PLAN NAME:	CANADIAN PACIFIC RAILWAY (including St. Lawrence & Hudson)
UNION:	CANADIAN COUNCIL OF RAILWAY OPERATING UNIONS
PLAN NUMBER:	51078
INSURANCE COMPANY:	Great West Life
EFFECTIVE DATE:	August 1, 1999
BENEFITS PROVIDED:	Dentalcare Benefits

TABLE OF CONTENTS

1.1 TABLE OF BENEFITS

This Table of Benefits by itself has no full meaning and must only be interpreted in conjunction with other provisions of this plan.

ELIGIBLE CLASSES:	All employees represented by the associated non-operating unions
DENTALCARE COVERED EXPENSES *	
Covered expenses	Routine, Major and Orthodontic Treatment
Dental fee guide	
- for treatment rendered inside Canada	dental fee guide in effect on the date the treatment is rendered for the province in which the treatment is rendered, up to and including December 31, 2002
- for treatment rendered outside Canada	dental fee guide in effect in the employee's province of residence on the date treatment is rendered, up to and including December 31, 2002
Individual Calendar Year Deductible Amount	$35
Family Calendar Year Deductible Amount	$35
Reimbursement Level:	
- for Routine Treatment	100%
- for Major Treatment	50%
- for Orthodontic Treatment *	80%
Routine/Major Maximum Amount	$1,000/calendar year 1999
Routine/Major Maximum Amount	$1,100/calendar year 2000
Routine/Major Maximum Amount	$1,200/calendar year 2001
Routine/Major Maximum Amount	$1,300/calendar year 2002
If eligible after July 1 of each year Maximum Amount will be adjusted by 50%	($500, $550, $600, $650.)
Orthodontic Maximum Amount *	$1,500 lifetime

2.1 DEFINITIONS

In this plan:

(1) "Employer" means a Railway.

(2) "Railway" means Canadian Pacific Limited and its subsidiaries, joint properties listed in the union agreement, an employer associated with the Railway, a group of whose employees have been admitted as provided by the union agreement and for the purpose of this plan, Algoma Central Railway.

(3) "Administrator" means the organization appointed by the Employer to administer the employee benefits program.

(4) "Employee" means an employee of the Railway who is eligible for dentalcare benefits pursuant to the eligibility requirements of the union agreement.

(5) "Service" and "Work" means employment with the Employer.

(6) "Work" means active work in the service of the Employer.

(7) "Dependent" means

(a) the employee's spouse, where spouse means

(i) the person who is legally married to you and who is residing with or supported by you, provided that there is no legally married spouse that is eligible, it is the person that qualifies as a "spouse" under the definition of that word in Section 2(1) of the Canadian Human Rights Benefits Regulations, so long as such person who may be of the same or opposite sex and was publicly represented by you as your "spouse" and cohabited with you in a conjugal relationship for:

- at least one (1) year if you and that person were free to marry:or

- at least three (3) years if either of you was not free to marry the other.

(b) any unemployed dependent child, stepchild or adopted child of an employee

(i) under age 21 and residing with the eligible employee or the eligible spouse of the employee, or
(ii) under age 25 if registered as a full-time college or university student, or
(iii) of any age if handicapped and solely dependent upon the employee.

the term "dependent" shall not include any person who is covered under the plan as an employee.

(8) "Physician" means a licensed doctor of medicine.

(9) "Surgeon" means a licensed doctor of medicine.

(10) "Dental Plan agreement" means the agreement entered into by the Employer and the Unions on December 10, 1985.

3.1 GENERAL LIMITATIONS

The following General Limitations are applicable to all Benefit Provisions.

General Limitation (a)

If an employee or dependent incurs covered expenses for an accidental bodily injury or a sickness arising out of employment for remuneration or profit, such covered expenses shall be reduced by the amount of any benefits to which the person is entitled in accordance with any Workers' Compensation or similar law.

General Limitation (b)

No benefits shall be payable for or on account of

(1) expenses, or portion thereof, for services and supplies covered under a government hospital or health plan or any other government plan, or
(2) services and supplies provided by a government hospital or health plan in which the employee or dependent is eligible to participate, or
(3) services and supplies rendered or provided to the employee or dependent to which such person is entitled without charge pursuant to any law, or for which there is no cost to the employee or dependent except for the existence of coverage against such cost, or
(4) services and supplies received in a hospital owned or operated by the Government of Canada or the Government of the United States, unless the employee or dependent is required to pay for such services regardless of the existence of coverage, or
(5) services and supplies provided by a dental or medical department maintained by the Employer, a mutual benefit association, labour union, trustee, or similar type of group, or
(6) services and supplies which are legally prohibited from coverage.

General Limitation (c)

No benefits shall be payable for or on account of services and supplies resulting from or associated with

(1) service, including part-time or temporary service, in the armed forces of any country, or

(2) war (declared or undeclared), insurrection, or participation in a riot, or
(3) any intentionally self-inflicted injury or disease, while sane or insane, or
(4) treatment rendered for aesthetic purposes.

4.1 EMPLOYEES ELIGIBLE FOR COVERAGE

(1) An employee is on the first day of the month following the date on which he completes 12 months of compensated service.

An employee who has compensated service for a regular or partial 8-hour shift for 252 days will be considered to have completed 12 months of compensated service. For employees who are covered by spare board provisions, days worked or available will be considered to be days of service.

(2) If the coverage of an employee was terminated during a leave of absence, temporary lay-off, strike or is dismissed and subsequently reinstated, it shall be automatically reinstated on the date his service recommences.

(3) Only employees listed in the Table of Benefits are eligible.

5.1 EFFECTIVE DATE OF AN ELIGIBLE EMPLOYEE'S COVERAGE

The coverage of an eligible employee becomes effective on the date he becomes eligible.

Coverage for an employee's dependents becomes effective when the employee's coverage becomes effective or when the dependent first qualifies as a dependent, whichever is later.

It is, however, specifically provided that the coverage of any employee who is not actively at work or receiving pay from the Employer on the date his coverage would otherwise become effective, shall not become effective until the date of his return to work.

6.1 AMOUNT OF COVERAGE

(1) Each employee covered hereunder shall be covered in the Eligible Class to which he belongs on the basis of the Table of Benefits.

On the date on which the factors which determine to what Class an employee belongs change so as to move the employee from the Eligible Class in which he is then covered into another Eligible Class, he shall become automatically covered in the new Class, provided

(a) he is then actively at work or receiving pay from the Employer, otherwise on the date of his return to work, and

(b) that payment in respect of any dependent for a benefit period which commenced prior to the date of the change in Class shall be made in accordance with the previous Class.

(2) The benefits for which an employee is covered in respect of himself and his dependents shall be those shown in the Table of Benefits for the Class in which he is covered.

Any increase in benefits for an employee who is not actively at work or receiving pay from the Employer on the date such increase would otherwise become effective shall not become effective until the date of his return to work. Payment in respect of a dependent for expenses incurred during a period of hospital confinement which began before the date of the increase in benefits shall be made in accordance with the terms of the plan prior to the increase.

7.1 TERMINATION OF AN EMPLOYEE'S COVERAGE

The coverage of an employee under this plan terminates automatically on the earliest of the following dates:

(1) the date of termination of this plan, or

(2) the date he ceases to be in an eligible class, or

(3) the date which is

(a) the last day of the month during which an employee transfers from an eligible class into a class which is not eligible for coverage under this plan, or

(b) the date his service terminates, or

(c) the date of termination of coverage determined by the Employer in accordance with a plan which precludes individual selection.

If federal or provincial legislation requires the Employer to continue an employee's coverage beyond the date it would otherwise terminate in accordance with this item (3), then his coverage will be continued to the end of the period required by law.

Coverage for an employee's dependents terminates when the employee's coverage terminates or when the dependent ceases to qualify as a dependent in accordance with the DEFINITIONS provision.

GENERAL PROVISIONS

8.1 Notice of Claim

Written notice of claim must be given to the Administrator within sixty days after any expense covered by the Dental Plan has been incurred, or as soon thereafter as is reasonably possible.

9.1 Time of Payment of Benefits

Benefits payable under this Dental Plan for any Covered Expense will be paid by the Administrator immediately upon receipt of due written proof of such Expense.

10.1 Payment of Claims

If any benefit of this Dental Plan shall be payable to the estate of an Eligible Employee or to an Eligible Employee not competent to give a valid release, the Administrator shall pay such benefit up to the maximum provided for under the Dental Plan to the proper legal representative of the Eligible Employee. Any payment made by the Administrator in good faith pursuant to this Provision shall fully discharge the Employer to the extent of such payment.

The benefits provided by this Dental Plan shall be paid directly to the Eligible Employee unless he directs on the claim form that such benefits or part thereof shall be paid directly to the provider of the services covered hereby.

11.1 Claims Review Procedure

Any employee who is denied all or any part of a claim for reimbursement by the Administrator shall receive from the Administrator a notice in writing setting forth the specific reasons for such denial, specific reference to the Dental Plan's provisions on which the denial is based, a description of any additional material necessary for the claimant to support the claim, and explanations both as to why such material is necessary and as to the terms of the Dental Plan's claims review procedure, all written in a manner calculated to be understood by the person whose claim has been denied.

Any employee whose claim has been denied by the Administrator may submit, within sixty days after such denial, information and material in support of the claim to the Administrator's claims review section. Within sixty days of receiving such submission, the claims review section shall review it and make a determination. This determination shall be final, shall be in writing, shall include specific reasons for the decision and specific reference to the Dental Plan provisions on which it is based; it shall also be written in a manner calculated to be understood by the claimant. In connection with any such review, the claimant will be permitted to examine pertinent documents and to submit issues and comments in writing.

12.1 Physical Examinations

The Administrator, at its own expense, shall have the right and opportunity to have the Eligible Employee or Dependent examined when and as often as it may reasonably require during the pendency of a benefit payment hereunder.

13.1 Legal Actions

No action at law shall be brought to recover benefits payable under this Dental Plan prior to the expiration of sixty days after written proof of loss has been furnished in accordance with the requirements of this Dental Plan. No such action shall be brought after the expiration of three years after the time written proof of loss is required to be furnished.

14.1 GENDER

Words implying the masculine gender shall include the feminine, unless the context otherwise requires.

15.1 PROVISION FOR CO-ORDINATION BETWEEN THIS PLAN AND OTHER BENEFITS

A. Benefits Subject to this Provision

All of the benefits provided under the plan are subject to this provision.

B. Definitions

(1) "Arrangement" means, to the extent permitted by law, any arrangement providing benefits or services for or by reason of medical or dental care or treatment, which benefits or services are provided by

(a) any group or group-type

(i) insurance policy,
(ii) prepayment subscriber contract, or
(iii) automobile insurance plan,

but shall not include

(i) any group or group-type hospital 'indemnity' plan providing a benefit of $30 or less per day UNLESS the benefit is characterized as a 'reimbursement' type benefit but the insured has the right to elect an 'indemnity' type benefit at the time of the claim,

(ii) any group or group-type school accident plan which provides coverage for grammar or high school students for accidents only and for which the parent pays the entire premium;

(b) any labour-management trustee plan, union welfare plan, employer organization plan, or employee benefit organization plan;

(c) any governmental plan which provides benefits or services, and any coverage required or provided by any statute;

(d) any individual automobile insurance plan.

The term "group-type" means any policy, contract or plan which

(i) is not available to the general public, and
(ii) can be obtained and maintained only because of the covered person's membership in or connection with a particular organization or group,

regardless of whether individual policy forms are utilized, and whether such plan is designated as 'franchise', 'blanket' or in some other fashion.

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

(2) "This arrangement" means that portion of this plan which provides the benefits that are subject to this provision.

(3) "Allowable Expense" means any necessary, reasonable, and customary item of expense at least a portion of which is covered under at least one of the arrangements covering the person for whom claim is made or service provided.

Benefits under a governmental plan shall be taken into consideration without expanding the definition of "Allowable Expense" beyond the hospital, medical and surgical benefits as may be provided by such governmental plan.

When an arrangement provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

(4) "Claim Determination Period" means a calendar year (the period of one year commencing on a January 1.

C. Effect on Benefits

(1) This provision shall apply in determining the benefits as to a person covered under this Plan for any Claim Determination Period if, for the Allowable Expenses incurred as to such person during such period, the sum of

(a) the benefits that would be payable under this Plan without this provision, and

(b) the benefits that would be payable under all other Plans without similar provisions,

would exceed such Allowable Expenses.

(2) As to any Claim Determination Period with respect to which this provision is applicable, the benefits that would be payable under this Plan without this provision for the Allowable Expenses incurred as to such person during such Claim Determination Period shall be reduced to the extent necessary so that the sum of (a) such reduced benefits and (b) all the benefits payable for such Allowable Expenses under all other Plans, except as provided in item (3) of this Section C, shall not exceed the total of such Allowable Expenses. Benefits payable under another Plan include the benefits that would have been payable had claim been duly made therefor.

(3) If

(a) another Plan which is involved in item (2) of this Section C and which contains a provision co-ordinating its benefits with those of this Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined, and

(b) the rules set forth in item (4) of this Section C would require this Plan to determine its benefits before such other Plan,

then the benefits of such other Plan will be ignored for the purposes of determining the benefits under this Plan.

(4) For the purposes of item (3) of this Section C, the rules establishing the order of benefit determination are:

(a) Benefits will be determined first under the Plan which covers the person for whom expenses have been incurred:

(i) other than as a dependent; or
(ii) as a dependent of the person whose date of birth, excluding year of birth, is earlier in the calendar year.

(b) When rules (i) and (ii) do not establish an order of benefit determination, or another Plan contains different rules, benefits will be pro-rated between or amongst the Plans in proportion to the amounts that would have been paid under each Plan in the absence of other coverage.

(5) When this provision operates to reduce the total amount of benefits otherwise payable as to a person covered under this Plan during any Claim Determination Period, each benefit that would be payable without this provision shall be reduced proportionately, and such reduced amount shall be charged against any applicable benefit limit of this Plan.

D. Right to Receive and Release Necessary Information

For the purposes of determining the applicability of and implementing the terms of this provision of this arrangement or any provision of similar purpose of any other arrangement, the Employer may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person any information, with respect to any person, which the Employer deems to be necessary for such purposes. Any person claiming benefits under this arrangement shall furnish to the Employer such information as may be necessary to implement this provision.

E. Claim Payment Time Limit

If the investigation of possible other coverage for COB purposes delays payment beyond 60 days, payment of the claim shall be made. If such payment is made as the primary arrangement because there is insufficient information to make payment as the secondary arrangement, the Employer shall have the right to recover such excess benefits in accordance with the RIGHT OF RECOVERY provision.

F. Facility of Payment

Whenever payments which should have been made under this arrangement in accordance with this provision have been made under any other arrangements, the Employer shall have the right, exercisable alone and in its sole discretion, to pay over to any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this arrangement and, to the extent of such payments, the Employer shall be fully discharged from liability under this arrangement.

G. Right of Recovery

Whenever payments have been made by the Employer with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Employer shall have the right to recover such payments, to the extent of such excess, from among one or more of the following, as the Employer shall determine: any persons to or for or with respect to whom such payments were made, any insurance companies, any other organizations.

16.1 DENTALCARE EXPENSE BENEFITS

COVERAGE CLAUSE -

Subject to the other sections of this Benefit Provision, if an employee incurs Covered Expenses

(1) as a result of treatment necessarily rendered, and
(2) while covered under this Benefit Provision in respect of the person for whom such Covered Expenses are incurred,

the Employer shall pay the Reimbursement Level stated below of those Covered Expenses incurred in respect of any one person in any one calendar year which exceed the Individual Calendar Year Deductible Amount of $35:

(a) for Routine Treatment, 100%;
(b) for Major Treatment, 50%; and
(c) for Orthodontic Treatment, 80%.

DEFINITIONS -

(1) "Treatment necessarily rendered" means necessary treatment rendered

    (a) for the prevention of dental disease or dental defect, limited to those services and supplies listed in the definition of Covered Expenses, and
    (b) for the correction of dental disease, dental defect or accidental dental injury,

    provided that such treatment is consistent with generally accepted practice.

(2) "Reasonable and customary charges necessarily incurred" means charges for services and supplies of the level usually required for cases of the nature and severity of the case being treated, and which

    (a) in respect of services, are in accordance with the official fee schedule in the area, or are in accordance with representative fee practices and tariffs where there is no such fee schedule;

    (b) in respect of supplies, are in accordance with representative prices in the area.

(3) "Physician" and "Surgeon" mean physician and surgeon as defined in the DEFINITIONS section which forms part of the plan to which this Benefit Provision is attached.

(4) "Dentist" and "Oral Surgeon" mean persons licensed to practice dentistry.

(5) "Orthodontist" means a dentist who is certified to practice orthodontics.

(6) "Dental Assistant" means a person qualified to perform the service rendered, and shall include a dental hygienist and any other similarly qualified person.

(7) "Denturist" means a person qualified to perform the service rendered, and shall include a dental therapist, denturologist and any other similarly qualified person.

(8) "Treatment Plan" means a written report, in a form supplied or approved by the Employer, prepared by the attending practitioner as the result of his examination of the patient, and providing the following:

(a) the recommended treatment for the complete correction of any dental disease,defect or accidental dental injury, and

(b) the period during which the recommended treatment is to be rendered, and

(c) the estimated cost of the recommended treatment and necessary appliances.

(9) "Treatment Period" means the period during which a planned course of dental treatment is to be rendered, as estimated in the Treatment Plan, for the complete correction of any dental disease, dental defect or accidental dental injury.

(10) "Accidental Dental Injury" means an unexpected and unforeseen injury to the dental and contiguous structures happening without the direct intent of the person injured or happening as the direct result of his intentional act, such act not amounting to violent or negligent exposure to unnecessary danger.

COVERED EXPENSES -

Where permitted by law, the Employer shall consider as Covered Expenses reasonable and customary charges necessarily incurred for the types of dental treatment described below to the extent that such

treatment or portion thereof is not covered by the Medical Care Insurance Plan or any government dental plan or any other government health plan of the employee's home province. In no event shall Covered Expenses exceed the amount shown for a General Practitioner in the dental fee guide identified in the Table of Benefits for the employee's Class, except that

(1) if a service is rendered by a dentist who is a specialist, and such dental fee guide contains a separate fee guide for his specialty, the maximum Covered Expense for such service shall be the amount listed in the guide for such specialty, and

(2) if a service is rendered by a dental assistant or denturist who is a member of a provincial group of Dental Assistants or Denturists which has its own official fee guide, the maximum Covered Expense for such service shall be the amount listed in such guide.

Except as otherwise provided in the "Special Benefit Payment Provision Applicable to Orthodontic Treatment", a Covered Expense is deemed to have been incurred on the date the service was rendered or the supply purchased.

Covered Expenses for an employee of Algoma Central Railway shall include Routine and Major Treatment Covered Expenses. Covered Expenses for any other employee shall include Routine, Major and Orthodontic Treatment Covered Expenses.

Routine Treatment - rendered or prescribed by a Physician, Surgeon, Dentist or Oral Surgeon, or rendered by a Dental Assistant under the direct supervision of a Physician, Surgeon, Dentist or Oral Surgeon, or rendered by a Denturist:

(1) The following services (a) to (d) inclusive, each limited to once every nine months for adults over the age of 18 and twice in any calendar year for children under 18.

(a) oral examination;

(b) polishing of teeth;

(c) bite-wing x-rays;

(d) topical application of fluoride solutions;

provided that, for each of the above services, a period of at least 5 consecutive months has elapsed since the last such service was rendered.

(2) Scaling of teeth.

(3) Full-mouth series of x-rays, provided that a period of at least 24 consecutive months has elapsed since the last such series of x-rays was performed.

(4) Extraction's and alveolectomy at the time of tooth extraction.

(5) Amalgam, silicate, acrylic and composite restorations.

(6) Dental surgery.

(7) Diagnostic x-ray and laboratory procedures required in relation to dental surgery.

(8) General anesthesia required in relation to dental surgery.

(9) Endodontic treatment - diagnosis and treatment of diseases of the nerve, including root canal therapy.

(10) Periodontal treatment - the treatment of gums and bone surrounding the teeth.

(11) Necessary treatment for relief of dental pain.

(12) The cost of medication and its administration when provided by injection in the dentist's office.

(13) Space maintainers for missing primary teeth, and habit-breaking appliances.

(14) Consultations required by the attending dentist.

(15) Surgical removal of tumors, cysts, neoplasm.

(16) Incision and drainage of an abscess.

(17) Cover pit and fissure sealant for children under the age of 18.

Major Treatment - rendered or prescribed by a Physician, Surgeon, Dentist or Oral Surgeon, or rendered by a Denturist:

(1) Provision of crowns and inlays.

(2) Provision of an initial prosthodontic appliance (e.g. fixed bridge restoration, removable partial or complete dentures).

(3) Replacement of an existing prosthodontic appliance if

(a) the replacement appliance is required because at least one additional natural tooth was necessarily extracted after the date the employee first became covered under this Benefit Provision in respect of the person requiring the replacement appliance and the existing appliance cannot be made serviceable.

If the existing appliance can be made serviceable, only the expense for that portion of the replacement appliance which replaces the extracted teeth extracted after the date the employee first became covered in respect of the person requiring the replacement appliance shall be covered.

(b) the replacement appliance replaces an existing appliance which is at least 5 years old and cannot be made serviceable.

(c) the replacement appliance replaces an existing appliance which was temporarily installed after the date the employee first became covered under this Benefit Provision in respect of the person requiring the replacement appliance; in this event such replacement appliance shall be considered a permanent (as opposed to temporary) installation.

(d) the replacement appliance is required as the result of the installation of an initial opposing denture after the date the employee became covered under this Benefit Provision in respect of the person requiring the replacement appliance.

(e) the replacement appliance is required as the result of accidental dental injury which occurs after the date the employee first became covered under this Benefit Provision in respect of the person requiring the replacement appliance.

(4) Relines and rebases to existing dentures.

(5) Repairs to existing prosthodontic appliances.

(6) Adjustments to an initial or replacement prosthodontic appliance after the 3-month post-insertion care period.

(7) Procedures involving the use of gold if such treatment could not have been rendered at lower cost by means of a reasonable substitute consistent with generally accepted dental practice.

If such treatment could have been rendered at lower cost by means of a reasonable substitute, only the expense that would have been incurred for treatment by means of the reasonable substitute shall be covered.

Orthodontic Treatment - Treatment rendered by an Orthodontist, including the provision of orthodontic appliances, for the correction of Class I, Class II, or Class III malocclusions in relation to a primary, mixed, or permanent dentition, provided that treatment in respect of a dependent child shall be deemed to be a Covered Expense only if it commences on or after the child's 6th birthday. Treatment shall be deemed to commence on the date the initial orthodontic appliance is installed.

Special Benefit Payment Method Applicable to Orthodontic Treatment

The Covered Expenses for Orthodontic Treatment shall be deemed to be incurred on a monthly basis, commencing with the date on which the initial orthodontic appliance is installed and subsequently thereafter on the monthly anniversary of such date, during the continuance of the treatment period.

(1) SINGLE CHARGE BASIS - If the estimated cost of Orthodontic Treatment stated in the Treatment Plan does not include a separate initial fee, the amount of each monthly Covered Expense for Orthodontic Treatment is deemed to be

    (a) the total estimated Covered Expense in respect of the Orthodontic Treatment, divided by

    (b) the number of months of the treatment period.

(2) ITEMIZED CHARGE BASIS - If the estimated cost of Orthodontic Treatment stated in the Treatment Plan includes a separate initial fee, the amount of the monthly Covered Expense for Orthodontic Treatment is deemed to be

    (a) for the first month of treatment, the lesser of

        (i) the initial fee, and

        (ii) 25% of the total estimated Covered Expense in respect of the Orthodontic Treatment;

    (b) for each subsequent month of treatment

        (i) the difference between the total estimated Covered Expense and the Covered Expense calculated for the first month of treatment under (a) above, divided by

        (ii) the number of subsequent months of the treatment period.

The amount of the monthly Covered Expense as determined above is subject to adjustment if the actual expense or period of treatment differs from the estimate given in the Treatment Plan.

Benefits in respect of Orthodontic Treatment shall be paid at the end of each period of 3 consecutive months, the amount of each such payment being the sum of the benefits payable in respect of Covered Expenses incurred during such period.

TREATMENT PLAN PROVISION -

Solely to permit the pre-determination of benefits, but not as a pre-requisite for benefit payment, an employee should submit a Treatment Plan to the Employer prior to the commencement of

(1) a course of Routine Treatment or Major Treatment for which the estimated cost is $200 or more, or

(2) any course of Orthodontic Treatment.

Upon receipt of the Treatment Plan, the Employer shall advise the employee of the benefits payable under the plan on the basis of the Treatment Plan estimate at the time of Benefit determination, but the benefits so determined shall be valid only if the course of treatment commences within 90 days after the Treatment Plan submission.

DEDUCTIBLE PROVISIONS -

(1) The Individual Calendar Year Deductible Amount is the amount of Covered Expenses which must be incurred by an employee in respect of himself or one of his dependents in a calendar year before benefits become payable under this Benefit Provision.

(2) The Individual Deductible Amount shall be applied only once to a course of treatment

   (a) for which a Treatment Plan was submitted in accordance with the TREATMENT PLAN PROVISION, and
   (b) which was actually rendered in the treatment period estimated in the Treatment Plan, and
   (c) which continued beyond the calendar year in which the course of treatment commenced.

(3) Not more than the Family Calendar Year Deductible Amount of $35 shall be applied against the Covered Expenses of an employee and all his dependents in any one calendar year.

COVERED EXPENSE LIMITATIONS -

Expenses incurred for the following shall in no event be Covered Expenses:

(1) Services and supplies rendered for oral hygiene instructions, for plaque control or for dietary planning for the control of dental caries.

(2) Dental treatment which is not yet approved by the Canadian Dental Association or which is clearly experimental in nature.

(3) Broken appointments or the completion of claim forms required by the Plan Administrator.

(4) Dental treatment that is not "treatment necessarily rendered" as defined in the DEFINITIONS section. It is provided, however, that the plan shall consider as Covered Expenses (subject to the definition of "Reasonable and Customary Charges") that portion of the expense that would have been incurred for an alternate form of treatment that would qualify as "treatment necessarily rendered".

(5) Dentures which have been lost, mislaid or stolen.

(6) Services and supplies rendered for facings on crowns or pontics posterior to the second bicuspid.

(7) Services and supplies rendered for a full mouth reconstruction, for a vertical dimension correction, or for correction of a temporomandibular joint dysfunction.

(8) Services and supplies rendered for the correction of any congenital or developmental malformation which is not a Class I, Class II or Class III malocclusion.

(9) That portion of Orthodontic Treatment rendered after but which is part of a course of treatment that commenced before the date the employee became covered in respect of the person requiring the Orthodontic Treatment. It is provided, however, that the Employer shall consider as Covered Expenses (subject to the definition of "Reasonable and Customary Charges") that portion of the expense which is not covered under any other group plan.

(10) Services and supplies referred to in the provision of this plan entitled GENERAL LIMITATIONS.

MAXIMUM AMOUNT -

Routine/Major Maximum Amount - The maximum amount payable under this Benefit Provision for Routine and Major Treatment for any person in any one calendar year shall be as follows:

(1) for the period from the date the employee became covered up to and including the last day of the calendar year in which he became covered,

   (a) if he became covered prior to July 1, the Routine/Major Maximum Amount stated in the Table of Benefits for the employee's Class, and

   (b) if he became covered on or after July 1, the Routine/Major Adjusted First Year Maximum Amount stated in the Table of Benefits for the employee's Class.

(2) for each calendar year thereafter, the Routine/Major Maximum Amount stated in the Table of Benefits for the employee's Class.

Orthodontic Maximum Amount - The maximum amount payable under this Benefit Provision for all Orthodontic Treatment for any one person during the entire time the employee is covered hereunder in respect of such person is the Orthodontic Maximum Amount stated in the Table of Benefits for the employee's Class.

EXTENDED BENEFITS -

Routine/Major Treatment - The Employer shall pay benefits under this Benefit Provision in respect of expenses incurred for Routine or Major Treatment if services required for treatment were ordered or if treatment had commenced, but only if the supplies are received or installed or treatment is completed within 30 days after the date of termination of the employee's coverage under this Benefit Provision in respect of such person.

This extension applies only to an employee or dependent whose coverage terminated because:

(1) the employee is absent from work for a period of more than 30 days, if absence is due to disability or maternity leave, or

(2) the employee is absent from work due to lay-off or strike, or

(3) the employee has died, or

(4) the employee transferred from an eligible class into a class which is not eligible for coverage under this plan.

Orthodontic Treatment - The Employer shall pay benefits only in respect of a course of Orthodontic Treatment

(1) which commenced prior to the date of termination of coverage, and

(2) for which the Employer commenced payment of benefits prior to the date of termination of coverage,

up to but not exceeding the amount that would have been paid in the 3-month period immediately following said termination of coverage had this coverage remained in force during such period.

Summary of Plan Revisions to January 1, 2002.

Dental Care Maximum Increases

(a) Effective January 1, 1999 the coverage for dental increased from $1,000 to $1,100 stated in 1.1 Table of Benefits and,
Effective January 1, 2001 increased to $1,200.
Effective January 1, 2002 increased to $1,300.

(b) Effective January 1, 2000, the frequency of exams will be extended from once every six months to once every nine months for adults over the age of 18.

(c) Effective January 1, 2000 coverage will be provided to cover pit and fissure sealant for children under the age of 18.