GROUP INSURANCE PLAN

for Retired Teachers
members of QPAT

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

Policy No.: ***97,000***

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

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

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

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

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

This booklet can also be viewed on our secure website My Client Space accessible via ia.ca, if offered as part of your plan.

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INTRODUCTION

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

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

New Participant

To participate in the present plan as a retiree, you have to fill out the form *Participation Request F54-018A(17)*, indicate the chosen benefits and transmit it to QPAT. This form is available at your association or at Industrial Alliance.

Modification to the Coverage

Any modification to the coverage of a participant should be transmitted to QPAT on the form *Participation Request F54-018A(17)*. This form is available at your association or at Industrial Alliance.

Claims

a) Life Insurance

If you die, a member of your family should communicate as soon as possible with the person designated by QPAT.

b) Health Insurance

i) **Drugs**: Present your drug card to your pharmacist. The required information to process your claim will be electronically transmitted to us. If the drug card system is not offered in your area, you have to fill out the form *Claim Request F54-326 (16)*, available at QPAT or at Industrial Alliance.

ii) **Other expenses**: Fill out the form *Claim Request F54-326 (16)*, available at QPAT or at Industrial Alliance.

All claims should be sent to the following address :

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

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

Administration Department

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

(514) 499-3800
or
1-877-422-6487

Claims Department

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

(514) 499-3800
or
1-877-422-6487

SUMMARY OF BENEFITS

The SUMMARY OF BENEFITS briefly describes the coverage of the group insurance plan, based on the class to which you belong.

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

SPECIAL PROVISIONS

You are covered under the following class:

Class

Retired Teachers

GENERAL PROVISIONS

ELIGIBILITY DATE

Subject to all other provisions, you become eligible on the effective date of the plan, if you are then retired. Otherwise, you become eligible on the date of your retirement.

NORMAL RETIREMENT AGE

For the purpose of this plan, the normal retirement age shall be the first day of the month following or coinciding with your 65th birthday.

YOUR LIFE INSURANCE

Sum Insured

$10,000

This benefit terminates on the first of January coinciding with or following your 75th birthday.

PARTICIPATION IN THIS BENEFIT IS OPTIONAL.

YOUR ADDITIONAL LIFE INSURANCE

Sum Insured

$25,000 (if you were insured for at least $50,000 immediately before retirement)

or

$50,000 (if you were insured for at least $75,000 immediately before retirement)

This benefit terminates on the first day of the month coinciding with or following your 65th birthday.

PARTICIPATION IN THIS BENEFIT IS OPTIONAL.

LIFE INSURANCE FOR YOUR SPOUSE

Sum Insured

$5,000

This benefit terminates on the first of January coinciding with or following your 75th birthday.

PARTICIPATION IN THIS BENEFIT IS OPTIONAL.

HEALTH INSURANCE

HOSPITALIZATION IN CANADA	
Deductible:	none
Reimbursement:	100%
Daily Maximum:	Semi-private room, maximum of 90 days per disability period

EMERGENCY EXPENSES OUTSIDE THE PROVINCE OF RESIDENCE and MEDICAL ASSISTANCE OUTSIDE CANADA	
Deductible:	none
Reimbursement:	100%
Maximum Per Insured Person:	$4,000,000 lifetime

OTHER MEDICAL EXPENSES IN CANADA	
Deductible if protection is:	
• for you only:	$25
• for you and your children:	$50
• for you, your children and your spouse:	$50
Reimbursement	
• drugs:	80% of the first $6,400 * (for the year 2016) per certificate and 100% of the excess
• other expenses:	80% (except if otherwise specified)
Maximum:	Unlimited

* This amount is indexed by $200 on January 1st of each year.

Your dependents, if applicable, are covered under the present benefit.

This benefit provides no termination.

PARTICIPATION IN THIS BENEFIT IS <u>MANDATORY</u> FOR RETIREES AGED LESS THAN 65 AND <u>OPTIONAL</u> FOR RETIREES AGED 65 AND OVER.

Medical Expenses

Covered Expenses	Maximums Per Insured Person
Fees for nursing care	$500 per day, maximum $10,000 per calendar year.
Fees for remote areas (travelling expenses)	$1000 per day, $500 per calendar year. **These expenses are reimbursed in full (100%).**
Therapeutic appliances	$10,000 lifetime.
Breast prostheses	$300 per 24 months.
Medical elastic stockings	3 pairs per calendar year.
Room and board in a rehabilitation institution or a convalescent home	Semi-private room rate, maximum of 90 days per disability period (including the period for hospitalization in Canada). **These expenses have no deductible and are reimbursed in full (100%).**
Cost of laboratory analyses, electrocardiograms, electro-encephalograms, nuchal scans, prenatal screening tests, radiation treatments, gastrointestinal diagnostic programs and x-rays, performed in a commercial establishment or a private clinic	**These expenses are reimbursed at 50% of the first $500 of expenses incurred in a calendar year and at 75% of the following $1,500.**
Eyeglasses, contact lenses or intraocular lenses following cataract surgery	$500 per eye per lifetime.

Medical Expenses (cont'd)

Covered Expenses	**Maximums Per Insured Person**
Wigs and hairpieces	$500 per calendar year.
Sclerosing injections	$20 per visit.
Paramedical fees for a physiotherapist and a physical rehabilitation therapist	$35 per visit. One (1) treatment per day. **These expenses are reimbursed in full (100%).**
Paramedical fees for a speech therapist, an audiologist and an occupational therapist	Unlimited. One (1) treatment per day.
Paramedical fees for a chiropractor, an osteopath, a podiatrist (chiropodist), a dietician and an acupuncturist	$30 per visit, $30 per x-ray. Combined maximum of $500 for all these professionals. One (1) treatment per day. **These expenses are reimbursed in full (100%).**
Paramedical fees for a psychologist, a psychotherapist, a psychiatrist and a psychoanalyst, and fees for a social worker and an orientation counsellor	Combined maximum of $1,000 per calendar year for all these professionals. **These expenses are reimbursed at 50%.**
Glucometer or reflectometer	One (1) device lifetime.
Closed treatment program for alcoholism or drug addiction (participant only)	$175 per day, 35 days per treatment program. One (1) treatment program lifetime. **These expenses are reimbursed in full (100%).**

Medical Expenses (cont'd)

Covered Expenses	**Maximums Per Insured Person**
Vision care	Eyeglasses (frame and lenses) or contact lenses up to a maximum of $100 or in excess of this amount for contact lenses, if medically necessary and purchased following surgery and if purchase is made within 12 months of the operation. Only one of these maximums is applicable per period of 24 consecutive months. **Vision care expenses are subject to the deductible and are reimbursed at 80%.**

DEFINITIONS

The terms and conditions of each of the benefits contained in this plan will prevail notwithstanding anything to the contrary in the GENERAL PROVISIONS.

Acceptance of Evidence of Insurability: The date of acceptance of any evidence of insurability means the date of receipt of the last document confirming the insurer's acceptance of the risk.

Accidental Injury: Any bodily injury sustained while the insurance is in force, directly and solely due to an external, sudden, violent and unintentional cause and requiring within thirty (30) days of the accident the care of a physician.

Day: A calendar day, except if otherwise mentioned in the present plan.

Dependents: The participant's spouse or the children of the participant or of the spouse. If dependents are insured, the words "spouse" and "child" have the following meanings:

a) Spouse

The person who became the participant's spouse by a marriage legally performed in Québec or elsewhere and recognized as valid under the laws of Québec, or, for an unmarried person, the person he or she has been permanently living with for at least one (1) year and whom he or she declares publicly to be his or her spouse. Dissolution of the marriage through divorce or annulment, or a de facto separation of more than three (3) months for participants who are not married, results in the loss of status as spouse.

b) Dependent Child

An unmarried child of the participant or the spouse, or both, or a child living with the participant for whom adoption procedures are under way, residing or domiciled in Canada, who depends on the participant for support, and who satisfies one of the following conditions:

i) He or she is under eighteen (18) years of age;

ii) He or she is under twenty-six (26) years of age and is a full-time student duly enrolled at a recognized educational institution;

iii) Regardless of his or her age, if he or she became totally disabled while he or she satisfied one of the above conditions, and has remained continually disabled since that time.

Employee: A full-time or part-time teacher who is a member of QPAT.

Illness: Any deterioration in health requiring regular, continuous and curative care actively provided by a physician and satisfactory to the insurer, and whose default would bring deterioration of the person's health.

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

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

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

Participant: Any retiree insured under this plan.

Physician: A person who is legally authorized to practice medicine.

Retiree: A person who, on the day preceding his retirement date, meets the definition of employee of the present plan.

Specialist: A physician licensed by the provincial licensing authority to practice medicine with specialization.

PARTICULARS

PLAN AMENDMENT

The benefits herein provided are complementary to the benefits provided by government plans. Any modification brought to one of these plans after the

effective date of the present plan will in no way modify the benefits herein provided, unless an agreement is signed by the authorized officers of the insurer and the policyholder.

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

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

INCONTESTABILITY

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

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

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

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

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

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

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

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

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

RENUNCIATION

In a case where the insurer does not require compliance with a provision of this plan, such occurrence in no way creates a commitment to act likewise in the event of a subsequent breach of the same provision. Moreover, no approval by the insurer of any act, on the part of the policyholder or of a participant, for which such approval was required, shall exempt the policyholder or the participant from having to obtain the insurer's approval for any subsequent similar act.

INDIVIDUAL CERTIFICATES

The insurer issues individual certificates to be delivered by the policyholder to each participant.

LAWFUL CURRENCY

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

BENEFICIARY

The participant’s beneficiary shall be the person or persons designated by the participant, in writing, to receive the death benefit payable under the Participant's Life Insurance benefit, and if applicable, the Participant's Accidental Death and Dismemberment Insurance benefit, Participant's Optional Life Insurance benefit and Participant's Optional Accidental Death and Dismemberment Insurance benefit. If the participant does not designate a beneficiary, any death benefit payable under such benefits will be payable to the participant’s estate.

All benefits, other than the Participant's Life Insurance benefit, Participant's Accidental Death and Dismemberment Insurance benefit, Participant's Optional Life Insurance benefit and Participant's Optional Accidental Death and Dismemberment benefit, will be payable only to the participant, or if the participant is deceased at the time of the payment of the benefit, to his estate.

The participant will be able to designate a beneficiary or change a named beneficiary by a signed written declaration, subject to the provisions of the law.

The insurer will not be responsible for the sufficiency or validity of the beneficiary designation or change of beneficiary.

If the participant had named a beneficiary under the Policyholder's prior group policy, such designation will be applicable to the insurance provided under this policy, unless the participant has changed the designation in writing with the insurer. The participant should review the beneficiary designation made under the Policyholder's prior group policy to ensure that it reflects the participant's current intentions in regard to his insurance.

This policy contains a provision removing or restricting the right of the group insured to designate persons to whom or for whose benefit insurance money is to be payable.

INSURANCE

ELIGIBILITY

a) Retirees who are members of QPAT are eligible for Health Insurance and Life Insurance if they were covered under these benefits on the day prior to their retirement date.

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

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

PARTICIPATION IN HEALTH INSURANCE

Participation in this benefit is optional for all retired employees who are members of QPAT and who retire before January 1, 1997, and is mandatory for all other participants of less than sixty-five (65) years of age taking their retirement on or after January 1, 1997. To enrol, retirees must complete an application to this effect and send it to the insurer within sixty (60) days following their retirement date.

If the application is received by the insurer after the aforementioned period, the said application will be refused and the insurance will cease retroactively to the employee's retirement date. However, in the case of a retiree living in Québec

and aged less than sixty-five (65), the insurer would be in the obligation to accept such application.

However, with prior written notice from his or her employer, a participant of less than sixty-five (65) years may refuse or cease participation in the said benefit as of the end of the premium period stipulated in the notice, provided he or she can provide satisfactory proof that he or she is insured under group insurance coverage with similar benefits.

Any retiree having one or more dependents may insure himself or herself as a retiree without dependents, or as a retiree with dependents, as the case may be, by completing a form and sending it directly to the insurer.

Any retiree may insure his or her dependent children, or his or her spouse and dependent children under the Health Insurance benefit.

PARTICIPATION IN LIFE INSURANCE

Participation in Life Insurance is optional, and assumes participation in Health Insurance unless an exemption is granted under the provisions described in the PARTICIPATION IN HEALTH INSURANCE section.

Any retired teacher member of QPAT may continue his or her participation in this benefit by completing an application to this effect and sending it to the insurer within sixty (60) days following his or her retirement date. If the application is received by the insurer after the aforementioned period, the said application shall be refused and the insurance will cease retroactive to the employee's retirement date.

Any retiree may insure his or her spouse under the Dependents' Life Insurance benefit.

EFFECTIVE DATE OF INSURANCE UNDER THE HEALTH INSURANCE BENEFIT

a) The coverage of a retiree who submits his or her application within the stipulated time periods shall continue on his or her retirement date.

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

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

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

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

EFFECTIVE DATE OF INSURANCE UNDER
THE LIFE INSURANCE BENEFIT

a) The insurance for a retiree who submits his or her application within the prescribed period shall continue on his or her retirement date.

b) The spouse's insurance takes effect on the latest of the following dates:

i) the date on which the retiree's insurance takes effect;

ii) the date that corresponds to the first day of the month following the insurer's acceptance of the evidence of insurability with respect to the retiree's spouse;

iii) the date on which the spouse becomes a dependent of the retiree.

TERMINATION OF INSURANCE

Health Insurance

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

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

b) The date on which he or she ceases to meet the eligibility requirements;

c) The date on which the participant ceases to participate under the terms of the PARTICIPATION IN HEALTH INSURANCE provision;

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

Life Insurance

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

i) The termination date of this plan;

ii) The date on which he or she ceases to participate in the Health Insurance benefit, unless he or she is exempted as provided in

the PARTICIPATION IN HEALTH INSURANCE provision of the present plan;

iii) The termination date of the benefit;

iv) Upon the death of the participant;

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

vi) At the age indicated in the Summary of Benefits;

b) Spouse: The insurance for a spouse terminates at midnight on the earliest of the following dates:

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

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

iii) The date on which he or she ceases to be a spouse under the terms of the present plan;

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

BENEFITS

CLAIMS NOTICE

Health Insurance:

The insurer must be notified of any claim for Health Insurance within twelve (12) months immediately following the date of the event which gives entitlement to benefits, on forms provided by the insurer and, if applicable, with satisfactory written proof.

However, no delay in presenting the documents required by the insurer may be held against the participant if he or she demonstrates that the documents were submitted as soon as possible.

Participant's Life Insurance, Spouse's Life Insurance:

All claims must be submitted on forms provided for that purpose by the insurer within the ninety (90) days immediately following the date of the event which gives entitlement to benefits, and satisfactory written proof must be provided to the insurer within five (5) months immediately following the date benefits became payable.

However, no delay in presenting the documents required by the insurer may be held against the participant (or his or her claimants, if applicable) if he or she demonstrates that the documents were submitted as soon as possible.

The insurer reserves the right to require additional proof or information whenever it deems necessary and to have the insured person examined by a physician of its choice.

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

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

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

SUBROGATION

(This provision is not applicable to the Life Insurance and Accidental Death and Dismemberment benefits, if applicable.)

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

Without limiting the generality of this provision, the term “damages” will include any lump sum or periodic payments received on account of (i) past, present or future loss of income, loss of wages, or loss of earnings, and (ii) any other benefits paid or payable under the group policy. The participant or dependent shall reimburse the insurer up to the amount of any benefits paid in the past or that are payable in the future under the group policy out of the gross damages recovered whether recovered at trial, or prior to trial by way of any form of settlement, and without regard to whether the participant or dependent has obtained full recovery of his losses.

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

In the event that the participant or dependent fails to reimburse the insurer in accordance with the group policy, no future benefits will be paid by the insurer until such time as the insurer recovers (a) the total amount of benefits paid to the participant or dependent; and (b) an amount that reasonably reflects, as determined by the insurer, the total amount or value of any future benefits payable to the participant or the dependent. The insurer’s recovery in this regard shall not exceed the participant or dependent’s gross damages or settlement recovered. The insurer shall also have the right to seek recovery directly from the participant or dependent in the event that any overpayment has resulted from the lack of reimbursement.

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

against the third party and, in this respect, the participant/dependent and his solicitor shall fully cooperate with the insurer in the pursuit of its claim.

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

BENEFIT PAYMENT

The insurer will pay the benefits according to the terms of the contract, within thirty (30) days following the receipt of the required satisfactory proof of claim.

EXTENSION OF DEPENDENTS' INSURANCE AT THE RETIREE'S DEATH

At the insured retiree's death, the spouse can maintain the participation and the dependent children's participation in the insurance benefits held on the day before the death of the retiree.

To do so, the spouse must become a member of QPAT within sixty (60) days following the retiree's death, remain a member afterwards, and pay the required insurance premiums.

LIMITATION ON LEGAL ACTIONS

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

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

PARTICIPANT'S LIFE INSURANCE

Upon your death, if the present benefit was chosen, the insurer undertakes to pay to the beneficiary the sum insured as indicated in the Summary of Benefits

PARTICIPANT'S ADDITIONAL LIFE INSURANCE

At the time of your retirement, you may keep an amount of additional life insurance, without having to provide evidence of insurability, if the request is made within days following your retirement.

The sum insured under this benefit is indicated in the Summary of Benefits.

EXCLUSION

If a participant commits suicide, while sane or insane, less than twelve (12) months after the beginning of his coverage under this benefit or under the benefit of the previous insurer, the insurer will only refund the premiums paid in respect of such participant and such refund will constitute a full discharge of the insurer's liability under this benefit.

The twelve (12) month period starts anew on the date:

a) the additional life insurance is reinstated;

b) the additional life insurance amount is increased at the participant's request, but only for the supplementary amount of insurance.

SPOUSE'S LIFE INSURANCE

Upon the death of your spouse, if the present benefit was chosen, the insurer undertakes to pay you the benefits specified in the Summary of Benefits.

The insurer undertakes to reimburse health care expenses incurred due to accidental injury, illness or pregnancy, subject to the terms and conditions hereinafter specified.

Québec residents:

For Québec residents, the insurer undertakes to reimburse coverage provided under the BASIC PRESCRIPTION DRUG INSURANCE PLAN of Québec, for every participant aged less than sixty-five (65), and all of their dependents regardless their age and of the risk associated with the insured person's state of health.

This coverage is mandatory for all retirees and their dependents who are eligible to the present plan, subject to the provisions of the Act respecting prescription drug insurance.

Coverage offered is in accordance with relevant provisions of the Act respecting prescription drug insurance and with any other provision of the Summary of Benefits, according to the class to which you belong.

Any modification to the Act respecting prescription drug insurance which relates to the BASIC PRESCRIPTION DRUG INSURANCE PLAN will also modify the relevant provisions of the present plan.

It is understood and agreed under the plan that insured participants aged sixty-five (65) and over who are residents of Québec are presumed covered by the BASIC PRESCRIPTION DRUG INSURANCE PLAN from the *Régie de l'assurance-maladie du Québec*.

However, the insured participant aged sixty-five (65) and over may choose to be covered under the present plan provided additional cost is paid as specified in the contract.

SPECIAL DEFINITIONS

Hospital: Hospital means an institution

a) legally acknowledged as such by the Loi sur l'assurance-hospitalisation du Québec and by the Loi sur le ministère de la santé et des services sociaux;

b) intended for the care of bedridden patients; and

c) which provides at all times the services of physicians and registered nurses.

Units in hospitals that are set aside for convalescent patients are excluded.

Rehabilitation institution or convalescent home: Such terms designate an institution or health unit

a) legally acknowledged as such; and

b) intended for the care of bedridden patients.

Nursing homes, homes for the aged, rest homes, chronic care institutions, reception centres and drug and alcohol treatment centres are excluded.

Prosthesis: A device designed to replace all or part of a limb or an organ.

Orthesis or Orthopedic Device: A device applied to a limb or part of the body in order to correct a functional disability.

Therapeutic or Medical Appliances: Appliances currently used according to the manufacturer's standards and recognized as specifically for the immediate treatment of a pathological condition following an illness or an accident, such as appliances for the control of pain, extended physiotherapy and the administration of medication, respiratory assistance and diagnostic devices, excluding orthopedic appliances, stethoscopes and sphygmomanometers.

Original or Generic Drug: If mention is made of these two types of drugs, the *original* drug refers to the drug that was first developed and launched on the market. The *generic* drug refers to any reproduction of the original drug and is usually less expensive.

HOSPITALIZATION IN CANADA

The insurer reimburses that part of hospital expenses incurred in Canada which exceeds the amount reimbursed by government plans, up to the maximums specified in the Summary of Benefits.

EMERGENCY EXPENSES OUTSIDE THE PROVINCE OF RESIDENCE

The insurer reimburses hospitalization, medical and surgical expenses outside the province of residence of the insured person, in case of emergency, for that

part of eligible expenses that exceeds the amount paid by a provincial health insurance plan whose coverage is compulsory for all insured persons.

Expenses must be incurred due to a sudden and unexpected illness or to an accident which occurred during any stay outside the province of residence or during a stay outside Canada whose expected length is less than one hundred and eighty (180) consecutive days.

Moreover, when hospitalized outside Canada, the insured person must get in touch with the MEDICAL ASSISTANCE SERVICE as soon as it is possible to do so, otherwise the insurer has the right to terminate coverage.

In the absence of medical contraindication, the insurer may request that the insured person be repatriated or treated elsewhere. Repatriation must be recommended and planned by the medical assistance company. If an insured refuses to follow a recommendation for repatriation, the insurer accepts no responsibility for expenses incurred thereafter.

The overall maximum reimbursed by the insurer, for expenses incurred outside the province of residence, is limited to a lifetime maximum of four million dollars ($4,000,000) per insured person, as specified in the Summary of Benefits.

MEDICAL EXPENSES IN CANADA

The following expenses are covered, but only if they were incurred after the effective date of the insurance:

a) Services, care and treatment prescribed by a physician, such as:

   i) Services rendered at the insured person's home by a registered nurse or certified nursing assistant provided:

      - the services were prescribed by a physician and pre-approved by the insurer;
      - the services are medically necessary;
      - the services fall within the scope of services provided by a registered nurse or certified nursing assistant; and
      - the registered nurse or certified nursing assistant is unrelated to the insured person and does not normally reside with him.

   ii) Licensed ambulance service by air, road or train for emergency transportation to the nearest hospital equipped to provide the required treatment, or for transportation therefrom, when the

physical condition of the insured person precludes the use of any other means of transportation;

iii) Oxygen and rental of equipment necessary for its administration;

iv) Transportation expenses, with the exception of ambulance service, for insured persons who have to undergo medical treatment that cannot be performed in their region, up to the maximums indicated in the Summary of Benefits;

v) Drugs (including drugs used for the treatment of obesity) which are dispensed by a pharmacist and which can only be obtained with a written prescription of a healthcare provider who is legally licensed to prescribe drugs, other than those drugs that are excluded under the Exclusions and Reductions provision of this benefit.

Drugs which by convention require a prescription such as, but not limited to, maintenance drugs that are used daily to treat an ongoing medical condition for an extended period of time, such as medication to treat asthma, diabetes, high cholesterol or high blood pressure, provided they are prescribed by a healthcare provider who is legally licensed to prescribe such drugs and dispensed by a pharmacist.

Insulin supplies, such as needles, syringes, lancets and diagnostic testing materials.

For Quebec residents, this medical expense is supplementary to the Prescription Drug Insurance benefit.

Dispensing Limitations

The quantity of drugs which may be dispensed for any one prescription will be limited to that amount sufficient for up to a 34 day period, except in the case of drugs for long-term therapy (maintenance drugs) for which up to a 100 day supply is allowable.

Certain drugs will require pre-authorization by the insurer prior to the commencement of their usage. For these drugs the insured person will be required to have his attending physician provide the insurer with information describing his medical condition, previous treatment history and the medical criteria for prescribing the drug.

As part of its pre-authorization process, the insurer may request that a drug be purchased from a preferred pharmacy network that

has been approved by the insurer. If the insured person should choose to use another pharmacy, the amount reimbursed to the insured person will be based on the amount which would have been charged by the insurer's approved pharmacy network. The insurer will not be responsible for any amounts in excess of the amounts that would have been reimbursed had the insured person used the approved pharmacy network.

The insurer reserves the right to exclude coverage of any drug where it has determined, at its sole discretion, that coverage of the drug causes or may cause a material change in the risk insured under this policy or a material change in risk for the insurer in general.

Mandatory Generic

If the drug is an original drug which has a generic equivalent, the amount payable will be based on the lowest priced interchangeable drug. However, if the insured person provides proof, satisfactory to the insurer, that due to a valid medical reason as verified by his attending physician, that he must take the original drug, the insurer will make payment based on the cost of the eligible drug prescribed.

As used above, lowest priced interchangeable drug will include, but is not limited to

- an alternative drug to the original drug deemed interchangeable by law; or
- a subsequent entry biologic.

vi) Purchase of artificial limbs and eyes, or external prostheses, if the loss occurred while insured;

vii) Rental or purchase of a non-motorized wheelchair, a hospital bed (excluding electric beds) and any respiratory assistance devices;

viii) Purchase or rental of therapeutic appliances and maintenance, adjustment and replacement expenses for these appliances, up to the maximum amount indicated in the Summary of Benefits.

Monitoring devices such as dextrometers, stethoscopes, sphygmomanometers or other devices of similar nature are not covered, unless specified in the present benefit;

ix) Purchase of breast prostheses, up to the maximum specified in the Summary of Benefits;

x) Purchase of medium or high compression support hose (more than 20 mm/Hg) due to a venous or lymphatic system deficiency, up to the maximum amount indicated in the Summary of Benefits;

xi) Room and board in a rehabilitation home or convalescent home duly authorized by an appropriate government body, while under the supervision of a physician or registered nurse and receiving curative treatment, up to the maximum indicated in the Summary of Benefits;

xii) Cost of orthopedic shoes as described below, up to the maximum indicated in the Summary of Benefits:

- Shoes designed and custom made for the insured person from a mould, when such shoes are required to correct a foot defect;
- Deep shoes, open shoes, in-flare or out-flare shoes or straight shoes required for *Dennis Browne* splints, as well as adjustments or additions to premanufactured shoes;

xiii) Cost of laboratory analyses, electrocardiograms, electro-encephalograms, nuchal scans, prenatal screening tests, radiation treatments, gastro-intestinal diagnostic programs and x-rays, performed in a commercial establishment or a private clinic, up to the maximum indicated in the Summary of Benefits;

xiv) Purchase or rental of orthopedic appliances other than orthopedic shoes, podiatric apparatus, eyeglasses, contact lenses, and hearing aids which are obtained from a recognized establishment or laboratory and which are required as a result of a bodily injury or illness. The purchase must be made while this coverage is in effect;

xv) Purchase or rental of crutches, as previously approved by the insurer, and purchase of hernial belts, corsets, splints and casts;

xvi) Glasses, contact lenses or intraocular lenses following cataract surgery, up to the maximum indicated in the Summary of Benefits;

xvii) Purchase of wigs and hairpieces following chemotherapy, up to the maximum indicated in the Summary of Benefits;

xviii) Fees for sclerosing injections that are medically necessary, up to the maximum indicated in the Summary of Benefits;

xix) Purchase of a blood glucose monitor for insured persons with diabetes who have an insulin-dependent medical condition;

xx) The daily cost of room and board in a recognized clinic, located in Canada or the United States, specializing in rehabilitation for alcoholism and other drug addiction where the patient actually receives curative treatment, up to the maximums indicated in the Summary of Benefits. The clinic must be run by a physician and under the constant supervision of a registered nurse. This benefit applies only to the participant;

xxi) Purchase of blood and blood plasma.

b) Dental care given out of hospital while the insurance is in force by a dentist, in accordance with the normal suggested fee for a general practitioner, and required as a result of accidental injury to whole, healthy, natural teeth.

Only care received within six (6) months of the accident is covered. All other dental expenses are excluded.

c) Fees for paramedical care given by one of the professionals specified in the Summary of Benefits, up to the maximums indicated in the Summary of Benefits.

Paramedical care must be given by a person duly authorized by the responsible provincial or federal organization to practice this profession in accordance with the rules of the profession.

If the services of the practitioner are covered by the provincial health plan, no coverage will be provided under this benefit for any amount payable for such services under the provincial plan.

X-ray fees of a chiropractor, osteopath, podiatrist (chiropodist) and acupuncturist, up to the maximum indicated in the Summary of Benefits.

d) Hearings Aids: Expenses incurred for the initial purchase, replacement or repair of hearing aids or any related devices (with the exception of batteries), and for the professional services given by a hearing aid acoustician following the purchase, are reimbursed, provided they have been prescribed by a physician, audiologist or speech therapist.

If the total cost of the expenses to be incurred is estimated to be more than one thousand dollars ($1,000), authorization must be obtained from the insurer prior to incurring such costs.

e) The following expenses are reimbursable when prescribed by an ophthalmologist or an optometrist:

i) Eyeglasses (frame and corrective lenses), excluding sunglasses or safety glasses, or contact lenses, at the option of the insured, up to the maximums specified in the Summary of Benefits;

ii) Contact lenses, when medically necessary, up to the maximum specified in the Summary of Benefits, if applicable, provided that:

- these lenses have been prescribed for a keratoconus (conical cornea) or as a result of surgery;
- satisfactory correction of vision cannot be obtained with eyeglasses;
- the lenses are purchased within twelve (12) months following the surgery.

EXCLUSIONS AND REDUCTIONS

a) This benefit does not cover:

i) Expenses which are or would normally be payable or reimbursable under a workers' compensation act, if a claim had been submitted;

ii) Expenses resulting from attempted suicide or voluntary self-inflicted injury, while sane or insane;

iii) Expenses resulting from injury or illness caused by civil unrest, insurrection or war, whether war be declared or not, participation in a riot or active service in the armed forces of any country;

iv) Surgery or treatment which is not medically required, and which is given for cosmetic purposes or for any reason other than curative;

v) Care and services rendered free of charge or which would be free of charge were it not for insurance coverage or which are not chargeable to the insured person;

vi) Eye examination;

vii) Purchase or rental of any comfort or massage apparatus, and of domestic accessories that are not exclusively for medical purposes, such as whirlpool baths, air purifiers, humidifiers, air conditioners and other similar devices;

viii) Purchase of food or nutritional supplements;

ix) The following products or drugs are not covered:

- products for esthetic or cosmetic care;
- "natural" products;
- artificial insemination products;

x) The contribution to the cost of drugs and pharmaceutical services which must be paid by the insured person under any provincial drug insurance plan;

xi) Expenses for any drugs which are excluded from coverage by the insurer under the Dispensing Limitations provision of this benefit;

xii) Services, supplies, tests or care required by a third party or received collectively;

xiii) Care or treatments related to fertility or infertility;

xiv) Expenses incurred for problems related to erectile dysfunction;

xv) Expenses incurred for any care or treatment which was provided by a healthcare provider who, or a service provider that:

- has been charged with professional misconduct or improper practices; or
- is under investigation by an official body resulting from a law or regulation; or
- is under investigation by the insurer in regards to his professional conduct or practice; or
- is a member of a profession that is not regulated by an officially recognized federal or provincial regulatory body in the jurisdiction where the services were provided and, in the reasonable opinion of the insurer, does not meet the industry standards relevant to his profession.

b) The amount of benefits is reduced by any benefit that is payable or reimbursable under a government plan, a group plan or an individual plan, or that would have been payable had the person submitted a claim.

CALCULATION OF REIMBURSEMENT

Deductible

The deductible is that portion of covered expenses which you must pay before any benefits are payable under the present benefit. The maximum deductible required per calendar year is specified in the Summary of Benefits, if applicable.

Carry-over Provision

If the deductible has been satisfied in whole or in part by the payment of expenses incurred in the last three (3) months of a calendar year, the deductible for the following year will be reduced by the amount of deductible already paid.

Reimbursement

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

Maximum Benefit Per Insured Person

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

Coordination of Benefits

This article applies to any coverage which pays expenses for care, services or supplies. The term "coverage" means any coverage providing care, services or supplies under

a) any group, individual or family insurance, travel insurance, creditor's or savings insurance coverage,

b) any government-sponsored plan providing coverage for similar care, and

c) any non-insured employee benefit plan.

CONVERSION PRIVILEGE

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

a) his employment; or

b) his group membership,

will be able to convert his supplemental health insurance coverage to an individual insurance contract without having to submit evidence of insurability to the insurer.

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

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

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

MEDICAL ASSISTANCE OUTSIDE CANADA

This coverage provides the insured person, who is already covered under a government health insurance plan, with medical assistance in case of emergency while on vacation or business trips of which the expected length is less than one hundred and eighty (180) days, for any accident or illness which occurs outside Canada, subject to the conditions that follow.

In order to take advantage of this coverage, the insured person must necessarily be covered by the HEALTH INSURANCE benefit that is part of the present plan.

SPECIAL DEFINITIONS

Medical Authority: A legally qualified medical practitioner lawfully entitled to practice medicine in the country where medical services are performed.

Accident: Any sudden, unforeseeable and violent event which directly results from an external cause, independent of the insured person's wishes, leads to bodily injuries and prevents the insured person from continuing his or her trip, and which occurs while this coverage is in effect.

Family Member: The insured person's spouse, father, mother, child, brother or sister.

Illness: Any sudden and unforeseeable deterioration in health verified by a competent medical authority which prevents the insured person from continuing his or her trip, and which occurs while this coverage is in effect.

Hospital: A hospital refers to an institution which provides short-term care and:

a) is legally recognized as such in the country where the institution is located;

b) provides care to bedridden patients;

c) is equipped with a laboratory and an operating room;

d) has legally qualified physicians and registered nurses working twenty-four (24) hours a day.

Rehabilitation homes, convalescent homes, rest homes, chronic care homes and hospital chronic care wards do not qualify as hospitals.

Claims: Any event, accident or illness which justifies intervention by the Medical Assistance Service.

MEDICAL ASSISTANCE

a) The following emergency medical assistance following an accident or illness is available:

i) Twenty-four (24) Hour Access

- The insured person can call the 24-hour hotline at any time of the day or night, and multilingual coordinators will put him or her in touch with a network of specialists to handle travel-related emergencies.

ii) Medical Care

The Medical Assistance Service will:

- Upon request by the insured person, organize consultations with general practitioners or specialists in order to obtain the best medical care available in the area.
- Provide assistance with admittance to the hospital nearest the scene of the accident or illness.
- Assure doctors and hospitals that the plan will cover the expenses.

iii) Medical Transportation

The Medical Assistance Service will:

- Arrange for transportation or transfer of the insured person by any appropriate means recommended by the attending physician, which the Medical Assistance Service agrees to, to a hospital near the scene of the accident or illness, if required by the medical emergency.
- Organize the return of the insured person to his or her residence or to a hospital near his or her residence after initial medical care has been provided, by an appropriate means of transportation, provided that the return is

medically necessary and permissible. The Medical Assistance Service arranges for the insured person's return using the most appropriate means of transportation: air ambulance, helicopter, commercial airline, train or ambulance.

- The expenses incurred for transporting or transferring the insured person as described in the two previous paragraphs will be paid by the insurer.

iv) Payment of Medical Expenses and Cash Advance

- The Medical Assistance Service will make the necessary arrangements to pay medical expenses covered under the HEALTH INSURANCE which is part of this plan for emergency hospitalization and medical or surgical care outside of Canada.

  If need be, the Medical Assistance Service will advance up to ten thousand dollars ($10,000) in legal Canadian tender, after reaching an agreement with the insurer, for the participant and his or her covered dependents.

  The participant must pay back any cash advance to the insurer in one lump sum and according to the exchange rates effective at the time of the cash advance, within ninety (90) days following his or her return to Canada. Should the participant fail to pay, the insurer reserves the right to compensate on health claims or any other claims which the participant or his or her dependents present under this plan.

v) Return of Deceased

- Should the insured person die due to an illness or accident, the Medical Assistance Service will take care of all the arrangements and pay up to five thousand dollars ($5,000) per insured person for the postmortem expenses, the coffin and transportation of the deceased to the place of burial in Canada. Funeral expenses will not be covered by the Medical Assistance Service or the insurer.

vi) Return of Dependent Children

- The Medical Assistance Service will organize the return of the insured person's children under age sixteen (16) who

are left unattended and will arrange and pay for economy transportation for the children, with an escort if necessary, to their usual place of residence in Canada. If the return tickets are still valid, only the additional cost for return transportation will be paid, after deducting the value of the tickets.

vii) Return of a Family Member

- The Medical Assistance Service will organize the return of a family member who has lost the use of his or her airplane ticket due to the insured person's hospitalization or death. The Medical Assistance Service will make the arrangements to provide economy transportation for a family member to his or her usual place of residence in Canada. If the return tickets are still valid, only the additional cost for return transportation will be paid, after deducting the value of the tickets.

viii) Visit from a Family Member

- The Medical Assistance Service will organize round-trip economy class transportation for a family member to visit the insured person if the person is hospitalized for at least seven (7) consecutive days and if the attending physician feels that the visit would be beneficial for the patient.

ix) Meals and Accommodation

- With regard to paragraphs vi), vii) and viii), the Medical Assistance Service will pay expenses incurred for meals and accommodation up to one hundred and fifty dollars ($150) per day for a maximum of seven (7) days. Receipts must be provided for these expenses before the Medical Assistance Service issues a reimbursement.

x) Vehicle Return

- The Medical Assistance Service will pay up to one thousand dollars ($1,000) to return the insured person's vehicle, either private or rental, to the insured person's residence or the nearest appropriate vehicle rental location.

xi) Cash Advances

- The Medical Assistance Service will advance cash, if need be, for the insured person to obtain the services described in paragraphs iii), vi), vii), viii), ix) and x), or will provide payment guarantees of up to one thousand dollars ($1,000) in legal Canadian tender. The participant must pay back any cash advance to the insurer according to the exchange rates effective at the time of the cash advance. The cash advance will be withheld by the insurer from any claim payments, if applicable.

b) Other emergency travel services also available to the insured person while travelling abroad:

i) Telephone Interpretation Service

- In case of an emergency, the Medical Assistance Service provides the insured person with telephone interpretation services in most foreign languages.

ii) Messages

- In case of an emergency, the Medical Assistance Service relays a message, upon request, to the insured person at his or her home, office or elsewhere, or holds messages for the insured person or his or her family members for fifteen (15) days.

iii) Legal Assistance

- Should an insured person require legal assistance, the Medical Assistance Service assists him or her in finding local legal aid for an accident or another cause of defence, and will also help the insured person to obtain a cash advance from his or her credit cards, family and friends, in order to pay for any bail or legal fees.

iv) Travel Information

- The Medical Assistance Service sends the insured person travel information related to transportation, vaccinations and precautionary measures before, during and after the trip.

v) Emergency Medication

- Should an insured person require medication not available locally that is indispensable for a treatment in progress, the Medical Assistance Service coordinates the search for and dispatch of the medication. The insured person is responsible for the cost of the medication unless it is covered under the HEALTH INSURANCE of this plan.

vi) Lost Baggage or Documents

- If the insured person loses or has his or her baggage stolen, the Medical Assistance Service will help him or her contact the appropriate authorities.

EXCLUSIONS

This benefit does not cover:

a) Expenses payable or reimbursable under a government, a group or individual plan, or which normally would have been payable if a claim had been submitted;

b) Expenses resulting from attempted suicide or voluntary self-inflicted injury, whether the insured person is sane or insane;

c) Expenses resulting from injury or illness caused by civil unrest, insurrection or war, whether war is declared or not, or participation in a riot;

d) Surgery or treatment which is not medically required, and which is given for cosmetic purposes, for any reason other than curative, or which exceeds ordinary surgery or treatment given in accordance with normal therapeutic practice, and surgery or treatment which is given in relation to an operation or treatment of an experimental nature;

e) The portion of the expenses which exceeds reasonable and customary fees for the area in which treatment is provided for an illness of the same nature and severity;

f) Care or services rendered free of charge or which would be free of charge were it not for insurance coverage or which are not chargeable to the insured person;

g) Any rest cure or travel for reasons of health.

PROVISIONS

Notice of Claim: As soon as the insured person is aware of an incident, he or she must take all reasonable precautions to stop its progression and must contact the Medical Assistance Service as soon as possible to indicate the circumstances and the known or presumed causes of the incident. Upon request by the Medical Assistance Service, the insured person must provide a certificate from the attending physician explaining the probable consequences of the illness or the injuries suffered during the accident.

Prescription: Claims must be made within twelve (12) months following the date of the incident.

Refund for the Return Ticket: When the insured person's transportation is arranged by the Medical Assistance Service, he or she must present the original return ticket or the reimbursement. If neither is available, the price of the ticket will be withheld by the insurer from the amounts payable to the insured person, if applicable.

LIABILITY

The Medical Assistance Service may not be held responsible for failure to provide medical assistance or for delays caused by strikes, civil wars, wars, invasions, intervention by enemy powers, hostilities (whether war is declared or not), rebellions, insurrections, acts of terrorism, military operations or coups, riots or uprisings, radioactive fallout, or any other situation beyond its control.

The doctors, hospitals, clinics, lawyers and other authorized practitioners or institutions to which the Medical Assistance Service directs insured persons are, for the most part, independent contractors and act on their own behalf and are not employees, agents or subordinates of the Medical Assistance Service.

The Medical Assistance Service and the insurer are not in any way responsible for negligence or other acts or omissions by these doctors, hospitals, clinics, lawyers or other authorized practitioners or institutions.

COPY OF CONTRACT AND ENROLMENT MATERIAL

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

PROTECTING PERSONAL INFORMATION

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

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

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

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

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

Participant's Right to Access His or Her Personal Information

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

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

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

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

ANNEX - VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Policy No. 100004461 issued by Special Markets Solutions, a division of Industrial Alliance Insurance and Financial Services Inc.

If you elect to participate, you are covered for injuries sustained as the result of any accident anywhere in the world - 24 hours per day - on or off the job, for the Principal Sum amount you have selected. You may select any Principal Sum of insurance from a minimum of $25,000.00 to a maximum of $350,000.00 in units of $25,000.00.

You may also elect to insure your family. If you do not have children, your spouse will be insured for 60% of the amount you have selected for yourself. If you and your spouse have children, your spouse will be insured for 50% of the amount you have selected and each child (regardless of the number) will be insured for 10% of the amount you have selected for yourself. If you do not have a spouse, each child will be insured for 20% of the benefit you have selected for yourself subject to a maximum of $50,000.00 and to a maximum of $75,000.00 with respect to the Child Enhancement Benefit.

Accidental Death, Dismemberment and Specific Loss Indemnity

The “loss” or “loss of use” must occur within 365 days after the date of the accident. These benefits are payable on a lump sum basis and in addition to any other benefits you may receive.

	% of Principal Sum
Life	100%
Both Hands or Both Feet or Entire Sight of Both Eyes	100%
One Hand and One Foot or One Hand and Entire Sight of One Eye	100%
One Foot and Entire Sight of One Eye or Speech and Hearing in both Ears	100%
One Arm or One Leg	75%
One Hand or One Foot or Entire Sight of One Eye or Speech or Hearing in both Ears	66 2/3%
Thumb and Index Finger of Either Hand or Four Fingers of Either Hand	33 1/3%
Hearing in One Ear	33 1/3%
All Toes of One Foot	25%
Quadriplegia (total paralysis of all four limbs)	200%
Paraplegia (total paralysis of the lower limbs)	200%
Hemiplegia (total paralysis of one side of the body)	200%

ANNEX - VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Child Enhancement Benefit

With the exception of loss of life, all amounts provided under the Accidental Death, Dismemberment and Specific Loss Indemnity are doubled with respect to insured dependent children, subject to a maximum of $75,000.00.

Common Disaster Benefit ($700,000)

In the event of the accidental death of both the participant and his/her insured spouse, and provided benefits for such loss becomes payable in accordance with the policy as a result of the same accident, and both deaths occur within 90 days after the date of the accident, the Principal Sum applicable to the participant's insured spouse will be increased to the amount of the participant's Principal Sum. In no event will the amount payable under this part exceed $700,000.00.

Repatriation Benefit ($15,000)

If injury results in loss of life, the Company will pay the expense incurred for shipment of the body to the city of residence of the deceased.

Spousal Retraining Benefit ($15,000)

If injury results in the loss of life of a participant, the Company will reimburse the spouse for the actual expenses incurred for a formal occupational training program in order to become qualified for active employment in an occupation in which the spouse would not otherwise have sufficient qualifications.

Education Benefit ($10,000)

If injury results in loss of life of a participant, the Company will pay 5% of the principal sum to any dependent child who, on the date of the accident, was enrolled as a full-time student in any institution of higher learning beyond the secondary school level (not to exceed four years). If, at the time of loss, there are no dependent children eligible for the Education Benefit, the Company shall pay an additional amount of $2,500.00 to the designated beneficiary.

Day Care Benefit ($5,000)

If injury results in the loss of life of a participant, the Company will pay 5% of the principal sum for each year the dependent child is enrolled in a legally licensed day care (not to exceed four years) for each dependent child who is under 13 years of age and enrolled in a legally licensed day care centre on the date of the accident, or within the 12 months following.

ANNEX - VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Seat Belt Benefit

If injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity, the principal sum will be increased by 10% if, at the time of the accident, the participant, insured spouse, or insured dependent child was driving or riding in a vehicle and wearing a properly fastened seat belt.

Hospital Indemnity Expense ($2,500)

A daily benefit, subject to the above-mentioned monthly maximum, will be payable when a participant, insured spouse, or insured dependent child is in a hospital, if such period of hospitalization is necessary for the treatment of an injury which results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity of the policy and begins while insurance is in force.

A period of hospitalization necessary for an injury other than for a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity will be covered as stated above, provided such hospitalization is of at least a four day period.

Family Transportation Benefit ($15,000)

If injury results in confinement as an inpatient in a hospital, and such injury results in a loss being payable under the Accidental Death, Dismemberment and Specific Loss Indemnity, and the hospital is located at least 150 km from the participant's, insured spouse's, or insured dependent child's residence, the Company will pay the expenses actually incurred by a member of the immediate family for hotel accommodation and transportation by the most direct route to the confined participant, insured spouse, or insured dependent child.

If transportation occurs in a vehicle or device other than one operated under a license for the conveyance of passengers for hire, then reimbursement of transportation expenses will be limited to a maximum of $0.35 per kilometre travelled.

Rehabilitation Benefit ($15,000)

If injury requires that the participant undergo special training in order to be qualified to engage in a special occupation in which the participant would not have engaged except for such injury, the Company will pay the reasonable and necessary expense incurred for such training. Provided such injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity.

Home Alteration and Vehicle Modification Benefit ($15,000)

If injury requires the use of a wheelchair to be ambulatory, the Company will pay the cost of alterations to the participant's, insured spouse's, or insured dependent child's principal residence and/or the cost of modification to one motor vehicle utilized by the participant, insured spouse, or insured dependent child. Provided such injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity.

Waiver of Premium

In the event a participant becomes totally disabled and the Waiver of Premium Benefit has been approved and accepted by the group life carrier, then premium under this plan will be waived until the earlier of: death, recovery, attainment of age 65 or the date the policy is cancelled.

Conversion Option

Upon termination of active employment with the Policyholder, a participant may convert his/her insurance only (and not that of his/her insured spouse or insured dependent children) to an individual accident insurance plan, with no evidence of insurability, for an amount of principal sum equal to or lower than the amount of principal sum in force at the time of termination. Application for conversion must be made within 31 days. Premiums become payable annually in advance.

Limited Air Travel Coverage

Coverage includes injury sustained in consequence of riding as a passenger and not as a pilot or member of the crew; in boarding or alighting from or being struck by; or making a forced landing with or from:

(a) any aircraft having a current and valid airworthiness certificate and which is operated by a person holding a current and valid pilot's license of a rating authorizing him to pilot such aircraft, or

(b) any transport-type aircraft operated by the Canadian Armed Forces or by the similar air transport service of any duly constituted governmental authority of the recognized government of any nation anywhere in the world, provided the aircraft is not being used for test or experimental purposes.

Notwithstanding (a) and (b) above, coverage excludes injury sustained while and in consequence of riding as a passenger, pilot, operator or member of the crew, in or on, boarding or alighting from or being struck by or making a forced landing with or from any aircraft owned, operated or leased by the policyholder.

Termination of Insurance of an Insured

Coverage will immediately terminate on the earliest of:

A. For the participant: (a) the policy termination date; (b) the premium due date if the Policyholder fails to pay the participant's premium, except as a result of an inadvertent error; (c) the premium due date coinciding with or immediately following the date a participant attains age 75; (d) the premium due date next following the date a participant is ineligible for coverage.
B. For the insured spouse and/or insured dependent child: (a) the date such person becomes ineligible for coverage; and (b) the date the participant's insurance is terminated.

When Does This Insurance Not Apply?

- declared or undeclared war or any act thereof;
- active full-time service in the armed forces of any country;
- suicide or any attempt thereat or intentionally self-inflicted Injury, while sane or insane;
- injury sustained in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as provided in the part titled "Limited Air Travel Coverage".

ANNEX - VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Beneficiary

Indemnity payable in the event of the loss of life of a Participant is payable to the beneficiary or beneficiaries designated in writing by the Participant on his enrollment card on file with the Policyholder, or if there is no such beneficiary designation with respect to the Participant, such indemnity is payable to the estate of the Participant. All other indemnities payable, including those payable for the insured Spouse and/or insured Dependent Children, are payable to the Participant, with the exception of indemnities payable under the following parts:

Day Care Benefit
Education Benefit
Family Transportation Benefit
Repatriation Benefit
Spousal Retraining Benefit

In the situation where the policy replaces an existing policy issued to the Policyholder, the beneficiary designation recorded under the replaced policy will be deemed to be valid and of full force and effect until changed in writing by the insured.

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

This summary is for information purposes only. For further details, refer to the Master Policy which is on file with the Policyholder. This Master Policy sets forth in detail the terms and conditions of the Plan and all rights and obligations are determined in accordance with the Master Policy issued by Special Markets Solutions, a division of Industrial Alliance Insurance and Financial Services Inc., not this summary.