece of similar equipment will be limited to once in five Consecutive Calendar Years.

SECTION 5D.2 - EXTENDED HEALTH BENEFIT - WORLDWIDE (Cont'd)

7. MOLDED ARCH SUPPORTS - Charges for molded arch supports to accommodate, relieve, or remedy some mechanical foot defect or abnormality, excluding their replacement (except for pathological change), when prescribed by an orthopedic surgeon, physiatrist, rheumatologist, podiatrist/chiropodist or the attending Physician.

8. ORTHOPEDIC FOOTWEAR & SUPPLIES - Charges for orthopedic footwear once in a Calendar Year when the footwear is customized with special features to accommodate, relieve or remedy some mechanical foot defect or abnormality, when prescribed by an orthopedic surgeon, physiatrist, rheumatologist or the attending physician. Also, charges for supplies when prescribed by one of the health care professionals noted above to accommodate, relieve or remedy some mechanical foot defect or abnormality up to a maximum payable of $75 in a Calendar Year.

9. HEARING AIDS - Charges for hearing aids (excluding batteries and exams), up to a total maximum payable of $600 (per ear) every 36 Consecutive Months, when prescribed by an otolaryngologist, otologist and/or recommended by a registered audiologist.

SECTION 5E - VISION BENEFIT PROVISIONS

SECTION 5E.1 - VISION BENEFIT

Medavie Blue Cross will pay the Usual, Customary and Reasonable charges for the following Eligible Expenses. These benefits are subject to any Deductible, Co-insurance or maximum amount shown in the Policy Summary, and the Benefit Maximums specified below.

1. EYE EXAMINATION/LENSES/FRAMES/CONTACT LENSES - Charges of a registered, licensed optometrist or ophthalmologist for eye examinations. Charges for corrective eyeglasses, including lenses, frames, contact lenses but excluding safety glasses or glasses/contacts for cosmetic purposes. The maximum payable is indicated in the Policy Summary.

2. CONTACT LENSES DUE TO DISEASE - Charges for contact lenses when prescribed by a licensed ophthalmologist for ulcerated keratitis; severe corneal scarring, keratoconus (conical cornea) or aphakia, provided sight can be improved to at least the 20/40 level by contact lenses but cannot be improved to that level by spectacle lenses. The total maximum payable is $250 every 24 Consecutive Months.

3. VISUAL TRAINING - Charges of a registered, licensed optometrist or ophthalmologist for visual training and remedial eye exercises.

SECTION 5F - DRUG BENEFIT PROVISIONS

SECTION 5F.1 - DRUG BENEFIT

Medavie Blue Cross will pay for eligible Drug Benefits, subject to the Co-insurance, Deductible or Co-payment and Benefit Maximum amounts, as shown in the Policy Summary. The Drug Benefit list applicable to this Policy is identified also in the Policy Summary.

1. Drug Benefits means drugs as defined in Section 3.1.

2. Medavie Blue Cross agrees to make payment for eligible Drug Benefits in the quantity prescribed and deemed reasonable by Medavie Blue Cross.

3. Medavie Blue Cross reserves the right on an ongoing basis to add, delete or amend the list of eligible Drug Benefits, at its discretion and without notice.

4. Certain drugs may require prior authorization to be eligible for payment, as specified by Medavie Blue Cross.

5. For Direct Payment Policy, when an eligible Interchangeable Drug has been prescribed, Medavie Blue Cross will make payment based on the criteria defined in our Pharmacy agreement.

6. For Direct Payment Policy, Drug Benefit claims received for reimbursement directly from a Participant will be reimbursed to a maximum of the amount that would have been reimbursed directly to the Direct Payment Provider, as defined in our Pharmacy agreement.

7. Medavie Blue Cross will reimburse only for the lowest priced Interchangeable Drug when prescribed by a Physician and dispensed by an approved Provider, unless the Physician indicates no substitution.

SECTION 5G - DENTAL BENEFIT PROVISIONS
(Applicable to 93489-002, 004, 008, 009 and 012)

SECTION 5G - DENTAL BENEFITS

Medavie Blue Cross will pay the dentist's Usual, Customary and Reasonable fee(s), up to the Dental Society Fee Guide for general practitioners. Benefits are subject to the co-insurance, maximum amount and applicable fee guide as shown in the Policy Summary.

If the employee is referred to a specialist by a general practitioner, the Dental Fee Guide for specialists will be used.

The amount of payment made by Medavie Blue Cross is not intended to fix the values of the dentists' services and, therefore, dentists are privileged to charge their usual and customary fees. Any charge in excess of the payment made by Medavie Blue Cross shall remain the responsibility of the Subscriber.

All benefits described in this dental contract are available from the effective date of coverage, if the Participant enrolled within 31 days of the date of eligibility. For late applicants, who enrol after the 31 day period, the benefits of this dental contract will be limited to an eligible expense of $100 per Participant during the first 12 months of coverage. This restriction in benefits does not apply to services required as a result of natural teeth being damaged by a direct, accidental blow to the mouth which occurs after the effective date of the late applicant's coverage.

5G.1 BASIC DENTAL BENEFITS

1. DIAGNOSTICS

Clinical Oral Examination
Complete oral examination of new patient (one every 36 Consecutive Months)
Recall oral examination (one every five Consecutive Months)
Emergency oral examination
Specific oral examination

Radiographs
Periapical
Occlusal (four films every five Consecutive Months)
Bitewing (four films every five Consecutive Months)
Extraoral (four films every five Consecutive Months)
Sialography
Postero-anterior and lateral skull and facial bone
Use of radiopaque dyes
Full mouth series (one occurrence every 12 Consecutive Months)
Panoramic (one film every 12 Consecutive Months)
Cephalometric (five every 24 Consecutive Months)

5G.1 BASIC DENTAL BENEFITS (Cont'd)

1. DIAGNOSTICS (Cont'd)

Tests and Laboratory Examinations
Microbiological tests
Cytological tests
Pulp vitality tests
Diagnostic casts
Diagnostic photographs

Case Presentation
Treatment Planning (two units of time* in a Calendar Year)
Consultation with patient (two units of time* in a Calendar Year)

2. PREVENTIVE SERVICES

Polishing (once, up to one unit of time* every five Consecutive Months)
Scaling (once every five Consecutive Months)
Fluoride treatment (one every five Consecutive Months)
Nutritional counselling
Oral hygiene instruction/plaque control (one unit of time* in a Calendar Year)
Finishing restorations
Athletic protective appliance (mouth guard) (one every 12 Consecutive Months)
Pit and fissure sealants and space maintainers for missing primary teeth and habit-breaking appliances;
Space maintainer appliances, maintenance and repairs
Interproximal disking of teeth
Occlusal Equilibration

3. BASIC RESTORATIVE SERVICES

Caries, trauma and pain control
Amalgam (silver) and tooth coloured (white) restorations
Full coverage prefabricated restorations
Tooth coloured veneer applications
Porcelain staining (chairside)
Recontouring of existing crowns
Repairs to inlays, onlays or crowns
Removal of inlays, onlays, crowns or veneers
Recementation/rebonding of inlays, onlays, crowns or veneers
Retentive pins

* one unit of time is equal to 15 minutes

5G.1 BASIC DENTAL BENEFITS (Cont'd)

4. ENDODONTIC SERVICES

Treatment of Pulp Chamber
Pulpotomy
Pulpectomy

Root Canal Therapy
Root canals
Apexification (insertion of dentogenic media)

Periapical Services
Apicoectomy/apical curettage
Retrofilling
Root amputation
Hemisection
Perio-radicular lesion decompression
Exploratory endodontic surgery
Intentional removal of tooth, apical filling and replantation
Canal and/or pulp chamber enlargement
Surgical and non-surgical root repair or pulp chamber repair

Other Endodontic Procedures
Isolation of endodontic tooth (teeth) for asepsis
Emergency opening and drainage of canal
Bleaching (non vital)
Post removal to allow retreatment
Appliances (Periodontal, TMJ or Myofacial) (limited to any one maxillary (upper) appliance and any one mandibular (lower) appliance every 24 Consecutive Months)

5G.1 BASIC DENTAL BENEFITS (Cont'd)

5. PERIODONTIC SERVICES

Non-Surgical Services
Desensitization

Surgical Services
Gingival curettage
Gingivoplasty
Gingivectomy
Flap approach surgery
Grafts
Guided tissue regeneration
Miscellaneous procedures
- distal wedge procedure
- post surgical treatment
- periodontal abscess or pericoronitis

Adjunctive Periodontal Services
Provisional splinting or ligation
Periodontal scaling and root planing

Miscellaneous Periodontal Services
Periodontal re-evaluation
Subgingival periodontal irrigation

6. BASIC PROSTHODONTIC SERVICES - REMOVABLE

Denture Adjustments (after three months of the initial insertion)
Minor adjustments
Remount and occlusal equilibration

Denture Repairs and Additions
Denture repairs
Additions to partial dentures

Denture Reline, Rebase (limited to one upper and one lower denture reline or rebase every 24 Consecutive Months)

Other Basic Prosthetic Services
Tissue conditioning
Resilient liner
Resetting of teeth

5G.1 BASIC DENTAL BENEFITS (Cont'd)

7. BASIC PROSTHODONTIC SERVICES - FIXED

Repairs
Recontouring of abutments/pontics
Replace broken prefabricated attachable facings
Removal of fixed bridge
Repair of fixed bridge
Recementation

8. ORAL SURGERY

Extractions
Erupted teeth
Impacted teeth
Residual roots

Alveoplasty
- in conjunction with extractions

Other Oral Surgery Services
Replantation of avulsed teeth
Repositioning of traumatically displaced teeth
Control of hemorrhage
Post surgical care

9. ADJUNCTIVE GENERAL SERVICES

Emergency treatment of dental pain
Local anesthesia (not in conjunction with operative or surgical procedures)
General anesthesia (related to surgery)
Conscious sedation
- inhalation technique

SECTION 5G - DENTAL BENEFIT PROVISIONS
(Applicable to 93489-002, 004, 008, 009 and 012)

EXCLUSIONS AND LIMITATIONS

This benefit does not cover the following expenses.

1. Treatment or appliance, related directly or indirectly to full mouth reconstruction, to correct vertical dimension.

2. Services rendered by a dental hygienist but not administered under the supervision of a dentist, except in those provinces where it is no longer a legal requirement.

3. Dental services eligible under the Accident and sickness insurance forming part of the EXTENDED HEALTH BENEFITS portion of the Policy.

4. Any services and supplies to which the Participant is entitled under any Workers' Compensation statute or any other legislation.

5. Any suicide attempt or any self-inflicted injury, whether the Insured is sane or not.

6. Services that are not medically required, that are given for cosmetic purposes or that exceed the ordinary services given in accordance with current therapeutic practice.

7. Splinting for periodontal reasons, where cast crowns or inlays are used for this purpose, with or without onlays.

8. All charges, services, articles or items that are not included in the list of Eligible Expenses described in this benefit.

9. Veneers for cosmetic purposes.

SECTION 6 - HEALTH SPENDING ACCOUNT BENEFIT PROVISIONS
(Applicable to 93489-001, 007, 011, 013, 014, 016 and 017)

SECTION 6.1 - DEFINITIONS

Whenever used within the Agreement herein, unless the context otherwise requires:

1. Agreement: Agreement shall mean the Health Spending Account Benefit Provisions of this contract and the Health Spending Account Administrative Services Only Contract entered into between Medavie Blue Cross and the Plan Sponsor on behalf of its Employees for a Health Spending Account plan.

2. Allowable Expenses: Allowable Expenses shall mean the expenses incurred by a Participant for which payment is to be or was made by Medavie Blue Cross pursuant to the terms of this Agreement.

3. Calendar Year: A Calendar Year is that period of time commencing with the first day of January in a given year and ending the 31st day of December in the same year.

4. Claims Limitation Period: Claims Limitation Period shall mean the period of time commencing at the end of the Calendar Year within which claims for reimbursement must be submitted to Medavie Blue Cross to be considered an Allowable Expense. This period of time is specified in the Health Spending Account Benefit Provisions.

5. Credits: Credits shall mean the dollar amount that may be paid by Medavie Blue Cross on the Plan Sponsor's behalf to the Subscriber to cover Allowable Expenses.

6. Current Credit Balance: Current Credit Balance shall mean Credits already accrued in a Subscriber's Health Spending Account less payments made in the current Calendar Year.

7. Dependent: Dependent shall have the same meaning as defined under the Canadian Federal Income Tax Act.

8. Health Spending Account: Health Spending Account (HSA) shall mean an account established at the Plan Sponsor's discretion for the benefit of an eligible Subscriber to cover Allowable Expenses incurred by the Subscriber and his eligible Dependents. Funds will be paid by Medavie Blue Cross through such an account, up to limits specified by the Plan Sponsor.

9. Medical Expense: Medical Expense shall mean any item or service allowed under the Canadian Federal Income Tax Act as a medical expense on the date such expense was incurred.

10. Participant: Participant shall mean and include the Subscriber and each of his eligible Dependents, as defined under the Canadian Federal Income Tax Act, who are entitled to benefits under this Agreement.

SECTION 6 - HEALTH SPENDING ACCOUNT BENEFIT PROVISIONS
(Applicable to 93489-001, 007, 011, 013, 014, 016 and 017)

SECTION 6.1 - DEFINITIONS (Cont'd)

11. Subscriber: Subscriber shall mean any Employee who is eligible for coverage in accordance with this Agreement.

12. Total Annual Allocation: Total Annual Allocation shall mean the total number of Credits to which a Subscriber is entitled in any particular Calendar Year.

SECTION 6.2 - ALLOWABLE EXPENSES

1. Under a HSA, Subscribers shall be reimbursed for dental-related expenses not covered by any other provincial health care programs or private health care plans. In general, any dental-related expense which could be used to meet requirements for deductibility on a Subscriber's personal income tax return (in accordance with the Canadian Federal Income Tax Act) is eligible for reimbursement. For example, deductible and co-payment amounts, and amounts exceeding plan maximums shall be reimbursed for dental benefits along with the cost of other procedures not covered by the supplemental dental plans (such as ineligible dental procedures, etc.). In addition, the expenses covered by the HSA could include allowable Dental Expenses in accordance with the Canadian Federal Income Tax Act, as long as these are not covered by any other provincial health care programs or private health care plans.

SECTION 6.3 - LIMITATIONS

1. Benefits are payable for Allowable Expenses incurred only during the period this Agreement is in force.

2. Subscribers shall be entitled to receive benefits to the extent hereinafter provided upon payment of the required administration charges and subject to the conditions and limitations hereinafter provided.

3. The total liability of Medavie Blue Cross to any Subscriber for Allowable Expenses shall not exceed the Subscriber's HSA Current Credit Balance. Should a claimed amount exceed the HSA Current Credit Balance, the claim, if eligible, will be reimbursed up to the Current Credit Balance. No payment shall be made by Medavie Blue Cross, under the terms of this Agreement, for amounts in excess of Credits recorded on behalf of any Subscriber within the HSA.

4. Total reimbursement for any claim will never exceed 100% of the total amount charged for the Allowable Expenses incurred.

SECTION 6 - HEALTH SPENDING ACCOUNT BENEFIT PROVISIONS
(Applicable to 93489-001, 007, 011, 013, 014, 016 and 017)

SECTION 6.4 - EXCLUSIONS

1. Medavie Blue Cross shall not pay for the following:

   a) Expenses for services incurred by Participants prior to the Effective Date or following termination in accordance with this Agreement.

   b) Expenses for services not allowed as an eligible Dental Expense under the Canadian Federal Income Tax Act, as defined by Canada Revenue Agency.

   c) Expenses for services which are benefits under any other private health care plans or government sponsored programs.

   d) Interest charges on any amount payable as benefits.

2. Under no circumstances shall unused HSA Credits be paid out as cash.

SECTION 6.5 - GENERAL PROVISIONS

1. Except as provided in the HSA Administrative Services Only Contract, all other terms, provisions and conditions of the group contract remain in effect.

2. Interpretation of the provisions and terms of this Agreement shall be in the sole discretion of Medavie Blue Cross in discharging its obligations pursuant to this Agreement.

3. The Plan Sponsor agrees to indemnify and hold Medavie Blue Cross harmless from any and all claims, damages, lawsuits, loss, costs, and charges incurred by Medavie Blue Cross as a result of its performance of this Agreement, except where caused by a willful act, negligence, or a breach of the terms of this Agreement by Medavie Blue Cross.

4. All payments of benefits for Allowable Expenses under the terms of this Agreement shall be made by cheque in Canadian currency to the Subscriber. Should an Allowable Expense be incurred in other than Canadian currency, payment will be made by cheque in Canadian currency at the appropriate conversion rate in force when the claim was incurred. All monies payable hereunder shall be deemed to mean incurred benefit equivalent in Canadian dollars and not otherwise, unless specifically indicated herein to the contrary.

5. If any benefit under this Agreement is obtained by a Participant, or for any person, who is not entitled thereto, the monies paid by Medavie Blue Cross for such benefit shall be deemed to be a debt due by the Subscriber to Medavie Blue Cross. Once Medavie Blue Cross is reimbursed by the Subscriber, Medavie Blue Cross will, in turn, credit this amount to the Plan Sponsor's HSA account. This amount will also be re-established as HSA Credits to the Subscriber.

SECTION 6.5 - GENERAL PROVISIONS (Cont'd)

6. The invalidity of any particular provision of this Agreement shall not affect any other provision hereof. This Agreement shall be construed as if any invalid provision were omitted unless such invalid provision is an essential term hereof.

7. Medavie Blue Cross shall not be responsible for the availability, quality or results of any dental treatment or transportation or the failure of the Participant to obtain dental treatment.

SECTION 6.6 - OPERATING PROVISIONS

1. The entire Total Annual Allocation of Credits can be drawn upon by the Subscribers on the 1st day of January of each year.

2. Reimbursement for Allowable Expenses shall be made automatically upon receipt by Medavie Blue Cross.

3. The Plan Sponsor's HSA will allow for HSA Credits to be carried forward from one Calendar Year into the next. HSA Credits may not be carried forward more than one Calendar Year.

4. The Claims Limitation Period will extend thirty (30) days. This Claims Limitation Period will allow Medavie Blue Cross to reimburse for prior Calendar Year claims with prior year HSA Credits. Allowable Expenses from the prior Calendar Year will no longer be eligible immediately following the Claims Limitation Period and the ability to claim for these Allowable Expenses will be forfeited.

5. All prior Calendar Year HSA Credits not used as of the end of the Claims Limitation Period will be carried forward into the current Calendar Year. HSA Credits previously carried forward into the prior Calendar Year, if any, will be forfeited by the Subscriber at that time.

SECTION 6 - HEALTH SPENDING ACCOUNT BENEFIT PROVISIONS
(Applicable to 93489-001, 007, 011, 013, 014, 016 and 017)

SECTION 6.7 - MEDAVIE BLUE CROSS OBLIGATIONS

1. Medavie Blue Cross shall pay claims under the terms of this Agreement for Allowable Expenses which are accepted by Revenue Canada, as defined within the Canadian Federal Income Tax Act, as valid Dental Expenses.

2. Should a claim in Medavie Blue Cross' opinion not fall within the guidelines established by Revenue Canada for Allowable Expenses, the claim will be returned to the Subscriber along with a HSA Disclaimer Form which the Subscriber may complete and sign. In order to have this submitted claim processed against a Subscriber's HSA Current Credit Balance, the signed and completed HSA Disclaimer Form must be returned.

3. Should a claim be submitted for a Dependent not previously enroled under this Agreement, the claim will be returned to the Subscriber along with a HSA Disclaimer Form which the Subscriber may complete and sign. In order to have this submitted claim processed against a Subscriber's HSA Current Credit Balance, the signed and completed HSA Disclaimer Form must be returned.

4. Whenever a claim is paid from the HSA, Subscribers will receive an explanation of benefits statement. This explanation of benefits statement will indicate the amounts paid from the regular health and dental plan and from the HSA, as well as the HSA Current Credit Balance.

5. All Subscribers shall be provided with a HSA account statement. This statement shall be issued in the fourth quarter and will provide the HSA Current Credit Balance.

SECTION 6.8 - PLAN SPONSOR'S OBLIGATIONS

1. The Plan Sponsor shall furnish Medavie Blue Cross with eligibility records and other information that Medavie Blue Cross may require for the administration of this Agreement.

2. The Plan Sponsor shall provide Medavie Blue Cross with notice, in advance of the Calendar Year, of the Total Annual Allocation of Credits to be credited to each Subscriber's HSA.

SECTION 6 - HEALTH SPENDING ACCOUNT BENEFIT PROVISIONS
(Applicable to 93489-001, 007, 011, 013, 014, 016 and 017)

SECTION 6.9 - TERMINATION

1. In the event a Subscriber terminates coverage under this HSA Agreement, the Plan Sponsor will adjust HSA Credits for the terminating Subscriber to reflect actual contributions. Medavie Blue Cross will be notified of any adjusted amounts and the following will prevail:

   a) If the terminating Subscriber's adjusted HSA Credits exceed paid claims, the terminating Subscriber will have to the end of the Claims Limitation Period in which to submit of any incurred Allowable Expenses. Any remaining HSA Credits after the Claims Limitation Period will be forfeited by the terminating Subscriber.

   b) If the terminating Subscriber's adjusted HSA Credits are less than paid claims, Medavie Blue Cross will be reimbursed for these amounts consistent with the terms of the HSA Agreement.

   c) Only Allowable Expenses incurred prior to the termination date will be eligible for reimbursement.

Life Insurance Policy between Newfoundland Power and Medavie Blue Cross

Blue Cross Life Insurance Company of Canada (herein called the **"Company"**) hereby insures the Employees of:

NEWFOUNDLAND POWER INC.

(herein called the **"Policyholder"**) who are eligible for insurance in accordance with the provisions of this policy, and who make written application for such insurance as herein provided.

POLICY NUMBER:	93489 and Sections (Refer to Master Group Listing)
EFFECTIVE DATE:	This policy takes effect at 12:01 a.m. local time at the Policyholder's address on the 1st day of January 2009.
POLICY YEAR:	All policy years will commence on the 1st day of January of each year.
PREMIUMS:	Premiums are payable in advance on the effective date and on the first day of each subsequent month.
BENEFITS:	Employee Group Life Insurance Dependent Life Insurance Long Term Disability Insurance Optional Group Life Insurance

Signed for Blue Cross Life Insurance Company of Canada at Moncton, New Brunswick, Canada on this 20th day of February 2009.

Pierre-Yves Julien
Authorized signatory of the Board

Examined by: bckfras

MASTER GROUP LISTING

NEWFOUNDLAND POWER INC.

Policy Number	Group Name	Class Description
93489-001	Newfoundland Power Inc.	A. Newfoundland Power - Executives
93489-002	Newfoundland Power Inc.	B. Permanent Active Employees
93489-003	Newfoundland Power Inc.	C. Short-Term Temporary Active Employees
93489-004	Newfoundland Power Inc.	D. Retired Participants under age 65
93489-005	Newfoundland Power Inc.	E. Retired Participants Age 65 and Over
93489-006	Newfoundland Power Inc.	F. Surviving Spouses of Employees who passed away over the age of 65
93489-009	Newfoundland Power Inc.	I. Long-Term Temporary Employees
93489-015	Newfoundland Power Inc.	O. Surviving Spouses under age 65

AFFILIATED COMPANIES

FORTIS INC. AND AFFILIATED COMPANIES

93489-007	Newfoundland Power Inc.	G. Fortis Executives
93489-008	Newfoundland Power Inc.	H. Fortis Full-time Employees
93489-010	Newfoundland Power Inc.	J. Fortis Retirees Age 65 and Over
93489-011	Newfoundland Power Inc.	K. Fortis Executives
93489-012	Newfoundland Power Inc.	L. Fortis Full-time Employees
93489-013	Newfoundland Power Inc.	M. Fortis Executives
93489-014	Newfoundland Power Inc.	N. Fortis Executives
93489-016	Newfoundland Power Inc.	P. Fortis Executive Retirees under age 65
93489-017	Newfoundland Power Inc.	Q. Fortis Executive Retirees under age 65

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* If applicable to this Contract.

BENEFIT SUMMARY
(Blue Cross Life Insurance Company of Canada)

Policyholder: Newfoundland Power Inc.

Policy Number: 93489 and Sections

Effective Date: The effective date of the following summary of the terms and benefits of this policy is 01 January 2009.

Employee Eligibility:

Applicable to 93489-001, 002, 007, 008, 009, 011, 012, 013 and 014:
In order to be eligible for all benefits under this Policy, an Employee, as defined in Section 3.1(20), must be required to work at least 30 hours per week.

Applicable to 93489-003:
In order to be eligible for all benefits under this Policy, an Employee, as defined in Section 3.1(20), must be a temporary Employee working at least 20 hours per week.

Applicable to 93489-004:
In order to be eligible for all benefits under this Policy, a Retired Employee must:

i) have attained the age of 55 but under the age of 65 with a completion of 10 years of continuous service with the employer prior to the date of retirement; or
ii) have completed the combination of age + service as outlined by the defined benefit plan and is under the age of 65.

Applicable to 93489-005:
In order to be eligible for all benefits under this Policy, a Retired Employee must be:

i) over the age of 65 and have completed 10 years of continuous service with the employer prior to the date of retirement; or
ii) have completed the combination of age + service as outlined by the defined benefit plan and is over the age of 65.

Applicable to 93489-010:
In order to be eligible for all benefits under this Policy, a Retired Employee must be age 65 or over, completed at least 10 years of services with the employer as a permanent or long-term temporary Employee prior to the date of retirement and have been actively at work the date prior to retirement.

Policyholder: Newfoundland Power Inc.

Policy Number: 93489 and Sections

Effective Date: 01 January 2009

Employee Eligibility (cont'd):

Applicable to 93489-016 and 017:
In order to be eligible for all benefits under this Policy, a Retired Employee must be under age 65, completed at least 10 years of services with the Employer as a permanent Employee prior to the date of retirement, receiving a Pension from the employer, and have been actively at work the date prior to retirement.

Applicable to all Policies:
The policy shall apply to the Employee classes described in the Master Group Listing.

An Employee will become eligible for insurance at the expiration of the Plan Waiting Period. All Employee applications should be completed and submitted to Blue Cross within 31 days of the start of this eligibility period.

The term "Employee", used in this contract, shall mean an active Employee and shall be extended to mean a retired Employee, except where reference is made to employment, hours worked per week, or similar references which do not apply to a retired Employee.

Plan Waiting Period:

Applicable to 93489-001, 007, 011, 013 and 014:
Commences upon the first day of work.

Applicable to 93489-002, 008, 009 and 012:
Commences following three months of active permanent employment.

Applicable to 93489-003:
Commences following 60 continuous days of service.

Applicable to 93489-004, 005, 010, 016 and 017:
Commences upon the date of retirement.

BENEFIT SUMMARY
(Blue Cross Life Insurance Company of Canada)

Policyholder:	Newfoundland Power Inc.
Policy Number:	93489 and Sections
Effective Date:	01 January 2009

Coverage Change Date: The date an insured Employee's insurance will commence, increase or decrease in response to a change in status is the first of the month following the day on which the insured Employee's approved status changes. A change in status refers to an employment status change, the addition of a benefit or a change to an existing benefit.

Enrolment Requirements: The minimum enrolment for all lines of benefit, excluding optional benefits, is three lives.

The minimum enrolment for optional benefits is 10% of Employees or 5 lives.

Mandatory: The benefits provided under this policy are Mandatory for all eligible Employees. Excluding any Optional benefits, the required participation level for all lines of benefit is 100%.

BENEFIT SUMMARY
(Blue Cross Life Insurance Company of Canada)

Policyholder: Newfoundland Power Inc.

Policy Number: 93489-001

Effective Date: 01 January 2009

Employee Group Life Insurance

Classification of Employee	Benefit Formula	Maximum Benefit
A. Newfoundland Power - Executives	four x annual Earnings	$2,000,000

All amounts of insurance are rounded up to the next higher $1,000 amount.

Non-Evidence Limit:	$1,000,000
Reduction:	Reduces to $25,000 at age 65
Termination:	Ceases at the earlier of retirement or termination of employment.

Dependent Life Insurance

Classification of Employee	Amount of Insurance	
All Insured Employees with Dependents	Spouse	$10,000
	Child	$ 5,000
Termination:	Continues until the earliest of termination of employment or termination of the Basic Life coverage, or until the definition of Dependent is no longer met.	

BENEFIT SUMMARY
(Blue Cross Life Insurance Company of Canada)

Policyholder: Newfoundland Power Inc.

Policy Number: 93489-001

Effective Date: 01 January 2009

Long Term Disability Insurance

Classification of Employee	Benefit Formula
A. Newfoundland Power - Executives	60% of monthly Earnings
Elimination Period:	105 days
Benefit Period:	to age 65
Maximum Issue Limit:	$20,000 per month
Non-Evidence Limit:	$10,000
Termination:	Ceases at termination of employment, retirement or age 65. Coverage for insured Employees ceases at age 65 less the elimination period.

Benefits under this Long Term Disability Insurance provision are non-taxable.

Optional Group Life Insurance

Classification of Employee	Benefit Formula
All insured Employees with Basic Group Life coverage	Coverage is provided to the insured Employee and/or Spouse in units of $10,000 to a maximum of $300,000 per insured. The combined Basic Group Life benefit plus Optional Life cannot exceed $2,300,000.
Non-Evidence Limit:	Evidence of Insurability is required for all amounts of insurance.
Termination:	Ceases at the earlier of termination of employment or age 65.

BENEFIT SUMMARY
(Blue Cross Life Insurance Company of Canada)

Policyholder: Newfoundland Power Inc.

Policy Number: 93489-002

Effective Date: 01 January 2009

Employee Group Life Insurance

Classification of Employee	Benefit Formula	Maximum Benefit
B. Permanent Active Employees	three x annual Earnings	$2,000,000

All amounts of insurance are rounded up to the next higher $1,000 amount.

Non-Evidence Limit:	$1,000,000
Reduction:	Reduces to $25,000 at age 65
Termination:	Ceases at the earlier of retirement or termination of employment.

Dependent Life Insurance

Classification of Employee	Amount of Insurance	
All Insured Employees with Dependents	Spouse	$10,000
	Child	$ 5,000
Termination:	Continues until the earliest of termination of employment or termination of the Basic Life coverage, or until the definition of Dependent is no longer met.	

BENEFIT SUMMARY
(Blue Cross Life Insurance Company of Canada)

Policyholder: Newfoundland Power Inc.

Policy Number: 93489-002

Effective Date: 01 January 2009

Long Term Disability Insurance

Classification of Employee	Benefit Formula
B. Permanent Active Employees	60% of monthly Earnings
Elimination Period:	105 days
Benefit Period:	to age 65
Maximum Issue Limit:	$20,000 per month
Non-Evidence Limit:	$10,000
Termination:	Ceases at termination of employment, retirement or age 65. Coverage for insured Employees ceases at age 65 less the elimination period.

Benefits under this Long Term Disability Insurance provision are non-taxable.

Optional Group Life Insurance

Classification of Employee	Benefit Formula
All insured Employees with Basic Group Life coverage	Coverage is provided to the insured Employee and/or Spouse in units of $10,000 to a maximum of $300,000 per insured. The combined Basic Group Life benefit plus Optional Life cannot exceed $2,300,000.
Non-Evidence Limit:	Evidence of Insurability is required for all amounts of insurance.
Termination:	Ceases at the earlier of termination of employment or age 65.

BENEFIT SUMMARY
(Blue Cross Life Insurance Company of Canada)

Policyholder: Newfoundland Power Inc.

Policy Number: 93489-003

Effective Date: 01 January 2009

Employee Group Life Insurance

Classification of Employee	Benefit Formula	Maximum Benefit
C. Short-Term Temporary Active Employees	Flat Amount	$25,000

Non-Evidence Limit: $25,000

Reduction: Reduces to $10,000 at age 65

Termination: Ceases at the earlier of retirement or termination of employment.

Dependent Life Insurance

Classification of Employee	Amount of Insurance	
All Insured Employees with Dependents	Spouse	$10,000
	Child	$ 5,000

Termination: Ceases at the earlier of retirement, termination of employment, termination of basic life coverage or until the definition of Dependent is no longer met.

BENEFIT SUMMARY
(Blue Cross Life Insurance Company of Canada)

Policyholder: Newfoundland Power Inc.

Policy Number: 93489-003

Effective Date: 01 January 2009

Long Term Disability Insurance

Classification of Employee	Benefit Formula
C. Short-Term Temporary Active Employees	60% of monthly Earnings
Elimination Period:	105 days
Benefit Period:	to age 65
Maximum Issue Limit:	$800 per month
Non-Evidence Limit:	$800
Termination:	Ceases at termination of employment, retirement or age 65. Coverage for insured Employees ceases at age 65 less the elimination period.

Benefits under this Long Term Disability Insurance provision are non-taxable.

BENEFIT SUMMARY
(Blue Cross Life Insurance Company of Canada)

Policyholder: Newfoundland Power Inc.

Policy Number: 93489-004

Effective Date: 01 January 2009

Employee Group Life Insurance

Classification of Employee	Benefit Formula	Maximum Benefit
D. Retired Participants under age 65	three x annual Earnings	$2,000,000

All amounts of insurance are rounded up to the next higher $1,000 amount.

Non-Evidence Limit: $1,000,000

Termination: Ceases at age 65, at which time benefits change.

Dependent Life Insurance

Classification of Employee	Amount of Insurance	
All Insured Employees with Dependents	Spouse	$10,000
	Child	$ 5,000

Termination: Continues through lifetime of the Subscriber or until the definition of Dependent is no longer met.

Optional Group Life Insurance

Classification of Employee	Benefit Formula
All insured Employees with Basic Group Life coverage	Eligible to maintain coverage if transferring from sections 001, 002, 003, 007, 008, 009, 011, 012, 013 and 014. Volumes of insurance cannot be increased, however can be decreased.

Non-Evidence Limit: Evidence of Insurability is required for all amounts of insurance.

Termination: Cease at age 65.

BENEFIT SUMMARY
(Blue Cross Life Insurance Company of Canada)

Policyholder: Newfoundland Power Inc.

Policy Number: 93489-005

Effective Date: 01 January 2009

Employee Group Life Insurance

Classification of Employee	Benefit Formula	Maximum Benefit
E. Retired Participants age 65 and Over	25% of coverage prior to age 65	$10,000
Non-Evidence Limit:	$10,000	
Termination:	Continues through the lifetime of the Employee.	

Dependent Life Insurance

Classification of Employee	Amount of Insurance	
All Insured Employees with Dependents	Spouse	$10,000
	Child	$ 5,000
Termination:	Continues through the lifetime of the Employee or until the definition of Dependent is no longer met.	

BENEFIT SUMMARY
(Blue Cross Life Insurance Company of Canada)

Policyholder: Newfoundland Power Inc.

Policy Number: 93489-007

Effective Date: 01 January 2009

Employee Group Life Insurance

Classification of Employee	Benefit Formula	Maximum Benefit
G. Fortis Executives	four x annual Earnings	$2,000,000

All amounts of insurance are rounded up to the next higher $1,000 amount.

Non-Evidence Limit:	$1,000,000
Reduction:	Reduces to $25,000 at age 65
Termination:	Ceases at the earlier of retirement or termination of employment.

Dependent Life Insurance

Classification of Employee	Amount of Insurance	
All Insured Employees with Dependents	Spouse	$10,000
	Child	$ 5,000
Termination:	Continues through lifetime of the subscriber or until termination of employment, if earlier, or until the definition of Dependent is no longer met.	

BENEFIT SUMMARY
(Blue Cross Life Insurance Company of Canada)

Policyholder: Newfoundland Power Inc.

Policy Number: 93489-007

Effective Date: 01 January 2009

Long Term Disability Insurance

Classification of Employee	Benefit Formula
G. Fortis Executives	60% of monthly Earnings
Elimination Period:	105 days
Benefit Period:	to age 65
Maximum Issue Limit:	$20,000 per month
Non-Evidence Limit:	$10,000
Termination:	Ceases at termination of employment, retirement or age 65. Coverage for insured Employees ceases at age 65 less the elimination period.

Benefits under this Long Term Disability Insurance provision are non-taxable.

Optional Group Life Insurance

Classification of Employee	Benefit Formula
All insured Employees with Basic Group Life coverage	Coverage is provided to the insured Employee and/or Spouse in units of $10,000 to a maximum of $300,000 per insured. The combined Basic Group Life benefit plus Optional Life cannot exceed $2,300,000.
Non-Evidence Limit:	Evidence of Insurability is required for all amounts of insurance.
Termination:	Ceases at the earlier of termination of employment or age 65.

BENEFIT SUMMARY
(Blue Cross Life Insurance Company of Canada)

Policyholder: Newfoundland Power Inc.

Policy Number: 93489-008

Effective Date: 01 January 2009

Employee Group Life Insurance

Classification of Employee	Benefit Formula	Maximum Benefit
H. Fortis Full-time Employees	three x annual Earnings	$2,000,000

All amounts of insurance are rounded up to the next higher $1,000 amount.

Non-Evidence Limit:	$1,000,000
Reduction:	Reduces to $25,000 at age 65
Termination:	Ceases at the earlier of retirement or termination of employment.

Dependent Life Insurance

Classification of Employee	Amount of Insurance	
All Insured Employees with Dependents	Spouse	$10,000
	Child	$ 5,000
Termination:	Continues through lifetime of the subscriber or until termination of employment, if earlier, or until the definition of Dependent is no longer met.	

BENEFIT SUMMARY
(Blue Cross Life Insurance Company of Canada)

Policyholder: Newfoundland Power Inc.

Policy Number: 93489-008

Effective Date: 01 January 2009

Long Term Disability Insurance

Classification of Employee	Benefit Formula
H. Fortis Full-time Employees	60% of monthly Earnings
Elimination Period:	105 days
Benefit Period:	to age 65
Maximum Issue Limit:	$20,000 per month
Non-Evidence Limit:	$10,000
Termination:	Ceases at termination of employment, retirement or age 65. Coverage for insured Employees ceases at age 65 less the elimination period.

Benefits under this Long Term Disability Insurance provision are non-taxable.

Optional Group Life Insurance

Classification of Employee	Benefit Formula
All insured Employees with Basic Group Life coverage	Coverage is provided to the insured Employee and/or Spouse in units of $10,000 to a maximum of $300,000 per insured. The combined Basic Group Life benefit plus Optional Life cannot exceed $2,300,000.
Non-Evidence Limit:	Evidence of Insurability is required for all amounts of insurance.
Termination:	Ceases at the earlier of termination of employment or age 65.

BENEFIT SUMMARY
(Blue Cross Life Insurance Company of Canada)

Policyholder: Newfoundland Power Inc.

Policy Number: 93489-009

Effective Date: 01 January 2009

Employee Group Life Insurance

Classification of Employee	Benefit Formula	Maximum Benefit
I. Long-Term Temporary Employees	three x annual Earnings	$2,000,000

All amounts of insurance are rounded up to the next higher $1,000 amount.

Non-Evidence Limit:	$1,000,000
Reduction:	Reduces to $25,000 at age 65
Termination:	Ceases at the earlier of retirement or termination of employment.

Dependent Life Insurance

Classification of Employee	Amount of Insurance	
All Insured Employees with Dependents	Spouse	$10,000
	Child	$ 5,000
Termination:	Continues through lifetime of the subscriber or until termination of employment, if earlier, or until the definition of Dependent is no longer met.	

BENEFIT SUMMARY
(Blue Cross Life Insurance Company of Canada)

Policyholder: Newfoundland Power Inc.

Policy Number: 93489-009

Effective Date: 01 January 2009

Long Term Disability Insurance

Classification of Employee	Benefit Formula
I. Long-Term Temporary Employees	60% of monthly Earnings
Elimination Period:	105 days
Benefit Period:	to age 65
Maximum Issue Limit:	$20,000 per month
Non-Evidence Limit:	$10,000
Termination:	Ceases at termination of employment, retirement or age 65. Coverage for insured Employees ceases at age 65 less the elimination period.

Benefits under this Long Term Disability Insurance provision are non-taxable.

Optional Group Life Insurance

Classification of Employee	Benefit Formula
All insured Employees with Basic Group Life coverage	Coverage is provided to the insured Employee and/or Spouse in units of $10,000 to a maximum of $300,000 per insured. The combined Basic Group Life benefit plus Optional Life cannot exceed $2,300,000.
Non-Evidence Limit:	Evidence of Insurability is required for all amounts of insurance.
Termination:	Ceases at the earlier of termination of employment or age 65.

BENEFIT SUMMARY
(Blue Cross Life Insurance Company of Canada)

Policyholder: Newfoundland Power Inc.

Policy Number: 93489-010

Effective Date: 01 January 2009

Employee Group Life Insurance

Classification of Employee	Benefit Formula	Maximum Benefit
J. Fortis Retirees Age 65 and Over	25% of coverage prior to age 65	$10,000
Non-Evidence Limit:	$10,000	
Termination:	Continues throughout the lifetime of the Employee.	

Dependent Life Insurance

Classification of Employee	Amount of Insurance	
All Insured Employees with Dependents	Spouse	$10,000
	Child	$ 5,000
Termination:	Continues throughout the lifetime of the Employee or until the definition of Dependent is no longer met.	

BENEFIT SUMMARY
(Blue Cross Life Insurance Company of Canada)

Policyholder: Newfoundland Power Inc.

Policy Number: 93489-011

Effective Date: 01 January 2009

Employee Group Life Insurance

Classification of Employee	Benefit Formula	Maximum Benefit
K. Fortis Executives	four x annual Earnings	$2,000,000

All amounts of insurance are rounded up to the next higher $1,000 amount.

Non-Evidence Limit:	$1,000,000
Reduction:	Reduces to $25,000 at age 65
Termination:	Ceases at the earlier of retirement or termination of employment.

Dependent Life Insurance

Classification of Employee	Amount of Insurance	
All Insured Employees with Dependents	Spouse	$10,000
	Child	$ 5,000
Termination:	Continues through lifetime of the subscriber or until termination of employment, if earlier, or until the definition of Dependent is no longer met.	

BENEFIT SUMMARY
(Blue Cross Life Insurance Company of Canada)

Policyholder: Newfoundland Power Inc.

Policy Number: 93489-011

Effective Date: 01 January 2009

Long Term Disability Insurance

Classification of Employee	Benefit Formula
K. Fortis Executives	60% of monthly Earnings
Elimination Period:	105 days
Benefit Period:	to age 65
Maximum Issue Limit:	$20,000 per month
Non-Evidence Limit:	$10,000
Termination:	Ceases at termination of employment, retirement or age 65. Coverage for insured Employees ceases at age 65 less the elimination period.

Benefits under this Long Term Disability Insurance provision are non-taxable.

Optional Group Life Insurance

Classification of Employee	Benefit Formula
All insured Employees with Basic Group Life coverage	Coverage is provided to the insured Employee and/or Spouse in units of $10,000 to a maximum of $300,000 per insured. The combined Basic Group Life benefit plus Optional Life cannot exceed $2,300,000.
Non-Evidence Limit:	Evidence of Insurability is required for all amounts of insurance.
Termination:	Ceases at the earlier of termination of employment or age 65.

BENEFIT SUMMARY
(Blue Cross Life Insurance Company of Canada)

Policyholder: Newfoundland Power Inc.

Policy Number: 93489-012

Effective Date: 01 January 2009

Employee Group Life Insurance

Classification of Employee	Benefit Formula	Maximum Benefit
L. Fortis Full-time Employees	three x annual Earnings	$2,000,000

All amounts of insurance are rounded up to the next higher $1,000 amount.

Non-Evidence Limit:	$1,000,000
Reduction:	Reduces to $25,000 at age 65
Termination:	Ceases at the earlier of retirement or termination of employment.

Dependent Life Insurance

Classification of Employee	Amount of Insurance	
All Insured Employees with Dependents	Spouse	$10,000
	Child	$ 5,000
Termination:	Continues through lifetime of the subscriber or until termination of employment, if earlier, or until the definition of Dependent is no longer met.	

BENEFIT SUMMARY
(Blue Cross Life Insurance Company of Canada)

Policyholder:	Newfoundland Power Inc.
Policy Number:	93489-012
Effective Date:	01 January 2009

Long Term Disability Insurance

Classification of Employee	Benefit Formula
L. Fortis Full-time Employees	60% of monthly Earnings
Elimination Period:	105 days
Benefit Period:	to age 65
Maximum Issue Limit:	$20,000 per month
Non-Evidence Limit:	$10,000
Termination:	Ceases at termination of employment, retirement or age 65. Coverage for insured Employees ceases at age 65 less the elimination period.

Benefits under this Long Term Disability Insurance provision are non-taxable.

Optional Group Life Insurance

Classification of Employee	Benefit Formula
All insured Employees with Basic Group Life coverage	Coverage is provided to the insured Employee and/or Spouse in units of $10,000 to a maximum of $300,000 per insured. The combined Basic Group Life benefit plus Optional Life cannot exceed $2,300,000.
Non-Evidence Limit:	Evidence of Insurability is required for all amounts of insurance.
Termination:	Ceases at the earlier of termination of employment or age 65.

BENEFIT SUMMARY
(Blue Cross Life Insurance Company of Canada)

Policyholder: Newfoundland Power Inc.

Policy Number: 93489-013

Effective Date: 01 January 2009

Employee Group Life Insurance

Classification of Employee	Benefit Formula	Maximum Benefit
M. Fortis Executives	four x annual Earnings	$2,000,000

All amounts of insurance are rounded up to the next higher $1,000 amount.

Non-Evidence Limit:	$1,000,000
Reduction:	Reduces to $25,000 at age 65
Termination:	Ceases at the earlier of retirement or termination of employment.

Dependent Life Insurance

Classification of Employee	Amount of Insurance	
All Insured Employees with Dependents	Spouse	$10,000
	Child	$ 5,000
Termination:	Continues through lifetime of the subscriber or until termination of employment, if earlier, or until the definition of Dependent is no longer met.	

BENEFIT SUMMARY
(Blue Cross Life Insurance Company of Canada)

Policyholder: Newfoundland Power Inc.

Policy Number: 93489-013

Effective Date: 01 January 2009

Long Term Disability Insurance

Classification of Employee	Benefit Formula
M. Fortis Executives	60% of monthly Earnings
Elimination Period:	105 days
Benefit Period:	to age 65
Maximum Issue Limit:	$20,000 per month
Non-Evidence Limit:	$10,000
Termination:	Ceases at termination of employment, retirement or age 65. Coverage for insured Employees ceases at age 65 less the elimination period.

Benefits under this Long Term Disability Insurance provision are non-taxable.

Optional Group Life Insurance

Classification of Employee	Benefit Formula
All insured Employees with Basic Group Life coverage	Coverage is provided to the insured Employee and/or Spouse in units of $10,000 to a maximum of $300,000 per insured. The combined Basic Group Life benefit plus Optional Life cannot exceed $2,300,000.
Non-Evidence Limit:	Evidence of Insurability is required for all amounts of insurance.
Termination:	Ceases at the earlier of termination of employment or age 65.

BENEFIT SUMMARY
(Blue Cross Life Insurance Company of Canada)

Policyholder: Newfoundland Power Inc.

Policy Number: 93489-014

Effective Date: 01 January 2009

Employee Group Life Insurance

Classification of Employee	Benefit Formula	Maximum Benefit
N. Fortis Executives	four x annual Earnings	$2,000,000

All amounts of insurance are rounded up to the next higher $1,000 amount.

Non-Evidence Limit:	$1,000,000
Reduction:	Reduces to $25,000 at age 65
Termination:	Ceases at the earlier of retirement or termination of employment.

Dependent Life Insurance

Classification of Employee	Amount of Insurance	
All Insured Employees with Dependents	Spouse	$10,000
	Child	$ 5,000
Termination:	Continues through lifetime of the subscriber or until termination of employment, if earlier, or until the definition of Dependent is no longer met.	

BENEFIT SUMMARY
(Blue Cross Life Insurance Company of Canada)

Policyholder: Newfoundland Power Inc.

Policy Number: 93489-014

Effective Date: 01 January 2009

Long Term Disability Insurance

Classification of Employee	Benefit Formula
N. Fortis Executives	60% of monthly Earnings
Elimination Period:	105 days
Benefit Period:	to age 65
Maximum Issue Limit:	$20,000 per month
Non-Evidence Limit:	$10,000
Termination:	Ceases at termination of employment, retirement or age 65. Coverage for insured Employees ceases at age 65 less the elimination period.

Benefits under this Long Term Disability Insurance provision are non-taxable.

Optional Group Life Insurance

Classification of Employee	Benefit Formula
All insured Employees with Basic Group Life coverage	Coverage is provided to the insured Employee and/or Spouse in units of $10,000 to a maximum of $300,000 per insured. The combined Basic Group Life benefit plus Optional Life cannot exceed $2,300,000.
Non-Evidence Limit:	Evidence of Insurability is required for all amounts of insurance.
Termination:	Ceases at the earlier of termination of employment or age 65.

BENEFIT SUMMARY
(Blue Cross Life Insurance Company of Canada)

Policyholder: Newfoundland Power Inc.

Policy Number: 93489-016

Effective Date: 01 January 2009

Employee Group Life Insurance

Classification of Employee	Benefit Formula	Maximum Benefit
P. Fortis Executive Retirees under age 65	four x annual Earnings	$2,000,000

All amounts of insurance are rounded up to the next higher $1,000 amount.

Non-Evidence Limit: $1,000,000

Termination: Ceases at age 65, at which time your benefits change.

Dependent Life Insurance

Classification of Employee	Amount of Insurance	
All Insured Employees with Dependents	Spouse	$10,000
	Child	$ 5,000

Termination: Continues through lifetime of the subscriber or until termination of employment, if earlier, or until the definition of Dependent is no longer met.

Optional Group Life Insurance

Classification of Employee	Benefit Formula
All insured Employees with Basic Group Life coverage	Eligible to maintain coverage if transferring from sections 001, 002, 003, 007, 008, 009, 011, 012, 013 and 014. Volumes of insurance cannot be increased, however can be decreased.

Non-Evidence Limit: Evidence of Insurability is required for all amounts of insurance.

Termination: Ceases at age 65.

BENEFIT SUMMARY
(Blue Cross Life Insurance Company of Canada)

Policyholder: Newfoundland Power Inc.

Policy Number: 93489-017

Effective Date: 01 January 2009

Employee Group Life Insurance

Classification of Employee	Benefit Formula	Maximum Benefit
Q. Fortis Executive Retirees under age 65	four x annual Earnings	$2,000,000

All amounts of insurance are rounded up to the next higher $1,000 amount.

Non-Evidence Limit: $1,000,000

Termination: Ceases at age 65, at which time your benefits change.

Dependent Life Insurance

Classification of Employee	Amount of Insurance	
All Insured Employees with Dependents	Spouse	$10,000
	Child	$ 5,000

Termination: Continues through lifetime of the subscriber or until termination of employment, if earlier, or until the definition of Dependent is no longer met.

Optional Group Life Insurance

Classification of Employee	Benefit Formula
All insured Employees with Basic Group Life coverage	Eligible to maintain coverage if transferring from sections 001, 002, 003, 007, 008, 009, 011, 012, 013 and 014. Volumes of insurance cannot be increased, however can be decreased.

Non-Evidence Limit: Evidence of Insurability is required for all amounts of insurance.

Termination: Ceases at age 65.

SECTION 1.0 - GENERAL PROVISIONS

1.1 THE CONTRACT

The entire contract between the Company and the Policyholder shall consist of:

1. this policy and its amendments,
2. the Policyholder's application, a copy of which is attached,
3. the individual applications of the insured Employees, and
4. any document supporting or amending the applications of the Policyholder or insured Employees provided that the document has been signed by the Policyholder or insured Employee.

All statements made by the Policyholder and by any insured Employee shall, in the absence of fraud, be deemed representations and not warranties. In the event of a discrepancy between the Benefit Summary portion of this policy and the main portion of this policy, the provisions of the Benefit Summary shall govern.

1.2 NON-PARTICIPATION

This policy will not participate in the profits or surplus of the Company.

1.3 EXPERIENCE RATING

The Company may, from time to time, declare an experience rating refund if, in the opinion of the Company, the experience under this policy and similar policies is sufficiently favourable. The experience rating refund will be paid either as a reduction in premium for a policy year or as a cash refund provided the policy is being continued in force by the payment of premiums.

1.4 INCONTESTABILITY

All statements made by any insured Employee in their application for insurance or Evidence of Insurability, other than fraudulent statements and omissions, shall be incontestable by the Company after the life insurance has been in force for two consecutive years during the lifetime of the insured Employee.

1.5 NON-WAIVER OF POLICY PROVISIONS

Failure of the Company to enforce any provision of this policy at any given time shall not be construed to waive or modify such provision or to render it unenforceable at any other time or occurrence. No agent will have the authority to change or waive any provisions of this contract except as described in Policy Provision 1.8, Policy Amendments.

1.6 CONFORMITY WITH EXISTING LAWS

Any provision of this policy which is in conflict with any applicable federal or provincial law of the insured Employee's place of residence is hereby amended to conform with the minimum requirements of that law.

1.7 CONTRACT ADMINISTRATION

The Policyholder shall furnish the Company with all information that the Company will require in order to determine the insured Employees' eligibility, the effective date of the insurance, the amount of insurance and the premium to be charged. Any changes to this information shall be promptly reported to the Company. All pertinent records of the Policyholder shall be open to inspection by the Company at all reasonable times.

Clerical or mechanical errors shall not prejudice the rights of the Company or of any person having a beneficial interest in the insurance under this contract. If a clerical or mechanical error is discovered, the amount of insurance will be that amount which would have been in force had there been no such error. An equitable adjustment of premiums between the Company and the Policyholder shall be made for the full time that such insurance has been in force.

The Policyholder agrees to indemnify the Company for the amount of any benefit paid under the policy, and hold harmless the Company from and against any and all actions, causes of action, suits, claims, demands, liabilities, fines, assessments, damages and costs, including reasonable legal fees, which the Company may at any time incur arising as a result of an intentional administrative error or misrepresentation by the Policyholder.

The Policyholder or any participating employer shall not be considered to be the agent of the Company for any purpose under this policy.

1.8 POLICY AMENDMENTS

This contract can be amended if both the Policyholder and the Company agree. Any such amendment may take effect retroactively or otherwise.

An amendment at the request of the Policyholder will be considered accepted by the Policyholder if the amendment is signed by an authorized representative of the Policyholder or if premiums are paid after the Policyholder is given a copy of the proposed amendment. However, if the amendment was not requested by the Policyholder, the Policyholder will have 30 days from the date of receipt of the proposed amendment to object to it. If the Policyholder does not object during this period, the amendment will be considered effective.

1.8 POLICY AMENDMENTS (Cont'd)

The Company may amend this contract:

1. on any renewal rate effective date by giving 30 days written notice to the Policyholder, or
2. on the effective date of a change in legislation, a change to any government-sponsored plan or program or any other change impacting on the costs of services provided by health professionals, relating to the coverage provided under this contract.

1.9 POLICY RENEWAL AND TERMINATION

This policy may be renewed at the end of each policy year subject to the payment within the days of grace of the first premium due in the new policy year.

This policy will terminate if any premium remains unpaid at the end of the grace period allowed for its payment. The date of termination will be the end of the grace period. If the Policyholder has replaced this group insurance contract by another insurance contract covering the same group of insured Employees then the termination date of this policy shall be the earlier of the end of the grace period or one day before the effective date of the replacing contract.

The Policyholder may terminate this policy at the end of any month by giving the Company written notice of termination. The effective date of termination will be the later of the end of the month in which the notice of termination was received by the Company or the date requested in the notice of termination.

The Company may terminate this policy as of any premium due date by providing 30 days written notice to the Policyholder

1. if the enrolment and participation levels do not meet the Minimum Enrolment Requirements specified in the Benefit Summary, or
2. if the Policyholder does not perform in good faith its obligations under this policy.

The Company may terminate this policy on any policy anniversary by providing 30 days written notice to the Policyholder.

The termination of this policy shall not require the consent of or notice to any insured Employee, beneficiary or other person having a beneficial interest in the insurance provided by this policy.

1.10 PRIVACY LEGISLATION

Both parties agree that the collection, use, disclosure and retention of personal information undertaken in the course of administering this contract will be in accordance with the provisions of applicable privacy legislation.

SECTION 2.0 - PREMIUM PROVISIONS

2.1 CURRENCY

All payments under this policy, whether to or by the Company, shall be made in the lawful currency of Canada.

2.2 PAYMENTS AND DUE DATES

All premiums are due and payable by the Policyholder to the Company on the effective date of this policy and at the beginning of each month thereafter. The premium is payable at the Company's regional office designated to administer this policy.

2.3 GRACE PERIOD

After the first premium is paid, a period of thirty-one (31) days of grace from the next due date will be allowed for the payment of a premium without interest. This policy shall remain in force during the grace period unless it has been terminated in accordance with Policy Provision 1.9, Policy Renewal and Termination. If any premium remains unpaid at the end of the days of grace, this policy may be terminated as of the end of the grace period.

2.4 TERMINATION

If this policy is terminated, the Policyholder shall be liable to the Company for the premium from the due date of the first unpaid premium to the effective date of termination.

2.5 PREMIUM DETERMINATION

On any premium due date, the premium payable shall be determined by multiplying the premium rate then in effect for each insurance benefit provided in this policy by the benefit amount in force at that time subject to any adjustments as outlined in Policy Provision 2.6, Premium Adjustment.

The Company may change the premium rates in effect for this policy at any time when:

1. any of the terms or provisions of this policy are being amended,
2. any change in applicable law, such as the Employment Insurance Act, Workers' Compensation legislation, the Canada/Quebec Pension Plan, which shall, in the opinion of the Company, affect the claims experience under this policy, or
3. on any premium due date after the first policy year but not more often than once in any policy year, excluding any premium rate reduction resulting from an experience rating refund as outlined in Policy Provision 1.3, Experience Rating.

The Company will provide the Policyholder with 30 days written notice of any change in the premium rate.

SECTION 2.0 - PREMIUM PROVISIONS

2.6 PREMIUM ADJUSTMENTS

The premium for any increase in insurance or addition of insurance which becomes effective on other than a due date will be payable from the due date next following the change in insurance.

The premium for any decrease in insurance or termination of insurance which becomes effective on other than a due date will cease on the due date next following the change in insurance. The Company shall refund premiums due to the termination of an insured Employee's insurance for any period not greater than six months prior to the date that the notice of termination is received by the Company, provided no claims were paid during that period.

If the premiums are payable less frequently than monthly, all premium adjustments shall be made on a pro-rata basis from the first of the month on or next following the effective date of the change in insurance to the next premium due date.

SECTION 3.0 - GENERAL INSURANCE PROVISIONS

3.1 DEFINITIONS

This subsection contains the definitions of words used in this contract. In addition, words which have a definition that relate to a particular benefit line are defined in Policy Provision 5 of this contract. All references to the masculine gender in this contract shall include the feminine gender unless the context clearly indicates otherwise.

1. Actively at Work: An Employee shall be considered to be Actively at Work on a specified day if he reports for work at his usual place of employment with the Policyholder and is able to perform the regular duties of his occupation on a permanent basis. If an Employee is not required to report for work on the specified date due to holidays, shift variances, vacations or weekends, he shall be considered to be Actively at Work if he is not disabled to the degree that he could not have reported for work at his usual place of employment and performed the regular duties of his occupation.

2. Contributory: A benefit of this policy is Contributory if the insured Employee is required to pay part or all of the premium for the benefit.

3. Coverage Change Date: The Coverage Change Date defines the date that the insurance on a person will normally commence or increase in response to a change in status. The Coverage Change Date definition is shown in the Benefit Summary.

4. Dependent: For the purposes of this policy, a Dependent means the insured Employee's Spouse and unmarried Dependent Children as defined below. Dependents defined below shall exclude:

   a)any Spouse residing outside of Canada or the United States of America, or
   b) any person for whom Evidence of Insurability, if required, is not approved by the Company.

   Spouse: shall mean a Person of the opposite or same sex who is legally married to the Subscriber, or has continuously resided with the Subscriber for not less than one full year having been represented as members of a conjugal relationship (common law). In the event of divorce, legal separation, or discontinuance of cohabitation ("common law" Spouse), the Subscriber may elect to continue membership of the former Spouse or to provide notice to Medavie Blue Cross to terminate coverage for the Spouse. Medavie Blue Cross will at no time provide coverage for more than one Spouse under the same Policy.

   Children: Shall mean the insured Employee's natural, adopted or stepchildren who are dependent upon the insured Employee for financial care and support. Such Children must be:

   a)unmarried,
   b) unemployed (working less than 30 hours per week), and
   c) less than 23 years of age; or, if 23 years of age but less than 25 years of age, they must be attending an accredited educational institution, college or university on a full-time basis.

   The Children of the insured Employee's common-law Spouse shall be covered provided the Children are living with the insured Employee.

3.1 DEFINITIONS (Cont'd)

Children: (cont'd)
Unmarried, unemployed Children over 23 years of age shall qualify if they are dependent upon the insured Employee by reason of a mental or physical disability and have been continuously so disabled since the age of 23. Unmarried, unemployed Children who became totally disabled while attending an accredited educational institution, college or university on a full-time basis prior to their attaining age 25 and have been continuously so disabled since that time shall also qualify as a Dependent.

5. Earnings: Earnings shall mean the insured Employee's regular Earnings from his employer including regularly scheduled overtime Earnings and bonuses but excluding sporadic bonuses, sporadic overtime Earnings or dividends. Earnings with respect to insured employees who earn all or part of their remuneration on a commission or similar basis shall mean the insured Employee's actual Earnings in the preceding two calendar years based on their T4 slips. This amount will be pro-rated if less than two years' Earnings are available. The Earnings of hourly-rated, insured Employees shall be based on their regular number of hours worked per week. Insured Employees' Earnings for benefit calculation purposes shall be determined on the basis of 4.333 weeks per month and 12 months per year. With respect to the determination of benefits, Earnings or salary shall be the lesser of a) the above amount or b) the Earnings last reported to the Company and used in the calculation of the premium payable.

(Applicable to 93489-001, 002, 003, 009 and 015)

6. Employee: An Employee is a person who is an active, permanent or temporary, Employee of the Policyholder and is required to work at least the number of hours per week specified in the Benefit Summary. An Employee must belong at all times to the class or classes of employees covered by this policy as specified in the Benefit Summary. All employees must be residents of Canada in order to be eligible for coverage under the provincial government health care programs in the province of residence unless they are specifically mentioned in the Benefit Summary.

(Applicable to 93489-007, 008, 011, 012, 013 and 014)

Employee: An Employee is a person who is an active, permanent Employee of the Policyholder or its affiliated companies and is required to work at least the number of hours per week specified in the Benefit Summary. An Employee must belong at all times to the class or classes of employees covered by this policy as specified in the Benefit Summary. All employees must be residents of Canada in order to be eligible for coverage under the provincial government health care programs in the province of residence unless they are specifically mentioned in the Benefit Summary.

3.1 DEFINITIONS (Cont'd)

(Applicable to 93489-004, 005 and 006)

Employee: A retired Employee is a person who:

(i) has attained the age of 55 but under the age of 65 with a completion of 10 years of continuous service with the employer prior to the date of retirement; or

(ii) has completed the combination of age + service as outlined by the defined benefit plan and is under the age of 65.

All retired employees must be residents of Canada and be eligible for benefits under the provincial government health care programs in the province of residence in order to be eligible for coverage.

(Applicable to 93489-010, 016 and 017)

Employee: An Employee is a person either under or over age 65 who has completed at least 10 years of services with the employer or its affiliated companies as a permanent or long-term temporary retired employee prior to the date of retirement and has been actively at work the date prior to retirement. All employees must be residents of Canada in order to be eligible for coverage under the provincial government health care programs in the province of residence unless they are specifically mentioned in the Benefit Summary.

7. Evidence of Insurability: Evidence of Insurability shall mean all statements or medical evidence of a person's health and other information as required by the Company affecting his acceptability for insurance. All Evidence of Insurability must be submitted on forms approved by the Company for that purpose.

8. Health Care Practitioner: Shall mean a person who has met the professional and legal requirements of the jurisdiction where the care or services are provided to provide health care services. Where no such professional authority or legal requirements exist, the person must have a certificate of competency from a professional body which is responsible for established standards of competence for the conduct for the particular health care profession and the person must be acting within the scope of that license. In all instances, a person may not be a relative of the insured to be considered a Health Care Practitioner for the purposes of this plan.

3.1 DEFINITIONS (Cont'd)

9. Hospital: An institution licensed and operating under any federal or provincial health or insurance act, with facilities to provide the following: active in-patient treatment and care primarily for acute conditions; 24-hour nursing care, on-staff Physician care at all times, and diagnostic and surgical services. The term Hospital, as used in this Policy or as otherwise specified, shall not include a rehabilitation Hospital, a facility operating predominantly for the treatment of drug, alcohol or gambling addictions or mental illness, a maternity home, a nursing home, a health spa or hotel, a place for custodial care, a facility for the blind or deaf, or an institution used primarily for the treatment of a specific illness or disease.

10. Late Applicant: For Non-Mandatory benefits, a Late Applicant is an Employee or Dependent who applies for coverage under this policy more than 31 days after becoming eligible for benefits.

11. Mandatory: Shall mean the employer has made coverage under this policy a condition of employment and 100% of Employees must apply for coverage.

12. Medical Specialist: Shall mean a duly qualified Physician in Canada with an FRCP© or an FRCS© designation in his or her field which is recognized by the College of Physicians and Surgeons in that province. In all instances, a person may not be a relative of the insured to be considered a Medical Specialist for the purposes of this policy.

13. Non-Contributory: A benefit of this policy is Non-Contributory if the insured Employee is not required to pay any portion of the premium for the benefit.

14. Non-Evidence Limit: The Non-Evidence Limit shall mean the amount of insurance for which an Employee or Dependent may become insured without having to submit satisfactory Evidence of Insurability. The Non-Evidence Limits are shown in the Benefit Summary. The Non-Evidence Limit for Late Applicants is zero.

15. Non-Mandatory: Shall mean the employer has NOT made coverage a condition of employment. Standard participation levels apply. See Enrolment Requirements as shown in the Benefit Summary.

16. Physician: A Physician is a doctor of medicine who is duly licensed to prescribe and administer medical treatment and drugs and to perform surgery within the scope of this license.

17. Plan Waiting Period: The Plan Waiting Period is the period of continuous active permanent (or temporary) employment that must be completed by Employees in order to be eligible for coverage under this policy. The Plan Waiting Period is shown in the Benefit Summary. The Plan Waiting Period can be waived for any Employee at the written request of the Policyholder and only with the approval of the Company.

18. Previous Policy: The term Previous Policy as used in this policy shall mean a group insurance policy, contract or other arrangement which terminated within 31 days of the effective date of this policy and which insured Employees who are eligible for coverage under this policy. The term Previous Policy shall be construed separately for each benefit contained therein.

3.2 APPLICATION FOR INSURANCE

Eligible Employees must apply for insurance on a form which has been approved by the Company. The application shall be applicable to all benefits of this policy for which the Employee is eligible. Once dependent benefits have been added the insured Employee does not have to apply for dependent coverage for additional Dependents acquired after the original application. If this policy includes an Optional Group Life benefit on the Spouse of an insured Employee, then the Spouse must apply for the insurance on the applicable form.

3.3 COMMENCEMENT OF INSURANCE

The insurance on an Employee shall become effective on the later of the Coverage Change Date as defined in the Benefit Summary, the date of expiration of the plan waiting period and the date of completion of the application for insurance except when:

1. the Employee is not Actively at Work on the day that the insurance would otherwise become effective,
2. the amount of insurance applied for exceeds the Non-Evidence Limit, or
3. the Employee is a Late Applicant.

The insurance on each Dependent shall become effective on the later of the Coverage Change Date as defined in the Benefit Summary, the date of expiration of the plan waiting period and the date of completion of the application for insurance except when:

1. the Dependent is confined to a Hospital on the day that the insurance on the Dependent would otherwise become effective,
2. the amount of insurance applied for exceeds the Non-Evidence Limit,
3. the Dependent is a Late Applicant, or
4. other than for Optional Life, the Employee is ineligible for coverage.

If the Employee is not Actively at Work at the time that the insurance would otherwise be effective, then the insurance will take effect only when he returns to work and satisfies the Actively at Work definition. If a Dependent is confined to a Hospital on the day that the insurance would otherwise be effective, such insurance shall not become effective until the Dependent ceases to be so confined. In the case of a Child born while this coverage is in force, the Dependent coverage on the Child will be effective from their live birth or, in the case of a still birth, coverage on the Child will be effective from 28 weeks gestation.

If the amount of insurance exceeds the Non-Evidence Limit then the insurance in excess of the Non-Evidence Limit shall be subject to the submission and approval of Evidence of Insurability. The effective date of this excess insurance shall be the later of the Coverage Change Date and the date that the Evidence of Insurability is approved by the Company.

3.3 COMMENCEMENT OF INSURANCE (Cont'd)

In Non-Mandatory plans, if the Employee or Dependent is a Late Applicant, then all insurance shall be subject to the submission and approval of Evidence of Insurability. The effective date of the insurance shall be the later of the Coverage Change Date and the date that the Evidence of Insurability is approved by the Company. The Evidence of Insurability required for Late Applicants is to be provided free of expense to the Company.

In Mandatory plans, if an Employee or Dependent applies for coverage beyond 31 days of the effective date, coverage will be provided up to the Non-Evidence Limit, and retroactive premium will be collected.

3.4 TRANSFERRED BUSINESS

If this policy is replacing a Previous Policy, as that term is defined in Policy Provision 3.1, Definitions, then any person who was insured under the Previous Policy on the date that the Previous Policy terminated and who is eligible for insurance under this policy, shall become insured under this policy on the effective date of this policy. If any such person is eligible for any extended benefits under the Previous Policy, then he shall become eligible for insurance under this policy only after the extended benefits have terminated and he has returned to active permanent employment.

If such person is not Actively at Work at this date, then the benefits will be limited to the lesser of those for which he is eligible under this contract or the benefits for which he was insured under the Previous Policy on its termination date. He shall be eligible to apply for the balance of his benefits when he returns to active permanent employment.

3.5 CHANGES IN COVERAGE

A change in the coverage on an insured Employee or Dependent shall take effect on the Coverage Change Date except when:

1. the insured Employee is not Actively at Work on the Coverage Change Date,
2. the coverage on the insured Employee after the change exceeds the Non-Evidence Limit, or
3. the Company receives notification of the change in class or salary more than 31 days after the change.

If the insured Employee is not Actively at Work on the Coverage Change Date, then the change in coverage will take effect only when he returns to work and satisfies the Actively at Work definition.

If the amount of coverage exceeds the Non-Evidence Limit then the portion of the change in excess of the Non-Evidence Limit shall be subject to the submission and approval of Evidence of Insurability. The effective date of this portion of the change shall be the later of the Coverage Change Date and the date that the Evidence of Insurability is approved by the Company.

If the change was not reported to the Company within 31 days, then the change in coverage shall be subject to the submission and approval of Evidence of Insurability. The effective date of the change shall be the later of the Coverage Change Date and the date that the Evidence of Insurability is approved by the Company. The Evidence of Insurability required for late reported changes is to be provided free of expense to the Company.

3.6 TERMINATION OF INSURANCE

Except as provided in Policy Provision 3.7, Extension of Insurance, an insured Employee will cease to be insured under this policy on the earliest of the following dates:

1. the date of termination of this policy,
2. the date that he ceases to be an Employee as defined in Policy Provision 3.1, Definitions,
3. the end of the grace period for which any premium has not been paid in full, or
4. the date that he reaches the termination age specified in the Benefit Summary.

Except as provided in Policy Provision 3.7, Extension of Insurance, the insurance on each Dependent provided by this policy will cease on the earliest of the following dates:

1. the date of termination of this policy or the dependent coverage under this policy,
2. the date the insured Employee ceases to be insured under this policy, other than by death,
3. the date that the Dependent ceases to be an eligible Dependent,
4. the date that the insured Employee is no longer eligible for dependent coverage, or
5. the end of the month in which the insured Employee dies.

To the extent that a specific benefit provision contains a Termination of Insurance section, that section shall prevail.

3.7 EXTENSION OF INSURANCE

If an Employee ceases to be actively at work due to sickness or injury, the insured Employee will be considered to be still employed and eligible for continued insurance coverage until the earliest of:

1. Recovery from sickness or injury,
2. Such time as his employment with the Policyholder is terminated,
3. Such time as he ceases to be an insured Employee,
4. Such time as any disability benefits being paid under this policy are terminated,
5. One year from the date he ceases to be Actively at Work for life coverages when:
   a) an application for waiver of premium has been declined, or
   b) no application is submitted, or
   c) proof of loss is not received within 90 days following the end of the elimination period; or
6. Ninety days following the end of the elimination period, for disability coverages, when:
   a) an application for disability benefits has been declined, or
   b) no application is submitted, or
   c) proof of loss is not received within 90 days following the end of the elimination period.

If an insured Employee ceases to be actively at work due to leave of absence, strike, lock-out or temporary lay-off, the Policyholder may elect, on a basis that precludes individual selection, to continue insurance coverage for up to the maximum period indicated below:

1. Weekly Indemnity and Long Term Disability coverage can be continued for three months from the end of the month in which employment was interrupted.
2. All other coverages can be continued up to six months from the end of the month in which employment was interrupted.

If an insured Employee ceases to be Actively at Work due to a leave of absence pre-approved by the Company, the Policyholder may elect, on a basis that precludes individual selection, to continue Weekly Indemnity or Long Term Disability insurance coverage for a period not to exceed six months pre-determined and agreed upon by the Company.

If an insured Employee ceases to be Actively at Work due to an approved maternity leave and/or parental leave, the Employee shall be considered to be still employed and eligible for continued insurance coverage for the duration of the period allowed by the Employment Insurance Act, whether or not benefits are paid or payable under the Employment Insurance Act.

No change in coverage shall be permitted for an insured Employee who is not Actively at Work. All continuation of coverage is contingent upon the payment of the premiums to the Company in the normal manner.

In meeting with human rights, employment standards and employment insurance requirements, the Company will extend the terms of this policy to meet with minimum requirements of such applicable laws.

3.8 REINSTATEMENT OF INSURANCE

If an insured Employee's insurance has been terminated because of leave of absence (other than maternity and/or parental leave), strike, lock-out or temporary lay-off:

1. of less than six months, it can be reinstated immediately upon return to work provided that application is made within 31 days of the return to work.
2. of six months or more, the Employee will be considered a new Employee and any insurance will be subject to the terms of Policy Provision 3.3, Commencement of Insurance.

If an insured Employee's insurance has been terminated because of maternity and/or parental leave of absence:

1. which does not exceed the duration provided by the Employment Insurance Act, it can be reinstated immediately upon return to work provided that application is made within 31 days of the return to work,
2. which exceeds the duration provided by the Employment Insurance Act, the Employee will be considered a new Employee and any insurance will be subject to the terms of Policy Provision 3.3, Commencement of Insurance.

Under Non-Mandatory lines of benefit, if an Employee who was eligible for insurance under this contract but was not insured under this contract, for any reason whatsoever, should have his employment with the Policyholder terminated and be subsequently re-employed, then he shall be considered to be a Late Applicant. The commencement of any insurance shall be in accordance with the terms of Policy Provision 3.3, Commencement of Insurance. This provision shall be applied separately for each benefit in this policy.

Under Mandatory lines of benefit, if an Employee who was eligible for insurance under this contract but was not insured under this contract, for any reason whatsoever, should have his employment with the Policyholder terminated and be subsequently re-employed, then coverage will be provided up to the Non-Evidence Limit and retroactive premiums collected.

3.9 PROOF OF AGE AND MISSTATEMENT OF AGE

The Company shall have the right to require any insured person to provide satisfactory proof of age.

If the age of any insured person has been misstated, the benefits shall be adjusted upwards or downwards to the correct values based on the person's true age. If the person is not eligible for insurance due to age, then the insurance shall be voided and an equitable adjustment of premiums between the Company and the Policyholder shall be made for the full time that the insurance based on a misstated age has been in force.

3.10 ASSIGNMENT

No assignment by any insured Employee, or by a beneficiary of any insured Employee, of any interest in the insurance or benefits provided by this policy is permitted.

SECTION 4.0 - CLAIM PROVISIONS

4.1 PROOF OF CLAIM

Written proof, satisfactory to the Company, that a loss has been incurred under any Benefit Provision of this policy must be provided to the Company within the limits shown below. The Company does not accept liability for any loss if such proof is not provided as follows:

1. With respect to the Employee Group Life, Dependent Life, Accidental Death and Dismemberment, Critical Conditions and Waiver of Premium benefits, as soon as reasonably possible after the loss, and in no event later than one year from the date of the loss.
2. With respect to the Weekly Indemnity and Long Term Disability benefits, within 90 days immediately following the end of the Elimination Period.

The Company reserves the right to request additional proof at such intervals as it may reasonably require. Such additional proof must be provided to the Company within 90 days of any such request.

If this policy terminates, proof of loss must be provided to the Company as follows:

1. With respect to Weekly Indemnity benefits, within three months of the onset of the disability, or longer as required by applicable provincial legislation.
2. With respect to Long Term Disability benefits, within six months of the onset of the disability.

Any other claim must be submitted within six months following the termination of the policy. Failure to provide such proof will invalidate any claim.

4.2 CLAIM FORMS

Upon receipt of a written notice of claim, the Company will forward to the claimant, within 15 days after receipt of such notice, the forms that are required for filing proof of loss. If the forms are not received by the insured Employee within 15 days after giving notice, the claimant may submit proof of claim in the form of a written statement covering the occurrence, character and extent of the loss for which claim is made.

4.3 RIGHTS OF THE COMPANY AND THE CLAIMANT

The Company shall have the right and opportunity, at its own expense, to have an insured person, whose injury or Sickness is the basis of a claim, examined by a Physician(s) or Health Care Practitioner(s) designated by the Company. These examinations shall be conducted when and as often as the Company may reasonably require during the time that a claim for such person is pending under this policy.

The Company shall also have the right and opportunity to have an autopsy performed, at its own expense, in the event of the death of any insured person provided the performance of an autopsy is not forbidden by law.

4.3 RIGHTS OF THE COMPANY AND THE CLAIMANT (Cont'd)

With respect to Weekly Indemnity and Long Term Disability claims, the Company shall have the right to require that the insured Employee:

1. apply for all loss of time benefits and other income benefits to which reference is made in Policy Provision 5E.5 Integration of Benefits,
2. furnish all required proofs for such benefits, and
3. notify the Company of the amount and duration of such benefits payable to the insured Employee.

An insured Employee may select any Physician, other than himself or an immediate family member, as his attending Physician or Physicians. If this contract requires treatment by a duly qualified specialist with respect to a particular claim, then the insured Employee may select any such specialist as his attending Physician.

No legal action may be brought against the Company to claim benefits under this policy until 60 days have elapsed from the date written proof of loss has been furnished to the Company. Any such action must be brought within one year after filing such proof of loss. The time limitations expressed above shall be deemed extended to agree with the minimum limitation period for such claims in the jurisdiction in which an insured Employee resides.

4.4 PAYMENT OF CLAIMS

Benefits, other than Weekly Indemnity and Long Term Disability benefits, will be paid promptly after the receipt of the required proof of claim. Subject to the receipt of the required proof of claim, Weekly Indemnity benefits will be paid weekly in arrears and Long Term Disability benefits will be paid monthly in arrears.

Benefits that are payable as a result of the death of the insured Employee will be payable to the insured Employee's last designated beneficiary. If at the death of the insured Employee the beneficiary is not surviving or if no beneficiary has been designated, the benefit will be payable to the insured Employee's estate. All other benefits will be payable to the insured Employee. If the insured Employee dies before all benefits that are payable to him have been paid, then the remaining benefits will be made payable to the insured Employee's estate.

4.5 RIGHT OF RECOVERY

If Weekly Indemnity and Long Term Disability benefit payments made under this policy are later determined to be in excess of the amount of payment necessary to satisfy the intent of this policy, the Company reserves the right to recover any such excess. If the excess amount cannot be recovered, the Company reserves the right to reduce future benefit payments to that claimant until such excess amount is fully recovered.

4.6 SUBROGATION

Where permitted by law, the Company, upon making any payment or assuming liability therefore under the Weekly Indemnity or Long Term Disability benefits, shall be subrogated to all rights of recovery of the insured Employee against others and may bring action to enforce such rights.

If a claim, demand or action is initiated by the insured Employee with respect to the incident, event or accident that gave rise to the payment of benefits or the assuming of liability therefore under the Weekly Indemnity or Long Term Disability benefit plans, the insured Employee will include, in any such claim, demand or action, claims for all losses for which such benefits have been or may be received. Further, the insured Employee will prosecute any such claim, demand or action with diligence and good faith. The insured Employee will account to the Company in the event of a settlement, judgement or other interim or final disposition of the claim, demand or action in accordance with the following formula and terms:

1. The amount payable to the Company in relation to the insured Employee's recovery for past loss of income up to the date of settlement or judgement shall be calculated as follows:
   a) The amount by which benefits received from the Company together with any recovery from the third party or his insurer for past loss of income exceeds the actual loss of pre-disability income (net of applicable income tax if the plan is non-taxable) for any given month, plus
   b) Any prejudgement interest on the amount set out in (a) that is included in the judgement or settlement, less
   c) A proportionate share of legal fees and disbursements incurred by the insured Employee less any amount recovered in this respect through the judgement or settlement.
2. If the insured Employee recovers any amount for loss of future income under a settlement or judgement, no further benefits will be paid by the Company under this policy until such time as weekly or monthly benefits, which would otherwise be payable under this policy, equal the amount recovered for loss of future income plus any amount of legal fees and disbursement recovered in respect of such recovery less a proportionate share of legal fees and disbursement incurred by the insured Employee with respect to such recovery of loss of future income.
3. In the event of a lump sum settlement with the third party where no apportionment is made for loss of past or future income, the insured Employee must pay the Company 75% of the insured Employee's net recovery from the third party, to a maximum of the disability benefits paid to the insured Employee under this policy. This percentage of the net recovery is to be held in trust by the insured Employee for the Company until it is paid to the Company. If the net recovery is greater than the maximum of disability benefits paid to the insured Employee up to the date of the lump sum settlement, no further benefits will be paid to the insured Employee under this policy until such time as weekly or monthly benefits, which would otherwise be payable under this policy after the date of the lump sum settlement, in addition to the amounts already paid by the Company pursuant to this provision, equal 75% of the said net recovery.

4.6 SUBROGATION (Cont'd)

The insured Employee's net recovery is the total of all amounts recovered from the third party including all legal costs and disbursements, either through settlement or judgement, less the insured Employee's actual legal costs and disbursements paid to his solicitor for the said recovery.

The Company may require the insured Employee to sign an acknowledgement that the insured Employee is bound by this provision. The Company has the right to withhold or discontinue disability benefits if the insured Employee refuses or fails to comply with any of these terms.

In any case, the insured Employee will not prejudice the Company's right of subrogation. In particular, and without limiting the generality of the foregoing provision, the insured Employee will not release anyone from whom there is a potential right of recovery unless a prior written consent to the terms of settlement is provided by the Company to the insured Employee. Any release signed by the insured Employee will not bind the Company unless prior written consent is obtained from the Company.

4.7 REHABILITATION PROGRAM

A Rehabilitation Program shall mean a program of medical, employment or vocational rehabilitation. It shall consist of:

1. any medical care or treatment, diagnostic measures or any medication prescribed, or
2. full-time work, part-time work or any other employment for an insured Employee, whether or not wages or remuneration are payable, or
3. any vocational training or re-training program or period of work for the purpose of Rehabilitation.

An insured Employee who qualifies to receive Weekly Indemnity or Long Term Disability benefits under this policy may at any time be required to participate in a Rehabilitation Program, which the Company deems appropriate for his circumstances.

Benefits payable under this policy while an insured Employee is participating in a Rehabilitation Program approved by the Company will be coordinated in accordance with Policy Provision 5D.5, Weekly Indemnity, Reduction Clause and Policy Provision 5E.5, Long Term Disability, Integration of Benefits.

Refusal to enter, participate or comply with a Rehabilitation Program deemed appropriate by the Company will result in the termination of Weekly Indemnity or Long Term Disability benefit payments.

SECTION 5A - EMPLOYEE GROUP LIFE INSURANCE BENEFIT PROVISIONS

5A.1 DEATH BENEFIT

The Company will pay the beneficiary the amount of life insurance in force on the insured Employee as of the date of death upon receiving proof satisfactory to the Company that the insured Employee died by any means while insured for this benefit.

5A.2 TERMINAL ILLNESS

A special advance payment of the death benefit may be made provided that:

1. in the opinion of the Company, the insured Employee is suffering from a condition which is expected to result in death within 12 months of the date of the request for such payment, and
2. satisfactory medical certification to that effect has been provided to the Company by the insured Employee's attending Physician, and
3. the insured Employee is considered, or would be considered eligible under the terms and conditions of Policy Provision 5A.3, Total Disability Waiver of Premium Benefit provision, and
4. the insured Employee requests in writing payment of such advance.

Under no circumstances is the amount of the special advance payment to exceed 50% of the Basic Group Life coverage in force at the date of the request or $50,000, whichever is less, and only one such payment, payable in a lump sum to the insured Employee, will be made available.

It is understood that the special advance payment will be deducted from the Basic Group Life benefit otherwise payable upon the death of the insured Employee.

5A.3 TOTAL DISABILITY WAIVER OF PREMIUM BENEFIT

In this section "total disability" shall mean a state of continuous incapacity, resulting from illness or injury, which wholly prevents the insured Employee from performing the regular duties of any occupation for which he would earn 60% or more of his pre-disability Earnings and is reasonably qualified, or may so become, by training, education or experience.

Regular duties are defined as those work related activities which are considered essential to the insured Employee's performance of the occupation and which proportionately take the majority of time to complete.

The availability of such occupations, jobs or work will not be considered while assessing the insured Employee's disability.

The loss of a professional or occupational license or certification does not, in itself, constitute disability.

5A.3 TOTAL DISABILITY WAIVER OF PREMIUM BENEFIT (Cont'd)

However, if the insured Employee is disabled and qualified to receive any Long Term Disability benefits under this policy, and are not at pre-disability Earnings or working full-time hours, he shall be deemed to be totally disabled with respect to this benefit.

If, while insured under this policy, an insured Employee shall become totally disabled prior to attaining age 65 and remains so disabled for at least 105 days; then, subject to the provisions of this section, the Company shall waive the premiums for the amount of insurance in effect at the date of disability from the first of the month following any period in which the insured Employee was not at pre-disability Earnings or working full-time hours, while the insured Employee continues to be totally disabled. The subsequent termination of this policy will not affect the continuation of the insurance under this provision. This insurance shall be subject to any reductions in amount or terminations due to age included in the policy on the date that the disability commenced.

Initial written proof, satisfactory to the Company, of the insured Employee's total disability must be submitted to the Company within one year of the start of the disability. Premiums will be waived for an initial period of up to one year and for further periods each of up to one year during the continuance of total disability, provided that satisfactory proof of the continuance of such disability is submitted to the Company within three months after the Company requests such proof.

If the insured Employee has purchased an individual life insurance policy in accordance with the conversion option provision of this policy, then the insurance will not be continued under this provision unless the individual policy is first surrendered to the Company in return for an amount equal to the premiums paid thereunder.

The waiver of premium benefit under this provision will cease on the earliest of the following dates:

1. the date that his total disability ceases,
2. the date that he engages in any occupation for remuneration or profit,
3. the date that he fails to submit the required proof of disability,
4. the date on which his insurance would normally cease if he were not totally disabled, or
5. the insured Employee's 65th birthday.

5A.3 TOTAL DISABILITY WAIVER OF PREMIUM BENEFIT (Cont'd)

If the insurance under this provision is terminated because the insured Employee ceases to be totally disabled or because he fails to submit proof of total disability and,

1. if this policy is still in force and he is Actively at Work as an eligible insured Employee, he shall be immediately insured for the lesser of his scheduled amount of coverage or the amount of coverage he had while disabled, provided he applies for coverage within 31 days of returning to work,

2. if this policy is in force but the insured Employee is not eligible for coverage, he will be entitled to convert his insurance as if he had terminated his employment with the Policyholder, or

3. if this policy is no longer in force, then the insured Employee will be entitled to the same conversion rights to which he would have been entitled if his insurance had terminated because of the termination of this policy.

If the insurance under this provision terminates because the insured Employee has attained the termination age, then he will be entitled to convert his insurance as if he had terminated his employment with the Policyholder.

5A.4 RECURRENT DISABILITY

Successive periods of Total Disability occurring while this coverage is in force will be considered to be one period of Total Disability provided:

1. the insured Employee becomes Totally Disabled from the same or related causes for which his claim for total disability was previously approved by the Company, and

2. the insured Employee becomes Totally Disabled from the same or related causes within six months of being Actively at Work.

Disabilities that are due to unrelated causes are not recurrent under this provision.

If a Total Disability is considered to be a recurrent Total Disability under this provision, the Waiver of Premium benefit will resume based on the original Benefit Period and for the same amount of coverage in force on the original date of Total Disability subject to all limitations and exclusions in this Policy. A new elimination period will not be applied.

5A.5 CONVERSION OPTION

If an insured Employee's Group Life Insurance coverage ceases on or before attaining 65 years of age because of retirement, a termination of employment or termination of membership in the class of insured Employees eligible for insurance under this policy, then the insured Employee may purchase an individual life insurance policy from the Company in an amount not to exceed the lesser of the amount of Group Life Insurance for which the insured Employee was covered hereunder on the date of termination or $200,000.

This conversion option also applies to scheduled reductions or termination of coverage which become effective at specified ages.

If an insured Employee's Group Life Insurance coverage ceases on or before attaining 65 years of age because of the termination of group insurance to the group or class of insured Employees to which the insured Employee belongs, then he may purchase an individual life insurance policy from the Company. The amount of the converted policy shall not exceed the lesser of the amount of Group Life Insurance for which the insured Employee was covered on the termination date or $200,000. If this group insurance is replaced in whole or in part by another group insurance policy within 31 days of the termination date, then the amount of the converted policy will be further limited to the reduction in Group Life Insurance on the insured Employee caused by the replacement policy.

All individual life insurance issued under this provision shall be subject to the following terms and conditions:

1. The insured Employee must submit a written application and the required premium to the Company within 31 days of the date of termination of the group insurance. The individual policy shall be exchanged for all life insurance benefits on the insured Employee under this group policy.

2. The individual policy will be issued without requiring any Evidence of Insurability from the insured Employee.

3. The effective date of the individual policy will be 31 days after the date of termination. During the 31 day period that this conversion option may be exercised, the Group Life Insurance coverage for the amount of the conversion option is continued in force without charge.

4. The individual policy shall not include any disability or other supplementary benefits. The premium for the policy shall be based on the Company's individual policy rates in effect on the date of application and the age and sex of the insured Employee on the effective date.

5A.5 CONVERSION OPTION (Cont'd)

5. The types of individual plans available for conversion are:

   a) a one-year term insurance policy that can be exchanged prior to its expiry date for a life insurance policy as described in (b) and (c) below;
   b) a non-convertible term insurance policy that provides level term insurance to age 65; or
   c) a term to age 100 policy that provides lifetime coverage with no non-forfeiture options.

6. If the insured Employee decides to purchase an individual policy under this provision for an amount less than the amount of the conversion option, then the amount selected must not be less than the minimum amount that the Company will normally issue for the plan selected.

5A.6 BENEFICIARIES

Subject to any statutory restrictions, any insured Employee may designate a beneficiary for life insurance benefits. The designation must be in writing and on the forms approved for this purpose by the Company.

5A.7 OPTIONAL MODES OF SETTLEMENT

Any life insurance benefits shall normally be payable in a lump sum. An insured Employee may elect to have the proceeds payable in installments of such amounts and at such intervals as the insured Employee, with the consent of the Company, may select. The insured Employee may also revoke such election of an optional mode of settlement. If no such election is in effect at the insured Employee's death, then the beneficiary, with the consent of the Company, shall have the right to elect an optional mode of settlement. The interest rate applicable to optional modes of settlement shall be determined by the Company on the date that the claim is approved for payment.

SECTION 5B - DEPENDENT LIFE INSURANCE BENEFIT PROVISIONS

5B.1 DEATH BENEFIT

The Company will pay the insured Employee the amount of life insurance in force on a Dependent on the date of death upon receiving proof satisfactory to the Company that the Dependent died by any means while insured for this benefit.

5B.2 TOTAL DISABILITY WAIVER OF PREMIUM

Subject to the terms and conditions of Policy Provision 5A.3 (Total Disability Waiver of Premium Benefit for Group Life Insurance benefit), when the Group Life Insurance premiums are being waived for a disabled insured Employee, the Dependent Life Insurance premiums shall also be waived for the Dependent Life Insurance in effect at the date of disability. Notwithstanding the terms and conditions of Policy Provision 5A.3, termination of the master contract will also cause the Waiver of Premium on the Dependent Life Insurance to be terminated.

5B.3 CONVERSION OPTION

If the life insurance on a Spouse under this benefit terminates because of

1. the death of the insured Employee, or
2. the termination of the insured Employee's Group Life Insurance for any reason which entitles the insured Employee to convert this life insurance in accordance with Policy Provision 5A.5 Group Life Insurance - Conversion Option, or
3. divorce or legal separation from the insured Employee,

then the Spouse may purchase an individual life insurance policy from the Company in an amount not to exceed the amount of Spouse life insurance which terminates. If the Spouse is eligible to exercise the Conversion Option privilege, then the insurance on the Spouse shall be extended to the end of the 31 day conversion period.

All individual life insurance issued under this provision shall be subject to the terms and conditions described in Policy Provision 5A.5 with the provision that all references to the insured Employee shall pertain to the Spouse.

This Conversion Option shall not extend to any insurance on the Dependent Children of the insured Employee.

5B.4 PAYMENT OF INSURANCE

The death benefit for this coverage shall be payable in a lump sum to the insured Employee. Any beneficiary designation made under this policy shall have no effect on any benefits payable under the Dependent Life Insurance.

SECTION 5E - LONG TERM DISABILITY INSURANCE BENEFIT PROVISIONS

5E.1 DEFINITIONS

This subsection contains the definition of terms that will apply to the Long Term Disability benefit under this policy.

1. Accident: Accident means bodily injury suffered by accidental, external and violent means which, directly and independently of all other causes, results in the insured Employee's becoming disabled within 30 days after the date the injury was sustained.

2. Benefit Period: The Benefit Period is the period of time during which Long Term Disability benefits are payable, provided the insured Employee remains Totally Disabled. The Benefit Period commences upon the expiration of the Elimination Period. The Benefit Period for this policy is shown in the Benefit Summary, and it is expressed as a duration of time either in years and months or to an attained age.

3. Elimination Period: The benefit Elimination Period is that period of time which must elapse between the onset of the disability and the date on which the Company begins paying Long Term Disability benefits to the disabled Employee.

   Where the disability is not continuous, the days the insured Employee is disabled may be accumulated to satisfy the Elimination Period, provided that:

   a) coverage remains in force during the accumulation of the Elimination Period;
   b) no interruption is longer than 2 weeks;
   c) the disabilities are due to the same or related cause; and
   d) each period of Total Disability is completed within 365 days after the start of the Elimination Period, or as pre-approved by the Company if longer.

   The Elimination Period for this benefit is shown in the Benefit Summary.

4. Partial Disability: To be considered Partially Disabled, an insured Employee must be deemed Totally Disabled throughout the Elimination Period shown in the Benefit Summary. If, following the Elimination Period, an insured Employee is only capable of returning to the workforce in a reduced capacity, benefits will be paid in accordance with Policy Provision 5E.5, Integration of Benefits and Policy Provision 4.7, Rehabilitation Program.

5. Pre-Disability Earnings: With respect to Policy Provision 5E.5, Integration of Benefits, Pre-Disability Earnings for taxable plans shall mean the gross basic monthly earnings as defined in Policy Provision 3.1(5) received by the insured Employee immediately prior to the date of disability. For non-taxable plans, Pre-Disability Earnings shall mean gross Earnings as defined above minus income tax, as defined in the applicable Payroll Deductions Table authorized by Canada Revenue Agency.

6. Primary Benefits: With respect to Policy Provision 5E.5, Integration of Benefits, Primary Benefits under the Canada or Quebec Pension Plans refer to disability benefits made in respect of the plan member only.

SECTION 5E - LONG TERM DISABILITY INSURANCE BENEFIT PROVISIONS

5E.1 DEFINITIONS (Cont'd)

7. Sickness: All disabilities that are not the result of an Accident, as defined above, shall be deemed to be a result of Sickness.

8. Total Disability means:

   a) The complete and continuous inability of the insured Employee to perform the regular duties of his own occupation as a result of illness or injury, during the Elimination Period and for the following 24 months; and
   b) Thereafter, "Total Disability" means a state of continuous incapacity, resulting from illness or injury, which wholly prevents the insured Employee from performing the regular duties of any occupation for which he:

      - would earn 60% or more of his pre-disability Earnings; and
      - is reasonably qualified, or may so become, by training, education or experience.

   Regular duties are defined as those work related activities which are considered essential to the insured Employee's performance of the occupation and which proportionately take the majority of time to complete.

   The availability of such occupations, jobs or work will not be considered while assessing the insured Employee's disability.

   The loss of a professional or occupational license or certification does not, in itself, constitute disability.

5E.2 DISABILITY BENEFIT

If an Employee, while insured for this benefit, becomes Totally Disabled as defined in Policy Provision 5E.1, Definitions, then subject to the terms and conditions of this benefit, the Company will pay the insured Employee the Long Term Disability benefit for which he was insured on the date of disability during the Benefit Period while he remains so disabled.

If any benefit payment represents a period of disability for less than one month, then the payment shall be equal to one-thirtieth of the monthly benefit, otherwise payable, multiplied by the number of days for which payment is being made.

SECTION 5E - LONG TERM DISABILITY INSURANCE BENEFIT PROVISIONS

5E.3 RECURRENT DISABILITY

Successive periods of Total Disability occurring while this coverage is in force will be considered to be one period of Total Disability provided:

1. the insured Employee becomes Totally Disabled from the same or related causes for which his claim for Long Term Disability was previously approved by the Company, and
2. the insured Employee becomes Totally Disabled from the same or related causes within six months of being Actively at Work.

In the event an insured Employee returns to work for a new employer and is without disability coverage he may be eligible to claim under this provision provided:

1. his employment with the new employer is part of a return to work program that was pre-approved by the Company,
2. his claim for disability is not approved under any other plan, and
3. he becomes Totally Disabled from the same or related causes within six months of being Actively at Work.

Disabilities that are due to unrelated causes are not recurrent under this provision.

If a Total Disability is considered to be a recurrent Total Disability under this provision, benefits will resume based on the original Benefit Period and for the same amount of coverage in force on the original date of Total Disability subject to all limitations and exclusions in this policy. A new Elimination Period will not be applied.

5E.4 EXCLUSIONS AND LIMITATIONS

No benefit shall be payable if a disability, illness, injury or accident occurs while participating in or engaged in any criminal activity, regardless of whether charges are laid or a conviction obtained.

Also, Long Term Disability benefits are not payable for any of the following:

1. any period of disability during which the insured Employee is not under appropriate treatment and care of a medical Physician who is a registered Medical Specialist or Health Care Practitioner in the field of medicine which is applicable to the insured Employee's condition,

2. any period during which the insured Employee is not undergoing a course of medical treatment or participation in a program of Rehabilitation which, in the opinion of the Company, is deemed appropriate,

5E.4 EXCLUSIONS AND LIMITATIONS (Cont'd)

3. any period during which the insured Employee is imprisoned,

4. any disability due to or resulting from self-inflicted injury or Sickness, while sane or insane,

5. any disability due to or resulting from insurrection, war (declared or not) or the hostile actions of the armed forces of any country, or the participation in any riot or civil commotion,

6. any disability during the period:

   a) of formal maternity leave taken by the insured Employee pursuant to provincial or federal law, or pursuant to mutual agreement between the insured Employee and the employer, or
   b) in which employment insurance maternity benefits are being paid or would be paid if the insured Employee were eligible,

   whichever is the longer.

7. any period during which the insured Employee is absent from Canada due to any reason, unless the Company agrees in writing in advance to pay benefits during the period.

SECTION 5E - LONG TERM DISABILITY INSURANCE BENEFIT PROVISIONS

5E.5 INTEGRATION OF BENEFITS (Direct Offset)

The amount of monthly Long Term Disability benefit to which the insured Employee is entitled as of the date of disability will be coordinated with other income payments to which he becomes entitled as a result of the current disability. The benefit co-ordination shall be applied as follows:

1. The amount of monthly income otherwise payable is reduced directly by any disability benefits available from the Canada or Quebec Pension Plan (primary benefits only), the Workers' Compensation Act and "income from all other sources". "Income from all other sources" includes:

   a) disability benefits available under any other government program excluding secondary benefits under the Canada or Quebec Pension Plan,
   b) retirement benefits provided by any employer or government program,
   c) income or benefits payable under any group program provided by or through the employer,
   d) income or benefits payable under a plan sponsored by an association, union or fraternal organization of which the insured Employee is a member,
   e) income replacement benefits payable under any plan of automobile insurance, where such reduction is not prohibited by law, and
   f) wages or remuneration payable from any employer or from self-employment, but excluding 100% of Earnings received under an approved Rehabilitation Program. (For non-taxable plans, Earnings shall mean gross Earnings minus income tax. For taxable plans, Earnings shall mean gross Earnings).

2. The amount determined in 1. above is further reduced if necessary, so that the amount of monthly income, including all amounts of income mentioned in 1. above, does not exceed 100% of the insured Employee's Pre-Disability Earnings.

During the period of an approved Rehabilitation Program, the amount of monthly income as defined above, will be further reduced if necessary, so that the amount of monthly income together with all amounts of income mentioned in 1. above, including 100% of Earnings received from an approved Rehabilitation Program, does not exceed 100% of pre-disability Earnings.

The amount of the Long Term Disability benefit payable by the Company will not be affected by changes in the Canada or Quebec Pension Plan Benefit unless the changes result from:

1. the correction of an error made in the initial award,
2. change in dependent status, or
3. a change in the benefit formula under the Canada or Quebec Pension Plan.

The Company reserves the right to estimate the amount of the Canada or Quebec Pension Plan disability benefit pending receipt of advice of the actual benefit award.

SECTION 5E - LONG TERM DISABILITY INSURANCE BENEFIT PROVISIONS

5E.6 TOTAL DISABILITY WAIVER OF PREMIUM

Any premium due under this benefit with respect to a Totally Disabled insured Employee who qualifies for Long Term Disability benefits, and is not at pre-disability Earnings or working full-time hours, will be waived commencing with the first full calendar month following the expiration of the Elimination Period, or the first of the month following any period in which the insured Employee was not at pre-disability Earnings or working full-time hours, until such time as the insured Employee returns to active permanent employment or no longer qualifies for benefits. Subject to Policy Provision 5E.3, Recurrent Disability, Long Term Disability coverage will be reinstated upon the insured Employee returning to work and premiums will be charged commencing on the first of the next month.

5E.7 TERMINATION OF BENEFIT PAYMENTS

When an insured Employee becomes Totally Disabled according to the terms of this benefit and the Company has begun making monthly benefit payments, then the benefit payments shall cease on the earliest of:

1. the date the insured Employee ceases to be Totally Disabled, or
2. the date when the specified maximum benefit period has been reached, or attainment of age 65, whichever is earlier, or
3. the date on which the disabled Employee fails to furnish satisfactory proof of the continuance of Total Disability, or fails to submit to an examination requested by the Company, or
4. the date the disabled insured Employee is not under the continuous care and treatment of a Physician who has the medical credentials deemed appropriate to the Company, or
5. the date the disabled insured Employee refuses to enter a Rehabilitation Program which is considered appropriate by the Company, or
6. the date the insured Employee dies.

5E.8 EXTENSION OF BENEFITS

Termination of this policy or the Long Term Disability benefit will not prejudice any disability claim, provided that such disability occurred before the termination date and is reported to the Company not later than six months after the commencement of disability.

SECTION 5F – EMPLOYEE AND ELIGIBLE SPOUSE OPTIONAL GROUP LIFE INSURANCE BENEFIT PROVISIONS

5F.1 DEATH BENEFIT

The Company will pay the amount of Optional Group Life Insurance in force on the insured Employee or his/her covered Dependent as of the date of death upon receiving proof satisfactory to the Company that the covered person died while insured for this benefit.

5F.2 LIMITATION OF COVERAGE

In the event of the death of an insured person by suicide, while sane or insane, the payment to be made with respect to any amount of optional insurance, which has been in force less than two consecutive years during the insured person's lifetime, shall be limited to the return of premiums.

5F.3 TOTAL DISABILITY WAIVER OF PREMIUM BENEFIT

Subject to the terms and conditions of Policy Provision 5A.3, Total Disability Waiver of Premium Benefit for Group Life Insurance benefit, when the Group Life Insurance premiums are being waived for a disabled insured Employee, the Optional Group Life Insurance premiums shall also be waived for the Optional Group Life Insurance in effect at the date of disability.

5F.4 CONVERSION OPTION

If an Employee's Optional Group Life insurance coverage ceases on or before attaining 65 years of age because of retirement, a termination of employment or termination of membership in the class of Employees eligible for insurance under this policy, then the insured Employee may purchase an individual life insurance policy from the Company in an amount not to exceed the lesser of the total amount of Group Life plus Optional Group Life insurance for which the insured Employee was covered hereunder on the date of termination or $200,000.

If the life insurance on a Spouse under this benefit terminates on or before attaining 65 years of age because of:

1. the death of the insured Employee, or
2. the termination of the insured Employee's Group Life Insurance for any reason which entitles the insured Employee to convert this life insurance in accordance with Policy Provision 5A.5 Group Life Insurance, Conversion Option, or
3. divorce or legal separation from the insured Employee,

then the Spouse may purchase an individual life insurance policy from the Company in an amount not to exceed the amount of Optional Group Life Insurance on the Spouse which terminated.

SECTION 5F – EMPLOYEE AND ELIGIBLE SPOUSE OPTIONAL GROUP LIFE INSURANCE BENEFIT PROVISIONS

5F.4 CONVERSION OPTION (Cont'd)

All individual life insurance issued under this provision shall be subject to the terms and conditions described in Policy Provision 5A.5, Conversion Option, with the provision that all references to the insured Employee shall pertain to either the insured Employee or the Spouse as the case may be.

This Conversion Option shall not extend to any insurance on the Dependent Children of the insured Employee.

5F.5 TERMINATION OF INSURANCE

All Optional Group Life Insurance will terminate on the earliest of:

1. the date that the insured Employee ceases to be eligible for Group Life Insurance under this policy,
2. the date of termination of this provision,
3. the earlier of retirement or the day on which the insured Employee attains the termination age specified in the Benefit Summary, or
4. the date that the insured Employee ceases to pay the premium for this coverage.

The Optional Group Life insurance on an insured Employee's Dependent will cease on the earlier of the date that such person ceases to be a Dependent as defined in this policy or the day on which the Dependent attains age 65.

5F.6 PAYMENT OF INSURANCE

Any benefit payable under this coverage will be paid to the insured Employee, if living, or to the insured Employee's beneficiary as designated under this policy.