GROUP INSURANCE PLAN

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

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

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

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

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

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

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

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

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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 the participant belongs to.

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

SPECIAL PROVISIONS

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

Participants are insured under the following class:

Class

Retired Teachers

GENERAL PROVISIONS

ELIGIBILITY DATE

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

a) on the effective date of the group policy, if he is then in a retiree,

or

b) on the date on which he becomes a retiree.

NORMAL RETIREMENT AGE

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

PARTICIPANT'S LIFE INSURANCE

Sum Insured

$10,000

Reduction and Termination:

This benefit does not include any reduction based on the participant's age and terminates on the first of January coincident with or next following the participant's 75th birthday.

PARTICIPATION TO THIS BENEFIT IS OPTIONAL.

PARTICIPANT'S 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)

Termination:

This benefit terminates on the first day of the month coincident with or next following the participant's 65th birthday.

PARTICIPATION TO THIS BENEFIT IS OPTIONAL.

SPOUSE'S LIFE INSURANCE

Sum Insured

$5,000

Termination:

This benefit terminates on the first of January coincident with or next following the participant's 75th birthday.

PARTICIPATION TO THIS BENEFIT IS OPTIONAL.

SUPPLEMENTAL HEALTH INSURANCE

HOSPITALIZATION IN THE PROVINCE OF RESIDENCE

Deductible:	Reimbursement:	Daily maximum:
none	100%	Semi-private room rate, maximum of 90 days per disability period

EMERGENCY MEDICAL EXPENSES INCURRED OUTSIDE THE PROVINCE OF RESIDENCE and EMERGENCY OUT OF PROVINCE ASSISTANCE

Deductible:	Reimbursement:	Maximum per insured person:
none	100%	$5,000,000 per lifetime

ALL OTHER MEDICAL EXPENSES INCURRED IN CANADA

Deductible
– participant only: $25
– participant and children: $50
– participant, children and spouse: $50

Reimbursement
– drugs: 80% of the first $7,000* (for the year 2019) per certificate and 100% of the excess

If the maximum contribution [1] has been satisfied by the participant or spouse during the calendar year, the level of reimbursement will be 100% for the rest of the calendar year for such person and, if applicable, his dependent children.

– other expenses: 80% (except if otherwise specified)

Maximum: Unlimited

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

[1] *Maximum contribution for the participant and spouse during the calendar year: As stated under the Act respecting prescription drug insurance (R.S.Q., chapter A-29.01).*
The participant's maximum contribution will include any amounts paid as a deductible and/or coinsurance for a dependent child.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

Dependents, if applicable, are covered under the present benefit.

Termination:

This benefit provides no termination.

PARTICIPATION TO THIS BENEFIT IS MANDATORY FOR RETIREES AGED LESS THAN 65 AND OPTIONAL FOR RETIREES AGED 65 AND OVER.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

Medical Expenses

Covered Expenses	Maximums Per Insured Person
All covered expenses included under the Medical Expenses Incurred in Canada section of the Supplemental Health Insurance benefit, other than those listed below	Unlimited.
Fees for nursing care	$500 per day; maximum $10,000 per calendar year.
Fees for remote areas (travelling expenses)	$100 per day, $500 per calendar year. **These expenses are reimbursed at 100%.**
Therapeutic appliances	$10,000 per lifetime.
Breast prostheses	$300 per 24 consecutive 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 hospitalization). **These expenses have no deductible and are reimbursed at 100%.**

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

Medical Expenses

Covered Expenses	Maximums Per Insured Person
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 eligible 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.
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 at 100%.**

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

Medical Expenses (cont'd)

Covered Expenses	Maximums Per Insured Person
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 * *in Ontario and Saskatchewan only*	$30 per visit, $30 per x-ray. Maximum of $500 for all professionals combined. One (1) treatment per day. **These expenses are reimbursed at 100%.**
Paramedical fees for a psychologist, a psychotherapist, a psychiatrist and a psychoanalyst, and fees for a social worker and an orientation counsellor	Maximum of $1,000 per calendar year for all professionals combined. **These expenses are reimbursed at 50%.**
Diabetic monitoring equipment	One (1) device per lifetime.
Closed treatment program for alcoholism or drug addiction (participant only)	$175 per day, 35 days per treatment program. One (1) treatment program per lifetime. **These expenses are reimbursed at 100%.**

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

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 required 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.**

DEFINITIONS

Accident: A sudden, violent and unforeseeable occurrence which is external to the person.

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 30 days of the accident the care of a physician.

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

Association : The *Association provinciale des enseignantes et enseignants du Québec* (APEQ).

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

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

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

a) Spouse

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

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

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

b) Child

An unmarried child of the participant or his spouse, or both, or a child living with the participant for whom procedure of adoption is underway, who wholly depends on the participant for support and maintenance and who meets at least one of the following conditions:

i) He is under 18 years of age; or

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

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

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

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

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

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 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.

However, if a retiree is no longer residing in Canada, only the Participant's Life Insurance, the Participant's Additional Life Insurance and the Spouse's Life Insurance benefits will be maintained.

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

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

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.

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

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

CHANGES IN GOVERNMENT PLANS

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

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

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

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

INCONTESTABILITY

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

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

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

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

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

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

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

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

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

LAWFUL CURRENCY

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

COVERAGE ELSEWHERE

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

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

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

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

ELIGIBILITY

Retiree

A retiree who is a member of QPAT is eligible for Supplemental Health Insurance benefit and Life Insurance benefit if he or she is covered under these benefits on the day prior to his or her retirement date.

Dependents

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

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

PARTICIPATION TO THE SUPPLEMENTAL HEALTH INSURANCE BENEFIT

Participation to this benefit is optional for all retired employees who are members of QPAT and who retired before January 1, 1997, and is mandatory for all other participants under age 65 taking their retirement on or after January 1, 1997. To enroll, retirees must complete an application to this effect and send it to the insurer within 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 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 65 years may refuse or cease participation to the said benefit as of the end of the premium period stipulated in the notice, provided he or she can provide satisfactory proof that he or she is insured under group insurance coverage with similar benefits.

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 Supplemental Health Insurance benefit.

PARTICIPATION TO THE LIFE INSURANCE BENEFIT

Participation to the Life Insurance benefit is optional and assumes participation to the Supplemental Health Insurance benefit unless an exemption is granted under the provisions described in the PARTICIPATION TO THE SUPPLEMENTAL HEALTH INSURANCE BENEFIT 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 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 Spouse's Life Insurance benefit.

EFFECTIVE DATE OF INSURANCE UNDER THE SUPPLEMENTAL 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; or

   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

Supplemental Health Insurance Benefit

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

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

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

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

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

e) The date on which the participant ceases to participate under the terms of the PARTICIPATION TO THE SUPPLEMTAL HEALTH INSURANCE BENEFIT provision of this plan;

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

Life Insurance Benefit

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

a) The termination date of this plan;

b) The date on which the participant ceases to participate to the Supplemental Health Insurance benefit, unless he is exempted as provided in the PARTICIPATION TO THE SUPPLEMENTAL HEALTH INSURANCE BENEFIT provision of this plan;

c) The termination date of the benefit;

d) Upon the death of the participant;

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

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

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

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

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

c) The date on which the spouse ceases to be a spouse under the terms of the present plan;

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

e) The date on which the spouse is no longer covered by his provincial health plan;

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

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 to 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 60 days following the retiree's death, remain a member afterwards, and pay the required insurance premiums.

CLAIMS

- **Supplemental Health Insurance:**

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

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

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

- **Life Insurance, Additional Life Insurance and Spouse's Life Insurance:**

  The insurer must receive notice of any claim as soon as possible after the date of the event which gives entitlement to the benefit, but in any event within one year of the event.

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

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

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

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

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

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

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

INSURER'S RIGHT TO EXAMINATION OF A CLAIMANT

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

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

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 Participant's Additional Life 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 and Participant's Additional Life Insurance 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.

BENEFIT PAYMENT

The insurer will pay the insured amounts, in accordance with the terms of the contract, within 30 days of receipt of evidence satisfactory to the insurer.

SUBROGATION

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

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

LIMITATION ON LEGAL ACTIONS

No action or proceeding against the insurer shall be commenced within the first 60 days following the date on which written proof of claim is provided to the insurer in accordance with the terms and conditions of 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 the death of the participant while insured under this benefit, the insurer undertakes to pay to the beneficiary the sum insured as indicated in the Summary of Benefits, subject to the terms and conditions of this benefit and the group policy.

PARTICIPANT'S ADDITIONAL LIFE INSURANCE

A member under the age of 65 may obtain an additional amount of life insurance provided that he or she applies for it and provides evidence of insurability deemed necessary by the insurer.

A member at the time of retirement may maintain an additional amount of life insurance without having to submit evidence of insurability if he or she applies for it within 31 days of retirement.

The sum insured that will be applicable to the participant will be the amount of insurance requested as provided for in the Summary of Benefits.

The insurer undertakes to pay the beneficiary the sum insured at the time of the participant’s death, subject to the following terms and conditions.

EXCLUSION

If a participant commits suicide, regardless of any impairment, illness, or state of mind, less than 12 months after the beginning of his coverage under this benefit, no benefit will be paid. 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 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 a spouse while insured under this benefit, the insurer undertakes to pay to the participant the sum insured, as indicated in the Summary of Benefits, subject to the terms and conditions of this benefit and the group policy.

SUPPLEMENTAL HEALTH INSURANCE

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

DEFINITIONS

As used in this benefit:

Coinsurance payment: The coinsurance payment is the portion of the cost of the covered expenses that must be paid by the insured person until the maximum contribution is reached.

Convention: Drugs which by law do not require a prescription, but which would not ethically be dispensed by a pharmacist without one.

Deductible: The deductible is the portion of the cost of the covered expenses which must be paid by the insured person. The deductible, if applicable, is specified in the Summary of Benefits.

Hospital: An institution which

a) is legally licensed by the appropriate government body;

b) is intended for the care of bedridden patients; and

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

Maximum contribution: The maximum contribution is the total amount paid by the insured person beyond which the cost of the covered expenses which are eligible as per the list under the Basic Prescription Drug Insurance Plan of Quebec is covered 100% by the insurer.

Medical emergency: A sudden or unexpected occurrence that requires immediate medical attention.

Medically required: Certified by a physician as required to treat a condition which is detrimental to the patient's health.

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

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 in the marketplace. The *generic* drug refers to any reproduction of the original drug and is usually less expensive.

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

Rehabilitation institution or convalescent home: An institution or health unit which

a) is legally licensed by the appropriate government body; and

b) is intended for the care of bedridden patients.

Nursing homes, homes for the aged, rest homes, chronic care institution, residential and long-term care centres and drug and alcohol treatment centres are excluded.

Reimbursement: The reimbursement is the percentage of the covered expenses incurred that is reimbursed by the insurer after the deductible has been satisfied. The percentage is specified in the Summary of Benefits.

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.

PRESCRIPTION DRUG INSURANCE

(Applicable to Quebec Residents Only)

The insurer undertakes to reimburse the expense of prescription drugs which are listed under the Basic Prescription Drug Insurance Plan of Quebec, for each insured person who is a resident of Quebec and who is registered with

the *Régie de l'assurance-maladie du Québec* (hereafter referred to as the "RAMQ"), regardless of the insured person's state of health.

Coverage under this benefit is mandatory for all participants, retirees and their dependents who are eligible to be insured under the group policy, subject to the provisions of the Act respecting prescription drug insurance.

The coverage provided under this benefit is in accordance with the relevant provisions of the Act respecting prescription drug insurance and the Summary of Benefits.

Any modification to the Act respecting prescription drug insurance which relates to the Basic Prescription Drug Insurance Plan of Quebec will automatically result in the modification of the relevant provisions of this benefit and the group policy.

Special provision for insured persons age 65 and over

The insured person's choice to be covered by the RAMQ for the Basic Prescription Drug Insurance Plan is irrevocable.

For the purpose of the group policy, insured persons age 65 and over will be presumed to be covered with the RAMQ for the Basic Prescription Drug Insurance Plan of Quebec. In addition, dependents of a participant who is 65 years of age or over will be presumed to be covered with the RAMQ for the Basic Prescription Drug Plan of Quebec, regardless of age. However, dependents age 65 and over of a participant less than age 65 remain covered with the insurer under the present benefit.

The insurer reserves the right to modify the rates applicable to this benefit for any insured person age 65 and over, who is eligible for insurance under the group policy and who has chosen to be insured under this benefit.

Notwithstanding any stipulation to the contrary in the group policy, this benefit does not provide any termination with regard to the participant's age.

Covered expenses

The following expenses are covered, provided they are incurred in Quebec after the insured person became insured under this benefit:

a) The services of a pharmacist to fill or renew a prescription for a drug which is included on the list of the RAMQ or specified by government regulation;

b) Drugs which are included on the list of the RAMQ and which are provided by a pharmacist on a prescription of a healthcare provider who is legally licensed to prescribe drugs;

c) Any drug specified by government regulation, when prescribed for the conditions and the therapeutic indications as set out in the regulation.

This benefit does not include the cost of pharmaceutical services and drugs that an insured person may obtain or to which the person is otherwise entitled, pursuant to any government plan or act, other than the Act respecting prescription drug insurance in Quebec.

Dispensing Quantity 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.

HOSPITALIZATION IN THE PROVINCE OF RESIDENCE

Room and board charges made by a hospital in the province of residence which are in excess of the amount reimbursed by the government health plan, up to the daily maximum specified in the Summary of Benefits, provided:

a) the insured person is confined to the hospital on an in-patient basis;

b) the level of accommodation was specifically requested by the insured person; and

c) the insured person was hospitalized for acute care and not chronic or convalescent care.

EMERGENCY MEDICAL EXPENSES INCURRED OUTSIDE THE PROVINCE OF RESIDENCE

Expenses for the services and supplies listed herein will be covered, up to the maximum specified in the Summary of Benefits, when they are incurred as a result of a medical emergency which occurs during an insured person's absence from his province of residence provided:

a) the medical emergency occurs during an absence from his province of residence when such absence's expected length was 90 days or less, or if the absence is due to his or her attendance at an accredited educational institution on a full-time basis, the medical emergency occurs during the school year for which he is enrolled at the institution, or

   However, if the absence was expected to be 90 days or less but is extended due to unforeseen circumstances, coverage will be provided only for a medical emergency which occurs during the first 90 days of the absence.

   If the absence is expected to exceed 90 days, there is no coverage under this benefit during the entire absence

b) the insured person's absence was due to business, a vacation or full-time attendance at an accredited educational institution; and

c) the provision of the services and supplies could not have been delayed until the insured person had returned to his province of residence without endangering his health.

The following services and supplies which are received as a result of a medical emergency will be covered:

a) Services of a physician;

b) Accommodation in a hospital up to the level specified for the Hospitalization in the province of residence benefit;

c) Medical services, appliances and supplies furnished during a hospital confinement;

d) Diagnostic, medical imaging and laboratory services;

e) Paramedical services provided during a hospital confinement;

f) Hospital out-patient services and supplies;

g) Drugs;

h) Medical appliances and supplies provided out of hospital;

i) Professional ambulance service to transport the insured person to the nearest hospital equipped to provide the required medical treatment.

For paramedical services, drugs and medical appliances, only those drugs, appliances and services which would have been covered in the insured person's province of residence will be covered when they are received outside of his province of residence in a medical emergency.

Limitations For Emergency Medical Expenses Incurred Outside The Province Of Residence

If the insured person should become hospitalized outside his province of residence due to a medical emergency, the insured person will be required to contact the insurer's Medical Assistance Service provider as soon as the person is reasonably able to do so after the commencement of his hospitalization. Failure to do so may result in the insurer limiting or denying the insured person's claim resulting from the medical emergency.

In addition, if during a medical emergency, the insurer determines that the insured person can be repatriated to his province of residence without endangering his health and the insured person refuses to be repatriated, the insurer will not be responsible for any further expenses incurred by the insured person due to the medical emergency.

No coverage will be provided under this benefit for any expenses that are incurred for a medical emergency if:

a) The insured person's medical condition was not stable before the absence from his province of residence began; and

b) The medical emergency results directly or indirectly from that medical condition.

The insurer determines, at its sole discretion, what stable means. In this assessment, the insurer may take into consideration the following:

a) Medical status;

b) Medical treatment, examination, consultation or hospitalization;

c) Increase or worsening of any symptom or health problem;

d) Change in medical treatment or in medication;

e) Medical treatment or examination planned or for which results are pending for any symptom or health problem;

within a period of 90 days prior to that absence.

MEDICAL EXPENSES INCURRED IN CANADA, OTHER THAN EMERGENCY MEDICAL EXPENSES INCURRED OUTSIDE THE PROVINCE OF RESIDENCE

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

   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 required;
      - 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 or her.

   ii) Licensed ambulance service in a medical emergency for 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. The ambulance service is limited to the most adequate and least expensive 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 related to 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 provision.

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

ii) an alternative drug to the original drug deemed interchangeable by law; or

iii) 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 manual wheelchairs or electric wheelchairs when the insured person is incapable of operating a manual wheelchair due to a medical condition;

viii) Rental or purchase of a manually operated hospital beds or electrically operated hospital beds when the insured person is incapable of operating a manually operated hospital bed due to a medical condition, including bed rails and trapeze bars;

ix) Rental or purchase of any respiratory assistance devices;

x) Purchase or rental of diabetic administration equipment, 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;

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

xii) 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;

xiii) Room and board charges made in a facility licensed to provide rehabilitative or convalescent care provided:

i) the insured person is under the regular supervision of a physician or registered nurse;

ii) the confinement was recommended by a physician;

iii) the confinement is for rehabilitative or convalescent care.

However, there will be no coverage if the rehabilitative or convalescent care is for drug or alcohol abuse or addiction.

xiv) Cost of orthopedic shoes and deep shoes for which the medical necessity of was determined by a health practitioner operating within the scope of his license and which have been custom made, modified or custom molded for the insured person by a certified specialist in orthopedic footwear;

xv) Cost of foot orthoses for which the medical necessity of was determined by a health practitioner operating within the scope of his license and which have been specifically designed and constructed for the insured person by a certified specialist in foot orthoses. Off the shelf foot orthoses which have not been specifically designed and constructed for the insured person will not be eligible for coverage;

xvi) Cost of laboratory analyses, electrocardiograms, electroencephalograms, 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;

xvii) Rental or purchase of braces with rigid support; back supports; shoulder harnesses; head halters and cervical collars;

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

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

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

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

xxii) Purchase of diabetic monitoring equipment other than the insulin supplies such as needles, syringes, lancets and diagnostic testing materials;

xxiii) 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;

xxiv) Purchase of blood and blood plasma.

b) Dental care given out of hospital by a dentist which is required as a result of accidental injury to whole, healthy, natural teeth, provided

i) the accidental injury occurs while the insured person is covered under this benefit;

ii) the care is the least expensive that will provide a professionally adequate treatment;

iii) the charges do not exceed the amount shown for the treatment in the current provincial fee schedule for general practitioners in the insured person's province of residence; and

iv) the care is received within 6 months of the date of the accidental injury.

Any charges for dental care which is not related to the accidental injury will not be covered.

c) Fees for the care provided by one of the paramedical practitioners listed in the Summary of Benefits provided the practitioner is licensed by the appropriate provincial or federal organization to practice his profession in accordance with the rules of his 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) Charges for hearing aids or any related devices (including repairs and replacements but not batteries), and the professional services given by a hearing aid acoustician following the purchase of the hearing aid or related device 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 $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:

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

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

i) these lenses have been prescribed for a keratoconus (conical cornea) or as a result of surgery;

ii) satisfactory correction of vision cannot be obtained with eyeglasses;

iii) the lenses are purchased within 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 an illness or injury or any expenses resulting, directly or indirectly, from a self-inflicted injury unless medical evidence establishes that the injury was directly related to a mental health illness.

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) Expenses for an illness or injury resulting from the commission of or attempted commission of a criminal offence or provoking of an assault;

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

vi) Care or treatment included in the protocol of a research and development program for a product whose use has not been recommended by the manufacturer or which does not comply with government standards;

vii) Care or treatment of an illness or injury that is not recognized as normal, customary and common practice for such illness or injury;

viii) Any portion of a charge for care or treatment which is in excess of the reasonable and customary charge normally incurred for an illness or injury of the same nature and severity in the locality where the service is provided;

ix) 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;

x) Services or supplies which are for the sole purpose of facilitating the insured person’s participation in sports or recreational activities and not for daily living activities;

xi) Eye examination, except if specifically mentioned as being covered under this benefit;

xii) 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;

xiii) Purchase of food or nutritional supplements;

xiv) The following products or drugs are not covered:

i) products for esthetic or cosmetic care;

ii) "natural" products;

iii) artificial insemination products;

xv) Expenses for preventive immunization vaccines or the administration of serums, vaccines and injectable medications;

xvi) Expenses for contraceptives (other than oral), except if mention is made that these expenses are covered under this benefit;

xvii) Expenses for the following products unless such products can only be obtained with a written prescription of a healthcare provider who is legally licensed to prescribe them and they are required to be dispensed by a pharmacist:

- products for the care of contact lenses;
- proteins or dietary supplements, amino acids;
- baby food;
- mouthwash, bandages and throat lozenges;
- shampoos, oils, creams;
- toilet products including soaps and emollients;
- skin softeners and protectors;
- vitamins, vitamin supplements or multivitamins;
- minerals;
- homeopathic products;
- anabolic steroids;

xviii) Expenses for any contribution to the cost of drugs and pharmaceutical services which must be paid by the insured

person under the Basic Prescription Drug Insurance Plan of Quebec;

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

xx) Expenses for any drugs which are considered lifestyle drugs such as, but not limited to, drugs for the treatment erectile dysfunction;

xxi) Care or treatments related to fertility or infertility;

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

xxiii) Expenses for any prescriptions which are dispensed by a clinic or by any non-accredited hospital pharmacy or for treatment as an out-patient in a hospital, including emergency status and investigational status drugs;

xxiv) Expenses for any care or treatment received outside the province of residence due to a medical emergency which is related to (i) a pregnancy, if the medical emergency occurs after the 32nd week of gestation or (ii) the deliberate inducement of a miscarriage;

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

i) has been charged with professional misconduct or improper practices; or

ii) is under investigation by an official body resulting from a law or regulation; or

iii) is under investigation by the insurer in regards to his professional conduct or practice; or

iv) 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; or

v) in the opinion of the insurer, does not meet the insurer's standards relevant to his professional conduct or practice; or

vi) is an employee, contractor, principal, or member of

- any business, group or association who is the subject of any of the matters set out in subparagraphs (i) to (v) above; or
- any entity that is affiliated with or related to such business, group or association.

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

CALCULATION OF REIMBURSEMENT

Deductible

The deductible, if any, must be paid by the insured person during the calendar year before any benefits are payable under this benefit. The deductible is specified in the Summary of Benefits.

Carry-over Provision

If the deductible for a calendar year is satisfied in whole or in part by the payment of covered expenses incurred during the last 3 months of the calendar year, the amount of covered expenses incurred in such 3 month period and which were applied toward satisfaction of the deductible for that calendar year, shall be carried over and applied toward satisfaction of the deductible for the next calendar year.

Reimbursement

The insurer will reimburse the percentage of covered expenses incurred, as specified in the Summary of Benefits, once the deductible has been satisfied.

Maximum Benefit Per Insured Person

The maximum amount that will be reimbursed by the insurer under this benefit is specified in the Summary of Benefits.

Co-ordination of Benefits

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

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

ii) any government sponsored plan, and

iii) any non-insured employee benefit plan.

SURVIVOR BENEFIT

Upon the death of a retiree, the spouse may maintain his or her participation and the one for his or her dependent children to this benefits on the day prior to the retiree's death.

To do so, the spouse must become a member of QPAT within 60 days of the death of the retiree, remain thereafter and pay the required insurance premiums.

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 60 days of the termination date of his insurance under the group insurance plan. Failure to submit the application and premium within such 60 days will prevent the participant from obtaining the insurance under the individual insurance contract.

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

SUPPLEMENTAL HEALTH INSURANCE – EMERGENCY OUT OF PROVINCE ASSISTANCE

The services listed herein will be provided in connection with a medical emergency or personal emergency which occurs while the insured person is absent from his province of residence provided:

a) the insured person is covered by the Supplemental Health Insurance benefit at the time of the emergency;

b) the medical emergency or personal emergency occurs during an absence from his province of residence when such absence's expected length was 90 days or less.

However, if the absence is due to his attendance at an accredited educational institution on a full-time basis, the medical emergency or personal emergency occurs during the school year for which he is enrolled at the institution;

Moreover, if the absence was expected to be 90 days or less but is extended due to unforeseen circumstances, coverage will be provided only for an emergency which occurs during the first 90 days of the absence;

If the absence is expected to exceed 90 days, there is no coverage under this benefit during the entire absence; and

c) the insured person's absence was due to business, a vacation or full-time attendance at an accredited educational institution; and

d) in case of a medical emergency, the emergency is covered under the Emergency Medical Expenses Incurred Outside the Province of Residence section of the Supplemental Health Insurance benefit.

The services will be provided by the insurer's Medical Assistance Service provider. The insured person will be required to contact the Medical Assistance Service provider to request the services in an emergency.

DEFINITION

As used in this benefit:

Member of the immediate family: The insured person's spouse, father, mother, child, brother or sister.

SUPPLEMENTAL HEALTH INSURANCE – EMERGENCY OUT OF PROVINCE ASSISTANCE

MEDICAL EMERGENCY ASSISTANCE SERVICES

The following services will be provided during a medical emergency:

a) 24 Hour Telephone Access

- The Medical Assistance Service provider will provide a 24 hour hot-line, 365 days a year, staffed by multilingual co-ordinators to connect the insured person to a network of specialists who will handle the emergency.

b) Medical Care

The Medical Assistance Service provider will:

- If the insured person is unable to locate a physician or hospital, provide a referral to a physician or an appropriate hospital;
- Upon request of 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 a hospital;
- Confirm to doctors and hospitals that the insured person's group policy will cover the insured person's medical expenses.

c) Medical Transportation

The Medical Assistance Service provider will:

- Arrange and pay for the transportation or transfer of the insured person by appropriate means to a hospital as recommended by the attending physician, and which the Medical Assistance Service provider agrees to;
- Arrange and pay for the return of the insured person to his residence or to a hospital near his residence after initial medical care has been provided, by an appropriate means of transportation, provided the return is medically necessary and permissible based on his medical condition. The Medical Assistance Service provider will arrange for the insured person's return using the most appropriate means of

transportation: air ambulance, helicopter, commercial airline, train or ambulance.

d) Payment of Medical Expenses and Cash Advance

- The Medical Assistance Service provider will make the necessary arrangements to pay medical expenses which are covered under the Emergency Medical Expenses Incurred Outside of Province section of the Supplemental Health Insurance benefit;
- When necessary in order for the insured person to obtain needed medical treatment, the Medical Assistance Service provider will advance up to $10,000 (Canadian), after consultation with the insurer.

e) Return of Deceased

- Should the insured person die, the Medical Assistance Service provider will make all arrangements and pay all expenses associated with returning the body of the deceased person to the place of burial in his province of residence, up to a maximum of $3,000. Funeral expenses will not be covered.

f) Return of Dependent Children

- The Medical Assistance Service provider will organize the return of the insured person's dependent children under age 16 who are left unattended due to the hospitalization of the insured person. In addition, the Medical Assistance Service provider will arrange and pay for economy transportation for the children, with an escort if necessary, to their usual place of residence. If the return tickets are still valid, only the additional cost incurred for the return transportation, after deducting the value of the tickets, will be paid.

g) Return of an Insured Person or a Member of the Insured Person's Immediate Family

- The Medical Assistance Service provider will organize the return of the insured person and/or a member of the insured person's immediate family who has lost the use of his return ticket due to the insured person's hospitalization or death. The Medical Assistance Service provider will arrange and pay for economy transportation to

return the insured person and/or member of the immediate family to his usual place of residence. If the return tickets are still valid, only the additional cost incurred for the return transportation, after deducting the value of the tickets, will be paid.

h) Visit from a Member of the Immediate Family

- The Medical Assistance Service provider will arrange and pay for round-trip economy class transportation for a member of the immediate family to visit the insured person if the person is hospitalized for at least 7 consecutive days and the attending physician feels that the visit would be beneficial to him.

i) Expenses for Commercial Accommodation and Meals

- When a return is delayed due to the hospitalization of an insured person for a period of more than 24 hours or because of an insured person's death, the expenses for commercial accommodation and meals incurred due to the delay by the insured person, by a member of the immediate family accompanying the insured person or visiting the insured person in accordance with h) will be reimbursed, subject to a daily maximum of $150 per person, and an overall maximum of $1,500.

  Receipts must be provided before reimbursement will be made by the Medical Assistance Service provider.

j) Vehicle Return

- The Medical Assistance Service provider will pay up to $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.

k) Emergency Drugs

- Should an insured person require drugs for the treatment of a medical condition and such drugs are not available locally, the Medical Assistance Service provider will co-ordinate a search for the drugs and once located arrange for the delivery of the drugs. The insured

person will be responsible for the cost of the drugs unless they are covered under the Supplemental Health Insurance benefit.

PERSONAL EMERGENCY TRAVEL ASSISTANCE SERVICES

The following services will be provided during a personal emergency:

a) Telephone Interpretation Service

- The Medical Assistance Service provider will provide the insured person with telephone interpretation services in most foreign languages.

b) Messages

- The Medical Assistance Service provider will relay a message, upon request, from the insured person to his home, office or elsewhere, or hold messages for the insured person or the members of his immediate family for up to 15 days.

c) Legal Assistance

- The Medical Assistance Service provider will assist the insured person in finding local legal aid when required, and will also help the insured person obtain a cash advance from his credit cards, family and friends, in order to pay for any bail or legal fees.

d) Travel Information

- The Medical Assistance Service provider will provide the insured person with travel information related to transportation, vaccinations and precautionary measures before, during and after the insured person's trip.

e) Lost Baggage or Travel Documents

- If the insured person loses or has his travel documents and/or baggage stolen, the Medical Assistance Service provider will help him contact the appropriate authorities.

EXCLUSIONS

The medical emergency assistance services provided under this benefit will be subject to the exclusions that are applicable to the Emergency Medical Expenses Incurred Outside the Province of Residence section of the Supplemental Health Insurance benefit.

LIABILITY

The Medical Assistance Service provider and insurer will not be held responsible for the provider's 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 provider directs insured persons are independent contractors and act on their own behalf and are not employees, agents or subordinates of the Medical Assistance Service provider or the insurer.

The Medical Assistance Service provider and the insurer are not responsible and assume no liability for the negligence or other acts or omissions by the doctors, hospitals, clinics, lawyers or other authorized practitioners or institutions to which the insured person is directed by the Medical Assistance Service provider.

REIMBURSEMENT

If a cash advance was made to cover a charge that had been made or a charge was paid, and the participant submits to the insurer such charge as a covered expense under the Supplemental Health Insurance benefit at a later date, the insurer will only reimburse the participant an amount, less that which was previously advanced or paid for such expense, subject to the deductible and reimbursement level that is applicable to the expense.

If a cash advance to cover an expense had been made or an expense had been paid and (i) such expense is not a covered expense under the

SUPPLEMENTAL HEALTH INSURANCE – EMERGENCY OUT OF PROVINCE ASSISTANCE

Emergency Medical Expenses Incurred Outside the Province of Residence section of the Supplemental Health Insurance benefit or (ii) the amount advanced or paid was in excess of the insurer's responsibility under the group policy, the participant will be responsible for reimbursing the insurer the cash advancement or the excess amount, whichever is applicable, within 90 days of the insured person returning to his province of residence. Should the participant fail to pay back the cash advance or excess amount, the insurer will have the right to reduce future health claims or any other claims by the participant or his dependents under the group policy by the amount owing.

COPY OF CONTRACT AND ENROLLMENT MATERIAL

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

PROTECTING PERSONAL INFORMATION

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

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

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

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

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

Participant's Right to Access His or Her Personal Information

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

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

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

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

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%

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.

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".

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:

ANNEX - VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

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.

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