MHI RJ AVIATION ULC

Class 507
Employees - Retired on and after
January 1, 2017 (with 10 years of service or more on retirement date and who were covered under the Flex Plan)

Class 563
Pilots

Class 567
Salaried Employees

Class 572
Employees - Expatriates

GROUP INSURANCE PLAN

Policyholder:	***MHI RJ AVIATION ULC***
Policy No.:	***28770***
Policy Effective Date:	***June 1, 2020***

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

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

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

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

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

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

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SUMMARY OF BENEFITS

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

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

SPECIAL PROVISIONS

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

Participants are insured under the following classes:

<u>Classes</u>

507 – Employees - Retired on and after January 1, 2017 (with 10 years of service or more on retirement date and who were covered under the Flex Plan)

563 – Pilots

567 – Salaried Employees

572 – Employees - Expatriates

An Expatriate Employee is not covered for Quebec Prescription Drug Insurance, Supplemental Health Insurance and Dental Care Insurance benefits.

ENROLLMENT RULES

The following default Options and coverage type will apply to Actively at work Participants:

Long-Term Disability Insurance: Option 1

Supplemental Health Insurance: Versatility Option

Dental Care Insurance: Versatility Option

Coverage type: Single

Flexible credits: HSA Agreement

A Participant may decline coverage for Supplemental Health Insurance and Dental Care Insurance. However, in order to decline Supplemental Health Insurance, it is mandatory for the Participant to be covered for comparable insurance with his Spouse.

RE-ENROLLMENT RULES

- As of January 1, 2021, the annual re-enrollment period occurs on January 1 of each year thereafter.
- A Participant need not have the same coverage type for Supplemental Health Insurance as for Dental Care Insurance; the coverage type may be changed on each re-enrollment date.
- Option selections are independent for all benefits.
- A Participant who is Actively at Work may opt for a benefit option that provides a higher level of coverage, for any benefit, during any re-enrollment period. However, evidence of insurability is required to increase the Optional Life Insurance for the Participant or his Spouse, or to increase the Long-Term Disability coverage.
- For the Supplemental Health Insurance and the Dental Care Insurance, the Comfort or Serenity Options must be kept for two years before the Participant can select a lower level of coverage.

RE-ENROLLMENT RULES (cont’d)

- On the annual re-enrollment date, a Participant who does not make any new selections retains the coverage and selections that were in effect on the previous Day.

LIFE EVENTS

- A Participant may change his option selections and coverage type between two re-enrollment periods, if the request is submitted within 60 Days of a change in their family status, such as:
  - Change in matrimonial status
  - Birth or adoption of a first Child
  - Last Dependent Child’s cessation of eligibility
  - Spouse’s change of eligibility to his Employer's group policy
  - Death of the Spouse
  - Return to an accredited educational institution on a full-time basis of a Dependent Child who is over 22 years of age but under 26 years of age after no more Dependent Children are eligible

LONG-TERM DISABILITY

Participants on long-term disability can only be covered under the Comfort Option for the Supplemental Health Insurance and Dental Care Insurance.

GENERAL PROVISIONS

ELIGIBILITY DATE

Subject to all of the terms and conditions of the group policy, **a Permanent full time or part time Employee** shall become eligible on the latest of the following dates:

a) On June 1, 2020, if he is then an Employee;

or

b) On the Employee's first Working Day with the Employer.

Subject to all of the terms and conditions of the group policy, a **Retired Employee** shall become eligible on the latest of the following dates:

a) On June 1, 2020, if he is then considered a Retired Employee by the Policyholder;

or

b) On the date on which he is considered a Retired Employee by the Policyholder.

ELIGIBILITY PERIOD

As per the Eligibility Period above.

PARTICIPANT'S LIFE INSURANCE

Classes: 507, 563, 567, 572

Sum Insured

Class 507:

20% of the Annual Earnings in force the Day before retirement, the result being rounded to the next $100 [1].

[1] *The Participant may, at any time, choose not to participate to this benefit. The decision is irrevocable.*

Classes 563, 567 and 572:

1 times the Annual Earnings, the result being rounded to the next higher $1,000, if not already a multiple thereof.

Maximum: $760,000 without evidence of insurability

or

$1,650,000 with evidence of insurability.

PARTICIPANT'S LIFE INSURANCE (cont'd)

Classes: 507, 563, 567, 572

Reductions, Exclusions and Limitations:

Class 507:

The sum insured is reduced to $15,000 on the Participant's 70th birthday.

This benefit and any sum insured payable thereunder are subject to any other reductions, exclusions and limitations indicated in this benefit or in the General Provisions of the group policy.

Classes 563, 567 and 572:

This benefit and any sum insured payable thereunder are subject to any reductions, exclusions and limitations indicated in this benefit or in the General Provisions of the group policy.

Termination:

Class 507:

The insurance under this benefit terminates on the earliest of: the Participant's death; or such other earlier date indicated in this benefit or in the General Provisions of the group policy.

Classes 563, 567 and 572:

The insurance under this benefit terminates on the earliest of: the Participant's date of retirement or such other earlier date indicated in this benefit or in the General Provisions of the group policy.

At retirement, the Participant with a minimum of 10 years of service is transferred to class 507.

PARTICIPANT'S OPTIONAL LIFE INSURANCE

Classes: 563, 567, 572

Sum Insured

Units of $5,000

Maximum [1]: $40,000 without evidence of insurability
or
5 times the Annual Earnings, without exceeding $1,650,000, with evidence of insurability

[1] *The combined amount of basic and optional life insurance must not exceed $1,650,000.*

Reductions, Exclusions and Limitations:

A Participant may obtain the maximum amount without evidence of insurability within 31 Days of his initial enrollment.

At any other time, any amount of Optional life insurance requires evidence of insurability and are subject to the insurer receiving the required evidence of insurability and providing Approval of Evidence of Insurability in accordance with all of the terms and conditions of this benefit or in the General Provisions of the group policy.

This benefit and any sum insured payable thereunder are subject to any other reductions, exclusions and limitations indicated in this benefit or in the General Provisions of the group policy.

Termination:

The insurance under this benefit terminates on the earliest of: the Participant's 70th birthday; or his date of retirement; or such other earlier date indicated in this benefit or in the General Provisions of the group policy.

DEPENDENTS' OPTIONAL LIFE INSURANCE

Classes: 563, 567, 572

Sum Insured

Spouse:	Units of $5,000 Maximum: $40,000 without evidence of insurability [1] or $400,000 with evidence of insurability
Each Child upon a live birth:	Units of $5,000 Maximum: $50,000 [2]

Reductions, Exclusions and Limitations:

[1] The maximum without evidence of insurability is available, provided the request is made within 31 Days of the Participant's initial eligibility date, the Participant's marriage, the anniversary of cohabitation of the Participant with a common law spouse, or within 31 Days of the date of birth or of the adoption of a Child.

[2] No evidence of insurability is required for all amounts of children's optional life.

At any other time, evidence of insurability is required for all amounts of Optional life insurance and are subject to the insurer receiving the required evidence of insurability and providing Approval of Evidence of Insurability in accordance with all of the terms and conditions of this benefit or in the General Provisions of the group policy.

This benefit and any sum insured payable thereunder are subject to any other reductions, exclusions and limitations indicated in this benefit or in the General Provisions of the group policy.

DEPENDENTS' OPTIONAL LIFE INSURANCE (cont'd)

Classes: 563, 567, 572

Termination:

For the Spouse, the insurance under this benefit terminates on the earliest of: the Participant's 70th birthday; or the Participant's date of retirement; or the Spouse's 70th birthday; or such other earlier date indicated in this benefit or in the General Provisions of the group policy.

For each Child, the insurance under this benefit terminates on the earliest of: the Participant's 70th birthday; or the Participant's date of retirement; or such other earlier date indicated in this benefit or in the General Provisions of the group policy.

LONG-TERM DISABILITY INSURANCE

OPTION 1

Classes: 563, 567 and 572

Monthly Indemnity

60% of the Monthly Earnings, the result being rounded to the next higher dollar, if not already a multiple thereof.

Monthly maximum:

$10,600 without evidence of insurability [(1)]
or
$17,000 with evidence of insurability [(1)].

[(1)] *subject to applicable reductions*

However, the overall maximum must not exceed 80% of the Pre-Total Disability Gross Monthly Earnings.

Reductions, Exclusions and Limitations: This benefit and any amounts payable thereunder are subject to any reductions, exclusions and limitations indicated in this benefit or in the General Provisions of the group policy.

Elimination Period: 26 weeks

If Long-Term Disability benefits are approved, payment of benefits will begin after satisfaction of the maximum benefit payment period provided under the Short-Term Disability Insurance benefit, if such benefit is included under the group policy.

Maximum Benefit Payment Period: To the Participant's 65th birthday

LONG-TERM DISABILITY INSURANCE (cont'd)

OPTION 1 (cont'd)

Classes: 563, 567 and 572

Maximum Cost of Living Adjustment: Not Applicable

Benefit Payments are taxable.

Termination:

The insurance under this benefit terminates on the earliest of: the Participant's 65th birthday; or his date of retirement; or such other earlier date indicated in this benefit or in the General Provisions of the group policy.

LONG-TERM DISABILITY INSURANCE (cont'd)

OPTION 2

Classes: 563, 567 and 572

Monthly Indemnity

70% of the Monthly Earnings, the result being rounded to the next higher dollar, if not already a multiple thereof.

Monthly maximum:

$10,600 without evidence of insurability [(1)]
or
$17,000 with evidence of insurability [(1)].

[(1)] *subject to applicable reductions*

However, the overall maximum must not exceed 80% of the Pre-Total Disability Gross Monthly Earnings.

Reductions, Exclusions and Limitations:	This benefit and any amounts payable thereunder are subject to any reductions, exclusions and limitations indicated in this benefit or in the General Provisions of the group policy.
Elimination Period:	26 weeks If Long-Term Disability benefits are approved, payment of benefits will begin after satisfaction of the maximum benefit payment period provided under the Short-Term Disability Insurance benefit, if such benefit is included under the group policy.
Maximum Benefit Payment Period:	To the Participant's 65th birthday

LONG-TERM DISABILITY INSURANCE (cont’d)

OPTION 2 (cont’d)

Classes: 563, 567 and 572

Maximum Cost of Living Adjustment: Not Applicable

Benefit Payments are taxable.

Termination:

The insurance under this benefit terminates on the earliest of: the Participant's 65th birthday; or his date of retirement; or such other earlier date indicated in this benefit or in the General Provisions of the group policy.

LONG-TERM DISABILITY INSURANCE (cont'd)

OPTION 3

Classes: 563, 567 and 572

Monthly Indemnity

70% of the Monthly Earnings, the result being rounded to the next higher dollar, if not already a multiple thereof.

Monthly maximum:

$10,600 without evidence of insurability [1]
or
$17,000 with evidence of insurability [1].

[1] *subject to applicable reductions*

However, the overall maximum must not exceed 80% of the Pre-Total Disability Gross Monthly Earnings.

Reductions, Exclusions and Limitations: This benefit and any amounts payable thereunder are subject to any reductions, exclusions and limitations indicated in this benefit or in the General Provisions of the group policy.

Elimination Period: 26 weeks

If Long-Term Disability benefits are approved, payment of benefits will begin after satisfaction of the maximum benefit payment period provided under the Short-Term Disability Insurance benefit, if such benefit is included under the group policy.

Maximum Benefit Payment Period: To the Participant's 65th birthday

LONG-TERM DISABILITY INSURANCE (cont'd)

OPTION 3 (cont'd)

Classes: 563, 567 and 572

Maximum Cost of Living Adjustment: Equal to the lesser of:

a) the percentage rise in the Canadian Consumer Price Index; and
b) 3%

Benefit Payments are taxable.

Termination:

The insurance under this benefit terminates on the earliest of: the Participant's 65th birthday; or his date of retirement; or such other earlier date indicated in this benefit or in the General Provisions of the group policy.

SUPPLEMENTAL HEALTH INSURANCE

EXEMPTION OPTION

Classes: 563 and 567, Participant only

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

(for an absence due to business travel only)

Deductible:	Reimbursement:	Maximum per Insured Person:
none	100%	$5,000,000 per lifetime
		Duration of coverage per trip: the first 90 consecutive Days of the trip

Reductions, Exclusions and Limitations:

This benefit and any amounts payable thereunder are subject to any reductions, exclusions and limitations indicated in this benefit or in the General Provisions of the group policy.

Termination:

The insurance under this benefit terminates on the earliest of: the Participant's date of retirement; or such other earlier date indicated in this benefit or in the General Provisions of the group policy.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

VERSATILITY OPTION

Classes: 563 and 567

HOSPITALIZATION IN THE PROVINCE OF RESIDENCE

Deductible:	Reimbursement:	Daily maximum:
none	100%	Semi-private room rate

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
		Duration of coverage per trip: the first 90 consecutive Days of the trip

DRUGS

Deductible:	$1,000 per adult [1]
Reimbursement:	100% [2]
Maximum:	Unlimited

[1] *The Participant's Deductible for drugs includes any amounts paid as a Deductible for a Dependent Child, if applicable.*

[2] *Mandatory generic substitution: If the drug is an original drug which has a generic equivalent, the amount payable will be based on the lowest priced substitutable drug, if applicable.*

SUPPLEMENTAL HEALTH INSURANCE (cont’d)

VERSATILITY OPTION (cont’d)

Classes: 563 and 567

ALL OTHER MEDICAL EXPENSES INCURRED IN CANADA

Deductible:	None
Reimbursement:	
– Alcoholism, drug addiction or gambling treatment program:	100%
– Rehabilitative or convalescent care:	100%
– All other covered expenses:	70%
Maximum:	Unlimited

Reductions, Exclusions and Limitations:

This benefit and any amounts payable thereunder are subject to any reductions, exclusions and limitations indicated in this benefit or in the General Provisions of the group policy.

Termination:

The insurance under this benefit terminates on the earliest of: the Participant's date of retirement; or such other earlier date indicated in this benefit or in the General Provisions of the group policy.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

VERSATILITY OPTION (cont'd)

Classes: 563 and 567

Medical Expenses

Covered Expenses	Payable 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.
Anti-smoking aids	These expenses are reimbursed according to the *Régie de l'assurance-maladie du Québec* parameters.
Anti-addiction drugs	$1,000 per lifetime.
Drugs for fertility or infertility treatment	These expenses are reimbursed according to the *Régie de l'assurance-maladie du Québec* parameters.
Vaccines, including preventive immunization vaccines *(excluding the administration)*	$500 per Calendar Year.
Fees for nursing care	$25,000 per 3 consecutive Calendar Years.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

VERSATILITY OPTION (cont'd)

Classes: 563 and 567

Medical Expenses (cont'd)

Covered Expenses	Payable maximums Per Insured Person
Physician fees for medical certificates in regards to disability	Unlimited. *These expenses are reimbursed from the second certificate, and for the Participant only.*
Licensed ambulance services	Unlimited.
Room and board in a facility licensed to provide rehabilitative or convalescent care	$40 per Day. Combined maximum of 180 Days per period of Hospitalization due to the same cause.
Medical appliances and supplies	Unlimited.
Diabetic monitoring equipment	One device per period of 24 consecutive months.
Artificial arm, hand and foot, *(including repairs and replacements)*	Unlimited for Insured Persons under age 16 and one device of each type per lifetime, for Insured Persons aged 16 and over.
Artificial eyes	One prosthesis per lifetime.
Tensiometers	One device per lifetime.
Breast prostheses and surgical brassieres	Combined maximum of $250 per period of 24 consecutive months.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

VERSATILITY OPTION (cont'd)

Classes: 563 and 567

Medical Expenses (cont'd)

Covered Expenses	Payable maximums Per Insured Person
Medical elastic stockings *(of 15mmHg or more)*	One pair per Calendar Year.
Orthopedic shoes	These expenses are not covered.
Foot orthoses *(custom made)* and alterations to regular or orthopedic shoes and arch supports	These expenses are not covered.
Intrauterine devices	One per period of 3 consecutives Calendar Years.
Diaphragms	One per Calendar Year.
Eyeglasses, contact lenses or intraocular lenses following cataract surgery	$200 per eye, per lifetime.
Diagnostic laboratory tests, x-rays for colonoscopy, fees for colonoscopy testing and Medical imaging services	Combined maximum of $300 per Calendar Year.
Capillary prostheses *(required as a result of chemotherapy)*	$300 per lifetime.
Sclerosing injections *(excluding administration)*	$30 per visit.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

VERSATILITY OPTION (cont'd)

Classes: 563 and 567

Medical Expenses (cont'd)

Covered Expenses	Payable maximums Per Insured Person
Dental care as a result of an accidental injury	Unlimited.
Hearing aids or any related devices	$550 per Calendar Year.
Treatment facility for the treatment of alcoholism, drug addiction or gambling	$1,500 per lifetime. *(Participant only)*
Eye examinations	These expenses are not covered.
Eyeglasses *(frame and lenses, including sunglasses and safety glasses),* contact lenses or corrective laser surgery and eyeglasses or contact lenses following the treatment of a keratoconus	These expenses are not covered.
Cosmetic surgery following an Accident	Unlimited.
Fees for the following paramedical practitioners: Physical rehabilitation therapist, Physiotherapist and Occupational therapist	Combined maximum of $250 per Calendar Year. One treatment per Day.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

VERSATILITY OPTION (cont'd)

Classes: 563 and 567

Medical Expenses (cont'd)

Covered Expenses	Payable maximums Per Insured Person
Fees for the following paramedical practitioners: Psychologist, Psychotherapist *(including expenses incurred for psychological evaluations),* Social worker, Psychometrist, Family therapist, Marriage counsellor, Clinical counsellor and Guidance counsellor	Participant: Combined maximum of $1,000 per Calendar Year. One treatment per Day. Dependent: Combined maximum of $600 per Calendar Year. One treatment per Day.
X-rays for the following paramedical practitioner: Chiropractor	These expenses are not covered.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

COMFORT OPTION

Classes: 563 and 567

HOSPITALIZATION IN THE PROVINCE OF RESIDENCE

Deductible:	Reimbursement:	Daily maximum:
none	100%	Semi-private room rate

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
		Duration of coverage per trip: the first 90 consecutive Days of the trip

DRUGS

Deductible:	$6 for each prescription item or refill of a prescription item [1]
Reimbursement:	80% [1] [2]
Maximum:	Unlimited

[1] *The yearly Maximum Contribution for all drugs covered under the group policy is $1,000 per adult (any amounts paid as a deductible and coinsurance for a Dependent Child are included in the Participant's yearly Maximum Contribution). Once this maximum reached, drugs are reimbursed at 100%.*

[2] *Mandatory generic substitution: If the drug is an original drug which has a generic equivalent, the amount payable will be based on the lowest priced substitutable drug, if applicable.*

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

COMFORT OPTION (cont'd)

Classes: 563 and 567

ALL OTHER MEDICAL EXPENSES INCURRED IN CANADA

Deductible:	None
Reimbursement:	
– Alcoholism, drug addiction or gambling treatment program:	100%
– Rehabilitative or convalescent care:	100%
– All other covered expenses:	80%
Maximum:	Unlimited

Reductions, Exclusions and Limitations:

This benefit and any amounts payable thereunder are subject to any reductions, exclusions and limitations indicated in this benefit or in the General Provisions of the group policy.

Termination:

The insurance under this benefit terminates on the earliest of: the Participant's date of retirement; or such other earlier date indicated in this benefit or in the General Provisions of the group policy.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

COMFORT OPTION (cont'd)

Classes: 563 and 567

Medical Expenses

Covered Expenses	Payable 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.
Anti-smoking aids	These expenses are reimbursed according to the *Régie de l'assurance-maladie du Québec* parameters.
Anti-addiction drugs	$1,000 per lifetime.
Drugs for fertility or infertility treatment	These expenses are reimbursed according to the *Régie de l'assurance-maladie du Québec* parameters.
Vaccines, including preventive immunization vaccines *(excluding the administration)*	$500 per Calendar Year.
Fees for nursing care	$25,000 per 3 consecutive Calendar Years.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

COMFORT OPTION (cont'd)

Classes: 563 and 567

Medical Expenses (cont'd)

Covered Expenses	Payable maximums Per Insured Person
Physician fees for medical certificates in regards to disability	Unlimited. *These expenses are reimbursed from the second certificate, and for the Participant only.*
Licensed ambulance services	Unlimited.
Room and board in a facility licensed to provide rehabilitative or convalescent care	$40 per Day. Combined maximum of 180 Days per period of Hospitalization due to the same cause.
Medical appliances and supplies	Unlimited.
Diabetic monitoring equipment	One device per period of 24 consecutive months.
Artificial arm, hand and foot, *(including repairs and replacements)*	Unlimited for Insured Persons under age 16 and one device of each type per lifetime, for Insured Persons aged 16 and over.
Artificial eyes	One prosthesis per lifetime.
Tensiometers	One device per lifetime.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

COMFORT OPTION (cont'd)

Classes: 563 and 567

Medical Expenses (cont'd)

Covered Expenses	Payable maximums Per Insured Person
Breast prostheses and surgical brassieres	Combined maximum of $250 per period of 24 consecutive months.
Medical elastic stockings *(of 15mmHg or more)*	One pair per Calendar Year.
Orthopedic shoes *(modified off the shelf, custom made or custom molded)*	One pair per Calendar Year.
Foot orthoses *(custom made)* and alterations to regular or orthopedic shoes and arch supports	Combined maximum of $250 per Calendar Year.
Intrauterine devices	One per period of 3 consecutives Calendar Years.
Diaphragms	One per Calendar Year.
Eyeglasses, contact lenses or intraocular lenses following cataract surgery	$200 per eye, per lifetime.
Diagnostic laboratory tests and Medical imaging services	Combined maximum of $500 per Calendar Year.
Capillary prostheses *(required as a result of chemotherapy)*	$300 per lifetime.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

COMFORT OPTION (cont'd)

Classes: 563 and 567

Medical Expenses (cont'd)

Covered Expenses	Payable maximums Per Insured Person
Sclerosing injections *(excluding administration)*	$30 per visit.
Dental care as a result of an accidental injury	Unlimited.
Hearing aids or any related devices	$550 per Calendar Year.
Treatment facility for the treatment of alcoholism, drug addiction or gambling	$1,500 per lifetime. *(Participant only)*
Eye examinations	One exam per Calendar Year.
Eyeglasses *(frame and lenses, including sunglasses and safety glasses)*, contact lenses or corrective laser surgery and eyeglasses or contact lenses following the treatment of a keratoconus	$200 per period of 24 consecutive months or per period of 12 consecutive months for Dependent Children under 18 years of age.
Cosmetic surgery following an accident	Unlimited.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

COMFORT OPTION (cont'd)

Classes: 563 and 567

Medical Expenses (cont'd)

Covered Expenses	Payable maximums Per Insured Person
Fees for the following paramedical practitioners: Physical rehabilitation therapist, Physiotherapist and Occupational therapist	Combined maximum of $750 per Calendar Year. One treatment per Day.
Fees for the following paramedical practitioners: Psychologist, Psychotherapist *(including expenses incurred for psychological evaluations),* Social worker, Psychometrist, Family therapist, Marriage counsellor, Clinician counsellor and Guidance counsellor	Participant: Combined maximum of $2,000 per Calendar Year. One treatment per Day. Dependent: Combined maximum of $1,200 per Calendar Year. One treatment per Day.
Fees for the following paramedical practitioners: Speech therapist, Audiologist, Chiropractor, Osteopath, Podiatrist (including x-rays), Acupuncturist and Dietician	Maximum of $300 per Calendar Year for each practitioner. One treatment per Day.
X-rays for the following paramedical practitioner: Chiropractor	$100 per Calendar Year.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

SERENITY OPTION

Classes: 563 and 567

HOSPITALIZATION IN THE PROVINCE OF RESIDENCE

Deductible:	Reimbursement:	Daily maximum:
none	100%	Semi-private room rate

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
		Duration of coverage per trip: The first 90 consecutive Days of the trip

DRUGS

Deductible:	$3 for each prescription item or refill of a prescription item [1]
Reimbursement:	90% [1] [2]
Maximum:	Unlimited

(1) *The yearly Maximum Contribution for all drugs covered under the group policy is $1,000 per adult (any amounts paid as a deductible and coinsurance for a dependent Child are included in the Participant's yearly Maximum Contribution). Once this maximum reached, drugs are reimbursed at 100%.*

(2) *Mandatory generic substitution: If the drug is an original drug which has a generic equivalent, the amount payable will be based on the lowest priced substitutable drug, if applicable.*

SUPPLEMENTAL HEALTH INSURANCE (cont’d)

SERENITY OPTION (cont’d)

Classes: 563 and 567

ALL OTHER MEDICAL EXPENSES INCURRED IN CANADA

Deductible:	None
Reimbursement:	
– Alcoholism, drug addiction or gambling treatment program:	100%
– Rehabilitative or convalescent care:	100%
– All other covered expenses:	90%
Maximum:	Unlimited

Reductions, Exclusions and Limitations:

This benefit and any amounts payable thereunder are subject to any reductions, exclusions and limitations indicated in this benefit or in the General Provisions of the group policy.

Termination:

The insurance under this benefit terminates on the earliest of: the Participant's date of retirement; or such other earlier date indicated in this benefit or in the General Provisions of the group policy.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

SERENITY OPTION (cont’d)

Classes: 563 and 567

Medical Expenses

Covered Expenses	Payable 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.
Anti-smoking aids	These expenses are reimbursed according to the *Régie de l'assurance-maladie du Québec* parameters.
Anti-addiction drugs	$1,000 per lifetime.
Drugs for fertility or infertility treatment	These expenses are reimbursed according to the *Régie de l'assurance-maladie du Québec* parameters.
Vaccines, including preventive immunization vaccines *(excluding the administration)*	$500 per Calendar Year.
Fees for nursing care	$25,000 per 3 consecutive Calendar Years.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

SERENITY OPTION (cont'd)

Classes: 563 and 567

Medical Expenses (cont'd)

Covered Expenses	Payable maximums Per Insured Person
Physician fees for medical certificates in regards to disability	Unlimited. *These expenses are reimbursed from the second certificate, and for the Participant only.*
Licensed ambulance services	Unlimited.
Room and board in a facility licensed to provide rehabilitative or convalescent care	$40 per Day. Combined maximum of 180 Days per period of Hospitalization due to the same cause.
Medical appliances and supplies	Unlimited.
Diabetic monitoring equipment	One device per period of 24 consecutive months.
Artificial arm, hand and foot, *(including repairs and replacements)*	Unlimited for Insured Persons under age 16 and one device of each type per lifetime, for Insured Persons aged 16 and over.
Artificial eyes	One prosthesis per lifetime.
Tensiometers	One device per lifetime.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

SERENITY OPTION (cont'd)

Classes: 563 and 567

Medical Expenses (cont'd)

Covered Expenses	Payable maximums Per Insured Person
Breast prostheses and surgical brassieres	Combined maximum of $250 per period of 24 consecutive months.
Medical elastic stockings *(of 15mmHg or more)*	One pair per Calendar Year.
Orthopedic shoes *(modified off the shelf, custom made or custom molded)*	2 pairs per Calendar Year.
Foot orthoses *(custom made),* alterations to regular or orthopedic shoes and arch supports	Combined maximum of $350 per Calendar Year.
Intrauterine devices	One per period of 3 consecutives Calendar Years.
Diaphragms	One per Calendar Year.
Eyeglasses, contact lenses or intraocular lenses following cataract surgery	$200 per eye, per lifetime.
Diagnostic laboratory tests and Medical imaging services	Combined maximum of $1,000 per Calendar Year.
Capillary prostheses *(required as a result of chemotherapy)*	$300 per lifetime.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

SERENITY OPTION (cont'd)

Classes: 563 and 567

Medical Expenses (cont'd)

Covered Expenses	Payable maximums Per Insured Person
Sclerosing injections *(excluding administration)*	$30 per visit.
Dental care as a result of an accidental injury	Unlimited.
Hearing aids or any related devices	$550 per Calendar Year.
Treatment facility for the treatment of alcoholism, drug addiction or gambling	$1,500 per lifetime. *(Participant only)*
Eye examinations	One exam per Calendar Year.
Eyeglasses *(frame and lenses, including sunglasses and safety glasses)*, contact lenses or corrective laser surgery and eyeglasses or contact lenses following the treatment of a keratoconus	$300 per period of 24 consecutive months or per period of 12 consecutive months for Dependent Children under 18 years of age.
Cosmetic surgery following an accident	Unlimited.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

SERENITY OPTION (cont'd)

Classes: 563 and 567

Medical Expenses (cont'd)

Covered Expenses	Payable maximums Per Insured Person
Fees for the following paramedical practitioners: Physical rehabilitation therapist, Physiotherapist and Occupational therapist	Combined maximum of $1,000 per Calendar Year. One treatment per Day.
Fees for the following paramedical practitioners: Psychologist, Psychotherapist *(including expenses incurred for psychological evaluations),* Social worker, Psychometrist, Family therapist, Marriage counsellor, Clinical counsellor and Guidance counsellor	Participant: Combined maximum of $3,000 per Calendar Year. One treatment per Day. Dependent: Combined maximum of $2,000 per Calendar Year. One treatment per Day.
Fees for the following paramedical practitioners: Speech therapist, Audiologist, Chiropractor, Osteopath, Podiatrist (including x-rays), Acupuncturist and Dietician	Maximum of $500 per Calendar Year for each practitioner. One treatment per Day.
Fees for the following paramedical practitioners: Massage therapist, Kinotherapist, Kinesitherapist, Orthotherapist and Naturopath	Combined maximum of $500 per Calendar Year. One treatment per Day.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

SERENITY OPTION (cont'd)

Classes: 563 and 567

Medical Expenses (cont'd)

Covered Expenses	Payable maximums Per Insured Person
X-rays for the following paramedical practitioner: Chiropractor	$100 per Calendar Year.

DENTAL CARE INSURANCE

VERSATILITY OPTION

Classes: 563 and 567

Deductible:	$150 per Insured Person Maximum of $300 per family

Reimbursement:

– Preventive treatments:	50%
– Basic treatments:	50%
– Endodontic and Periodontic treatments:	50%
– Major treatments:	50%

Maximum per Insured Person:

– Preventive, Basic, Endodontic, Periodontic and Major treatments:	$1,000 per Calendar Year

Expenses for a General Dental Practitioner and a Dental Specialist are reimbursed according to the Dental Surgeons Association's Fee Guide for the current year.

Expenses for a Dental Hygienists are reimbursed according to the Dental Surgeons Association's Fee Guide for the current year or, if applicable, the Dental Hygienists Association's Fee Guide for the current year.

Expenses for a Denturist are reimbursed according to the Denturists Association's Fee Guide for the current year.

If there is no fee guide for the reference year, the insurer will determine the level of dental expenses to be reimbursed according to the latest fee guide plus an inflationary adjustment.

DENTAL CARE INSURANCE (cont'd)

VERSATILITY OPTION (cont'd)

Classes: 563 and 567

Reductions, Exclusions and Limitations:
This benefit and any amounts payable thereunder are subject to any reductions, exclusions and limitations indicated in this benefit or in the General Provisions of the group policy.

Termination:
The insurance under this benefit terminates on the earliest of: the Participant's date of retirement; or such other earlier date indicated in this benefit or in the General Provisions of the group policy.

DENTAL CARE INSURANCE (cont'd)

COMFORT OPTION

Classes: 563 and 567

Deductible:	None
Reimbursement:	
– Preventive treatments:	80%
– Basic treatments:	80%
– Endodontic and Periodontic treatments:	50%
– Major treatments:	50%
– Orthodontic treatments:	50%
Maximum per Insured Person:	
– Preventive, Basic, Endodontic, Periodontic and Major treatments:	$1,500 per Calendar Year
– Orthodontic treatments:	$1,500 per lifetime

ORTHODONTIC TREATMENTS are available to any Insured Person.

Expenses for a General Dental Practitioner are reimbursed according to the Dental Surgeons Association's Fee Guide for the current year.

Expenses for a Dental Specialist are reimbursed according to the Dental Specialists Association's Fee Guide for the current year.

Expenses for a Dental Hygienists are reimbursed according to the Dental Surgeons Association's Fee Guide for the current year or, if applicable, the Dental Hygienists Association's Fee Guide for the current year.

Expenses for a Denturist are reimbursed according to the Denturists Association's Fee Guide for the current year.

If there is no fee guide for the reference year, the insurer will determine the level of dental expenses to be reimbursed according to the latest fee guide plus an inflationary adjustment.

DENTAL CARE INSURANCE (cont'd)

COMFORT OPTION (cont'd)

Classes: 563 and 567

Reductions, Exclusions and Limitations:
This benefit and any amounts payable thereunder are subject to any reductions, exclusions and limitations indicated in this benefit or in the General Provisions of the group policy.

Termination:
The insurance under this benefit terminates on the earliest of: the Participant's date of retirement; or such other earlier date indicated in this benefit or in the General Provisions of the group policy.

DENTAL CARE INSURANCE (cont'd)

SERENITY OPTION

Classes: 563 and 567

Deductible: None

Reimbursement:

- Preventive treatments: 90%
- Basic treatments: 90%
- Endodontic and Periodontic treatments: 80%
- Major treatments: 60%
- Orthodontic treatments: 50%

Maximum per Insured Person:

- Preventive, Basic, Endodontic, Periodontic and Major treatments: $2,500 per Calendar Year
- Orthodontic treatments: $2,500 per lifetime

ORTHODONTIC TREATMENTS are available to any Insured Person.

Expenses for a General Dental Practitioner are reimbursed according to the Dental Surgeons Association's Fee Guide for the current year.

Expenses for a Dental Specialist are reimbursed according to the Dental Specialists Association's Fee Guide for the current year.

Expenses for a Dental Hygienists are reimbursed according to the Dental Surgeons Association's Fee Guide for the current year or, if applicable, the Dental Hygienists Association's Fee Guide for the current year.

Expenses for a Denturist are reimbursed according to the Denturists Association's Fee Guide for the current year.

If there is no fee guide for the reference year, the insurer will determine the level of dental expenses to be reimbursed according to the latest fee guide plus an inflationary adjustment.

DENTAL CARE INSURANCE (cont'd)

SERENITY OPTION **(cont'd)**

Classes: 563 and 567

Reductions, Exclusions and Limitations:
This benefit and any amounts payable thereunder are subject to any reductions, exclusions and limitations indicated in this benefit or in the General Provisions of the group policy.

Termination:
The insurance under this benefit terminates on the earliest of: the Participant's date of retirement; or such other earlier date indicated in this benefit or in the General Provisions of the group policy.

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iA Special Markets, a division of Industrial Alliance Insurance and Financial Services Inc., is the insurer for the following benefits:

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE
Policy No. 100012339

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE
Policy No. 100012340

BUSINESS TRAVEL ACCIDENT GROUP INSURANCE
Policy No. 100012341

VOLUNTARY GROUP CRITICAL ILLNESS INSURANCE
Policy No. 100012342

For more details, please refer to the texts of the benefits at the end of the booklet.

DEFINITIONS

Accident means any event due to a sudden and unforeseeable external cause that inflicts bodily injuries directly and independently of any other cause, all of which is certified by a Physician.

Actively at Work means:

If it is a Working Day, the Employee is deemed to be Actively at Work for his Employer if he reports to work and performs all the essential duties of his regular occupation for the total number of scheduled hours for such Working Day.

If it is a weekend, holiday or a vacation Day, the Employee is deemed to be Actively at Work for his Employer if:

a) On that Day, he would have been able to report to work for his Employer and perform all the essential duties of his regular occupation for the total number of scheduled hours had it been a Working Day; and

b) On his last Working Day, he reported to work for his Employer and performed all of the essential duties of his regular occupation for the total number of scheduled hours for that Working Day.

Approval of Evidence of Insurability means the insurer actually accepts, in writing, the risk applied for after receiving each and every document required to assess such risk.

Calendar Year means the period from any January 1st to the next December 31st, both inclusive.

Day means a Calendar Day, except if otherwise defined in the group policy.

Day Surgery means surgery which is performed in a Hospital or out-patient clinic affiliated with a Hospital and requiring local, regional or general anaesthesia, but will not include minor surgery that can be performed in the Physician's office.

Dependent means:

The Participant's Spouse, or a Child of the Participant or of the Spouse, who is insured under the group policy and who satisfies the following respective definitions:

a) Spouse

Spouse of a Participant who is not an Expatriate Employee

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.

In all cases, a de facto separation of more than 3 months results in the loss of status as Spouse.

The Spouse must reside in the same country as the Participant.

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

Spouse of a Participant who is an Expatriate Employee

A person who

i) is Canadian; and

ii) was a full-time resident of Canada immediately prior to the commencement of the absence from Canada; and

iii) had been insured under the provincial health plan of his province immediately prior to the commencement of the absence from Canada; and

iv) 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. In all cases, a de facto separation of more than 3 months results in the loss of status as Spouse.

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

b) Child

Child of a Participant who is not an Expatriate Employee

Any unmarried Child of the Participant or of his Spouse residing in Canada who depends on the Participant for support and maintenance and who meets at least one of the following conditions:

i) He is under 22 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).

Child of a Participant who is an Expatriate Employee

A person who

i) is an unmarried child of the Participant or his Spouse; and

ii) wholly depends on the Participant for support and maintenance; and

iii) is residing with the Participant or if not residing with the Participant, he is a full-time resident of Canada; and

iv) is under 22 years of age; or

v) is under 26 years of age and attending a recognized educational institution on a full time basis, or

vi) 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 iv) or v).

Earnings means:

Annual Earnings, for classes 563, 567, means the remuneration stated by the Employer, excluding overtime, bonuses, and gratuities in accordance with the standards of the Employment Insurance Act.

Annual Earnings, for class 572, means the remuneration paid by the Employer, excluding bonuses, commissions, gratuities, overtime and any other form of additional remuneration.

Monthly Earnings means the Participant's Annual Earnings divided by 12.

Indexed Pre-Total Disability Gross Monthly Earnings means the Participant's Monthly Earnings immediately prior to the date his Total Disability commenced, increased by the Consumer Price Index (as published by the Government of Canada during the immediately preceding Calendar Year) each June 1st coincident with or next following the anniversary of the date on which the Participant became entitled to a Long-Term Disability benefit.

Pre-Total Disability Gross Monthly Earnings means the Participant's Monthly Earnings immediately prior to the date his Total Disability commenced.

Pre-Total Disability Net Monthly Earnings means the Participant's Monthly Earnings immediately prior to the date his Total Disability commenced, less the deductions for Income Tax, Canada or Quebec Pension Plan, Employment Insurance and the Quebec Parental Insurance Plan.

Amount of Earnings to Be Used

Where any benefit paid under the group policy is based on the Participant's Earnings, including any of the variations of the definition of Earnings above, the amount of Earnings that will be used to determine the benefit will be the lesser of:

a) The Earnings last reported to the insurer by the Policyholder, Employer, Employer's agent, or administrators and that has been used in the calculation of the premium payable; or

b) The Participant's actual Earnings received from his Employer at the time of the event for which a claim is being made; or

c) If the Participant is not Actively at Work at the time of the event for which the claim is being made, the Earnings on the last Working Day he was Actively at Work.

Eligibility Period means the continuous period, as specified in the Summary of Benefits, ending on or after the effective date of the group policy, during which the Employee or the Expatriate Employee must be Actively at Work.

Employee means any person who is actively employed by the Employer on a permanent, full-time or part-time basis, or on a temporary, full-time basis during any contract of a 12-month minimum period, working a minimum of 24 hours per week, and who is receiving regular salary for services rendered.

Employer means the Policyholder or any entities listed as Subsidiary or Associated Companies in the Summary of Benefits of the group policy.

Expatriate Employee means an Employee who

a) is Canadian; and

b) was working in Canada immediately prior to the commencement of his assignment outside of Canada; and

c) was a full-time resident of Canada immediately prior to the commencement of his assignment outside of Canada; and

d) has been assigned by the Policyholder to work temporarily outside of Canada for a period of more than 90 Days; and

e) had been insured under the group policy or a previous policy of the Policyholder as an Employee immediately prior to the commencement of his assignment outside of Canada; and

f) had been insured under the provincial health plan of his province of residence immediately prior to the commencement of his assignment outside of Canada.

An Expatriate Employee is not covered for the Quebec Prescription Drug Insurance, Supplemental Health Insurance and Dental Care Insurance benefits under the group policy.

Full-time Resident of Canada means to have a permanent residence in Canada, and to reside in the province of residence the minimum number of Days a year required to be covered under the applicable provincial health plan of that province of residence.

Hospital means an institution which:

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

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

c) Provides at all times the services of Physicians and registered nurses.

Hospitalization or Hospitalized means the occupancy of a Hospital room as an admitted bedridden patient where a room and board charge has been charged in connection with the confinement. A stay of more than 24 hours under observation in a Hospital, even if no charge is made, is considered a Hospitalization. Day Surgery is considered to be a period of Hospitalization.

Illness means any deterioration in health requiring continuous and curative care actively provided by a Physician and, where required by the group policy, by a Specialist in the field of medicine which is applicable to the Illness.

Insured Person means a Participant or a Dependent of a Participant who is insured under the group policy.

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 Basic Prescription Drug Insurance Plan of Quebec (if applicable), the Supplemental Health Insurance and the Dental Care Insurance benefits of the group policy and to maintain his rights to coverage, unless otherwise agreed previously with the insurer or unless mention to the contrary is made in the group policy.

Legal Capacity To Work means that the Participant must have each and every license, permit or other certification required to legally work in Canada.

Medically Required means broadly accepted and recognized by the Canadian medical profession as effective, appropriate, and essential in the treatment of an Illness or injuries, including injuries due to an Accident, in accordance with Canadian medical standards.

Participant means an Employee, an Expatriate Employee or a Retiree who is insured under the group policy.

Permanent Part-Time Employment means an employment which meets the following conditions:

a) Undetermined working period: the permanent part-time employment is created for an undetermined period. It cannot be associated to an on-call or occasional position.

b) The number of hours worked per week is at least 24 hours and can be allocated as per the supervisor’s request. The number of hours can differ from one day to another.

c) Fixed and determined work schedule: The Employee should have a determined work schedule, established in advance. This schedule should be constant from one week to the next. The supervisor is responsible for the schedule management.

Physician means a person who is legally licensed and authorized to practice medicine and who is operating within the scope of his license.

Policyholder means any entities listed as the Policyholder on the cover page of the group policy.

Retired Employee means any person who holds such status with the Policyholder. However, in order to be considered as such by the Policyholder, the Participant must have at least 10 years of service at the time of retirement.

Specialist means a Physician licensed by the appropriate provincial licensing authority to practice medicine with a specialization.

Travel Benefits means the following Supplemental Health Insurance benefits: Emergency Medical Expenses Incurred Outside The Province Of Residence, and Emergency Out of Province Assistance.

Working Day means a Day on which the Participant is scheduled to work for his Employer and perform all of the essential duties of his regular occupation for the total number of scheduled hours.

CHANGES IN GOVERNMENT PLANS

The benefits provided under the group policy are complementary to the benefits provided by government plans. Any modifications to these government 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.

Notwithstanding the preceding paragraph, the group policy 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 under the group policy or insurance under a benefit for a Participant or a Dependent; or

b) an increase, addition or change in such insurance 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 for which the evidence was provided; or

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

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

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, the insurer's right to void the insurance 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/or Dental Care Insurance and whose Spouse is covered for comparable insurance may decline insurance under the group policy for such insurance.

However, in order to decline Supplemental Health Insurance, it is mandatory for the Participant to be covered for comparable insurance with his Spouse.

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.

AGENTS

The Policyholder and the Employer are not agents of the insurer. The insurer shall not be bound by nor be liable for any act, or failure to act, on the part of the Policyholder or the Employer.

ERRORS

Clerical or inadvertent errors by the Policyholder, Employer or insurer shall not operate to:

a) Continue insurance otherwise validly terminated.

b) Increase any existing insurance.

c) Place in force any insurance which would, but for such error, not be validly in force.

d) Otherwise prejudice the insurer in any other way.

The insurer may, retroactively and at its sole discretion, in addition to any other legal remedy it may have, exercise any or all of the following rights:

a) Reimburse to the Policyholder any premiums that have been accepted through such error.

b) Terminate or rescind any such associated insurance.

c) Reduce the amount of insurance to the amount it should have been but for the error.

d) Take such other action as may be required to correct the error.

ELIGIBILITY

Participants who are not Expatriate Employees

An Employee or a Retired Employee will become eligible to be insured under the group policy as a Participant on the date (his "eligibility date") on which he satisfies all of the following conditions:

a) He satisfies the definition of Employee or Retired Employee in the group policy; and

b) He is a Full-Time Resident of Canada (does not apply to a Retired Employee); and

c) He is covered under the provincial health plan of his province of residence (does not apply to a Retired Employee); and

d) He has satisfied the Eligibility Period specified in the Summary of Benefits.

However, an Employee will not be eligible to become insured under the Long-Term Disability Insurance benefit if he will attain the termination age specified for this benefit in the Summary of Benefits before the end of the Elimination Period specified for this benefit.

Participants who are Expatriate Employees

An Employee will become eligible to be insured under this plan as a Participant on the date (his "eligibility date") on which he satisfies the following conditions:

a) He satisfies the definition of Expatriate Employee of the group policy; and

b) He has satisfied the eligibility period specified in the Summary of Benefits.

However, an Expatriate Employee will not be eligible to become insured under the Long-Term Disability Insurance benefit if he will attain the termination age specified for this benefit in the Summary of Benefits before the end of the Elimination Period specified for this benefit.

The Policyholder must notify the insurer prior to the date the Employee is to leave Canada on his assignment for the Employee to be eligible for coverage under the group policy as an Expatriate Employee.

Dependents of all Participants

A person will become eligible to be insured under the group policy as a Dependent on the date (his “eligibility date”) on which he satisfies all of the following conditions:

a) He satisfies the definition of Dependent in the group policy; and

b) He is a Full-Time Resident of Canada (not applicable to an Expatriate Dependent); and

c) He is covered under the provincial health plan of his province of residence (not applicable to an Expatriate Dependent); and

d) The Employee or the Retiree of whom he is a Dependent is insured under the group policy as a Participant.

APPLICATION FOR GROUP INSURANCE

An Employee who is eligible to become insured under the group policy as a Participant must complete and submit an application for himself and for each of his Dependents, on their respective eligibility dates, on forms supplied by, or satisfactory to the insurer.

EFFECTIVE DATE OF INSURANCE

Whether membership under the group policy is compulsory or voluntary, the Participant's insurance and Dependents' insurance, if any, will take effect on the person's eligibility date, if the application for group insurance has been received by the insurer on or prior to such date, or within 31 Days after such date.

If the application for group insurance is not received within 31 Days of the eligibility date, the insurance will not take effect until the date on which the insurer receives evidence of insurability and provides Approval of Evidence of Insurability.

However:

a) If the Employee was not Actively at Work on the date his insurance would otherwise become effective, the insurance will not take effect until the earliest date thereafter on which he is again Actively at Work.

b) If the Dependent is Hospitalized on the date his insurance would otherwise become effective, the insurance will not take effect until the earliest date thereafter on which he is no longer Hospitalized. (This clause shall not apply to the Life Insurance benefit or in the case of a newborn Child).

Any amount of insurance which is in excess of the non-evidence maximum(s) specified in the Summary of Benefits will not take effect until the date on which the insurer receives evidence of insurability and provides Approval of Evidence of Insurability. If the insurer does not provide Approval of Evidence of Insurability for the Participant, any future increases in the non-evidence maximum(s) will not automatically result in an increase in the Participant's insurance. The increase in the non-evidence maximum(s) will only result in an increase in the Participant's insurance if he submits evidence of his insurability and the insurer provides Approval of Evidence of Insurability.

The Participant may decline the Supplemental Health Insurance and Dental Care Insurance benefits, if he is covered for comparable coverage under the terms of the group policy or another policy.

Should the Participant decline the Supplemental Health Insurance benefit, the Participant will be covered under the group policy for Emergency Medical Expenses Incurred Outside the Province of Residence and Emergency Out of Province Assistance when the absence is related to business travel only.

TERMINATION OF INSURANCE

Participant

A Participant's insurance automatically terminates on the earliest of the following dates:

a) The date the group policy is terminated; or

b) The date on which the Participant retires, unless otherwise specified in the Summary of Benefits; or

c) The date the Participant reaches the age limit specified in the Summary of Benefits, if an age limit is indicated; or

d) The date the Participant is no longer a Full-time Resident of Canada (not applicable to an Expatriate Employee or to a Retired Employee); or

e) The date the Participant loses his Legal Capacity to Work in Canada (not applicable to an Expatriate Employee or to a Retired Employee); or

f) The date the Participant is no longer covered by his provincial health plan (not applicable to an Expatriate Employee or to a Retired Employee); or

g) The date of the Participant's death; or

h) The date the Policyholder terminates insurance for the Participant; or

i) The date on which the Participant pleads guilty or is found guilty of an offence for which he is confined in a penitentiary, prison, correctional facility, forensic psychiatric facility or any similar institution; or

j) The date the Participant ceases to qualify as an Employee or a Retired Employee, or ceases to be Actively at Work, as defined in the group policy.

   Insurance may be extended to a Participant during periods the Participant has ceased to be actively at work due to, but not limited to, Illness, injury, temporary layoff or a leave of absence. The Participant should contact the policyholder for further information.

Dependents

A Dependent's insurance automatically terminates on the earliest of the following dates:

a) The date the Participant of whom he is a Dependent ceases to be insured under the group policy; or

b) The date the Dependent ceases to meet the definition of Dependent; or

c) The date the Dependent reaches the age limit specified in the Summary of Benefits, if an age limit is indicated; or

d) The date the Dependent is no longer a Full-Time Resident of Canada (not applicable to an Expatriate Dependent or to the Dependent of a Retired Employee); or

e) The date the Dependent is no longer covered by the provincial health plan (not applicable to an Expatriate Dependent or to the Dependent of a Retired Employee); or

f) The date the Policyholder terminates insurance for the Dependent.

The above terms and conditions also apply in the case of the partial cancellation of insurance for a Participant or a Dependent owing to the cancellation of insurance under one or more benefits.

NOTICE AND PROOF OF CLAIM

Notice and proof of any claim must be submitted to the insurer in the format required by the insurer. The proof of claim must include all information that the insurer requires and deems necessary as to the circumstances and extent of the loss, or which the insurer otherwise requests in order to complete its assessment of a claim. The insurer will not be liable for any claim that is not submitted in accordance with all of the terms and conditions and time limits prescribed under the group policy.

- **Supplemental Health Insurance and Dental Care Insurance:**

  Notice and proof of any claim must be submitted to the insurer within 12 months (6 months in the case of the Travel Benefits) of the date of the event which gives entitlement to the benefit.

- **Life Insurance:**

  Notice of any claim must be submitted within 30 Days of the date of the event which gives entitlement to the benefit. Proof of claim must be submitted within 90 Days of the date of the event which gives entitlement to the benefit.

  Failure to submit notice and proof of any claim within the time prescribed does not invalidate the claim if the notice or proof is submitted as soon as reasonably possible, and in no event later than 12 months from the date of the event, if it is shown that it was not reasonably possible to submit notice or proof within the time so prescribed.

- **Long-Term Disability Insurance:**

  Notice of any claim must be submitted within 120 Days of the date of the event which gives entitlement to the benefit. Proof of claim must be submitted within 30 Days of the date of the beginning of the long-term disability.

NOTICE AND PROOF OF CLAIM IN CASE OF TERMINATION

In the event of the termination of the group policy or the termination of the Participant's insurance, the notice and proof of claim for any claim other than a Long-Term Disability claim, or a Supplemental Health Insurance or Dental Care Insurance claim, must be submitted to the insurer within 90 Days of the date of the termination of the group policy and, in the case of the termination of the Participant's insurance, within 90 Days of the termination of such insurance.

Notice and proof of claim for a Long-Term Disability claim must be submitted within 180 Days of the date of the date of the termination of the group policy and, in the case of the termination of the Participant's insurance, within 90 Days of the termination of such insurance.

Notice and proof of claim for a Supplemental Health Insurance and Dental Care Insurance claim must be submitted within 90 Days of the termination of the group policy and, in the case of termination of the Participant's insurance, within 12 months of the date of the event which gives entitlement to the benefit.

FRAUDULENT CLAIMS

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 or Dependent has submitted any 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, and notwithstanding any other provision in the group policy, the insurer will have the right to terminate the Participant's entire insurance under the group policy including any insurance for the Participant's Dependents, and will have the right to undertake the prosecution of the Participant and/or the Dependent in accordance with provincial and/or federal law.

APPEAL PROCESS

Where the insurer has made a decision to decline or terminate a claim or insurance under the group policy, the decision to decline or terminate may be appealed as long as this right of appeal is exercised within 60 Days of the initial letter of decline or termination.

The appeal must be in writing and must include the grounds of appeal, any new information to support the appeal and any further information that may be requested by the insurer.

EXPENSES

Unless the group policy expressly states otherwise, the Participant is solely responsible for all expenses and costs related directly and indirectly to submitting a claim, proof of a claim, appeals of any kind, or any other obligation the Participant has under the group policy, including but not limited to submitting any application or appeal, or obtaining any medical reports, clinical records, test results, or any other information.

BENEFICIARY

The Participant’s beneficiary shall be the person or persons designated by the Participant, in writing, to receive the death benefit payable under the Participant's

Life Insurance benefit, and if applicable, the Participant's Accidental Death and Dismemberment Insurance benefit, Participant's Optional Life Insurance benefit and Participant's Optional Accidental Death and Dismemberment Insurance benefit. If the Participant does not designate a beneficiary, any death benefit payable under such benefits will be payable to the Participant’s estate.

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

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

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

If the Participant had named a beneficiary under the Policyholder’s prior group policy, such designation will be applicable to the insurance provided under the group 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.

The group 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.

INSURER’S RIGHT TO EXAMINATION, RECORDS AND INVESTIGATION

The insurer, at its own expense and its sole discretion, shall have the right, whenever and how often it deems it necessary, to:

a) Require any medical, psychiatric, psychological, functional, vocational or any other examinations of a Participant who has submitted a claim or of any other Insured Person for whom a claim has been submitted. The insurer may designate, at its sole discretion, a Physician, a Specialist, a healthcare provider or any other examiner for such examination(s). The Participant or any other Insured Person being examined must comply with any terms and conditions of an examination that are required by such examiner; and

b) Require an autopsy, where it is not forbidden by law.

The insurer reserves the right to obtain the clinical notes and records or any other reports of a Participant who has submitted a claim or of any other Insured Person for whom a claim has been submitted, from any Physician or Specialist, including but not limited to, a psychologist, a psychiatrist, a healthcare provider or any other examiner who has treated, examined or assessed such Participant or Insured Person. The Participant and any Insured Person must cooperate fully with the insurer in obtaining any such records or reports.

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

SUBROGATION

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

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

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

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

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

Where the Participant or Dependent recovers damages in a lump sum, either by way of settlement or court order, and no allocation has been made in that settlement for the benefits paid or payable by the insurer, the insurer shall be reimbursed, out of the gross damages recovered, the full amount of benefits that have been paid to the Participant or Dependent. The insurer shall also be entitled

to be reimbursed an amount, as determined by the insurer, which reasonably reflects the value of the future benefits payable to the Participant or Dependent under the group policy. The insurer's recovery in this regard shall not exceed the Participant or Dependent's gross damages recovered or gross settlement. These rights of reimbursement shall be without regard to the terms of settlement or allocation that may have been agreed to by the Participant or Dependent and the third party.

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

a) The total amount of benefits paid to the Participant or Dependent; and

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

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

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

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

The insurer's subrogated claims shall not be settled or compromised in any way without its prior written consent. Unless the prior consent of the insurer has been obtained, no such settlement of any claim against the third party shall be binding

on the insurer and the insurer shall have the right to seek recovery directly from the Participant and Dependent in accordance with its rights under the group policy or under the law.

OVERPAYMENT

If the insurer determines that a benefit has been overpaid, the Participant or any other person to whom such benefit was overpaid is liable to reimburse the insurer immediately and in full as soon as the insurer requests such reimbursement.

In the event the overpayment is not reimbursed, the insurer shall have the right, at its sole discretion and in addition to any other legal remedy it may have, to recover such overpayment by exercising any or all of the following rights:

a) Reduce to zero the disability benefit payments payable to the Participant under the group policy until such time as the overpayment is fully recovered.

b) Reduce the sum insured of any life insurance benefits payable under the group policy, or reduce any other benefits payable under the group policy, by up to 100% of the amount of the outstanding overpayment, whether such benefits are payable to the Participant, or to the Participant's estate, Dependents, eligible survivors or beneficiaries.

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 all of the terms and conditions of the group policy.

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

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 all of the terms and conditions of this benefit and the group policy.

In the event that a Participant is in the terminal phase of an Illness, with a life expectancy of less than 12 months, an amount equal to the lesser of 50% of the sum insured and $50,000, may be paid to the Participant, subject to approval by the insurer.

DEFINITIONS

As used in this benefit:

Total Disability and Totally Disabled means that, the Participant is, due to an Illness or Accident, continuously unable to perform any Gainful Employment, as determined by the insurer.

Except as specifically permitted by the Rehabilitation Program provision of the group policy or specifically approved by the insurer, if a Participant engages in any occupation, any employment, or any other activity for compensation or profit, he will be deemed to no longer be Totally Disabled.

The following will not be taken into consideration in determining the Total Disability:

a) The availability of any Gainful Employment; and

b) The loss, revocation, withdrawal, or non renewal of a professional or occupational license, permit or any other certification required to perform such Gainful Employment.

However, if the Participant should be insured under the Long-Term Disability Insurance benefit under the group policy, the definitions of **Total Disability** and **Totally Disabled** shall be as defined under the Long-Term Disability Insurance benefit.

Gainful Employment means any occupation, any employment or any other activity for compensation or profit, for which the Participant is reasonably qualified (or may so become) by training, education or experience, and from which the Participant would be able to earn at least 70% of his Indexed Pre-Total Disability Gross Monthly Earnings.

CONVERSION PRIVILEGE

A Participant whose life insurance is cancelled on or prior to his 65th birthday due to termination of:

a) His employment; or

b) His group membership; or

c) The group policy and he has been continuously insured under a life insurance benefit provided by the Policyholder for at least 5 years,

will be able to convert all or part of his life insurance to an individual life insurance policy without having to provide evidence of insurability.

The Participant may choose to convert to one of the following types of insurance:

a) Permanent; or

b) Term to age 65; or

c) One year term convertible into permanent or term to age 65 at the end of one year.

The amount that can be converted to an individual life policy will include all amounts of life insurance that the Participant was insured for under this benefit, an optional life insurance benefit and any other group insurance policy issued by the insurer, and will not exceed the lesser of:

a) The amount selected by the Participant; or

b) The amount for which the Participant was insured immediately prior to the termination of his insurance; or

c) The difference between the amount for which the Participant was insured immediately prior to the termination of his insurance, and the amount for which he is eligible under a new group insurance policy; or

d) $200,000 ($400,000 for Participants living in the Province of Quebec).

The individual life insurance policy shall not include a disability benefit, nor an accidental death and dismemberment benefit, and the premium shall be based on the insurer's rates in effect which apply to the type and amount of such policy, according to the Participant's sex and attained age.

The individual life policy will only be issued if the insurer receives a written request to that effect, together with a deposit covering the monthly premium for

a one year term policy within 31 Days of the date of the termination of the Participant's life insurance, and will take effect only at the expiration of that period.

Should the Participant die during the period of 31 Days following the termination of his life insurance, the insurer shall pay an amount equal to that which he could have converted whether or not he made application for the individual life policy.

WAIVER OF PREMIUM

(This provision does not apply to Retired Employees)

a) A Participant who becomes Totally Disabled will be eligible to have his premiums waived for this benefit, if he is under age 65 and is eligible to receive a benefit under the Long-Term Disability Insurance benefit, if included in the group policy.

If the Participant is not eligible to receive a benefit under the Long-Term Disability Insurance benefit or there is no Long-Term Disability Insurance benefit included in the group policy, he will be eligible to have his premiums waived for this benefit provided:

i) The Participant was under 65 years of age at the onset of Totally Disability; and

ii) The Participant became Totally Disabled as defined under this benefit, while insured under this benefit and before any termination of employment; and

iii) The Participant has been Totally Disabled for at least 6 continuous months; and

iv) Proof of Totally Disability, satisfactory to the insurer, was submitted to the insurer within 12 months of the onset of the Totally Disability.

b) The amount of insurance for which the waiver of premiums applies will be that which was in force on the Participant's life at the onset of the Total Disability, and will be subject to any reductions and termination indicated in the Summary of Benefits, or otherwise indicated in this benefit or in the General Provisions of the group policy, which would have been applicable to the Participant if he had been Actively at Work.

c) The Participant's premiums will begin to be waived on the earliest of the following dates:

   i) The Day following completion of the Elimination Period under the Long-Term Disability Insurance benefit, if applicable; or

   ii) The Day following a continuous period of Total Disability of 6 months.

d) The Participant whose premiums are waived under this section must provide the insurer with proof of Totally Disability, as often as the insurer may reasonably require.

e) The waiver of premiums will terminate on the earliest of the following dates:

   i) The date on which the Participant ceases to be Totally Disabled; or

   ii) The date on which the Participant fails to submit to an examination in accordance with the terms and conditions of the group policy, if required by the insurer; or

   iii) The date on which the Participant retires or reaches the normal retirement age under the Employer's pension plan, but never beyond 65 years of age; or

   iv) The date on which the Participant reaches the termination age for his life insurance benefit as indicated in the Summary of Benefits, if applicable; or

   v) The date on which the Participant fails to provide any proof of Total Disability required by the insurer; or

   vi) The date on which the Participant pleads guilty or is found guilty of an offence for which he is confined in a penitentiary, prison, correctional facility, forensic psychiatric facility or any similar institution; or

   vii) The date on which the Participant refuses to actively and continuously participate and cooperate in a Rehabilitation program, if required by the insurer.

f) If on the date the waiver of premiums terminates with respect to the Participant, he is not eligible to be insured under the Participant's Life

Insurance benefit, he will be eligible to exercise the Conversion Privilege as provided for under this benefit.

REDUCTIONS

The sum insured is reduced as indicated in the Summary of Benefits. The sum insured is also subject to any applicable reductions indicated in this benefit or in the General Provisions of the group policy.

TERMINATION

The insurance under this benefit terminates as indicated in the Summary of Benefits, or such other earlier date indicated in this benefit or in the General Provisions of the group policy.

PARTICIPANT'S OPTIONAL LIFE INSURANCE

A Participant may obtain an amount of optional life insurance if he so requests it in writing to the insurer and furnishes evidence of insurability satisfactory to the insurer and the insurer provides Approval of Evidence of Insurability.

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.

Upon the death of the Participant while insured under this benefit, the insurer undertakes to pay the beneficiary the sum insured at the time of the Participant's death, subject to all of the terms and conditions of this benefit and the group policy.

NON-SMOKER STATUS

If the insurer provides reduced premium rates for non-smokers, the Participant must provide a non-smoker statement on his application card to receive such rates.

Misrepresentation of Non-Smoker Status

A Participant who states that he is a non-smoker on his application card or on his last evidence of insurability declaration, if it is more recent, when he is a smoker, will be considered to have made a misrepresentation.

If it is proven, after the Participant's death, that he had made a misrepresentation, the optional life insurance benefit of the Participant will become null and void and no optional life insurance will be payable under this benefit.

Proof of Status

The insurer reserves the right to request new proof of the Participant's non-smoker status each time evidence of insurability may be required.

EXCLUSIONS

If a Participant commits suicide, regardless of any impairment, Illness, or state of mind, less than 24 months after the date his insurance under this benefit commenced, no benefit will be payable by the insurer. The insurer will refund to the beneficiary the premiums paid in respect of the Participant's Optional Life

Insurance and such refund will constitute a full discharge of the insurer's liability under this benefit.

The 24 month period starts anew on the date:

a) The Optional Life Insurance is reinstated; or

b) The Optional Life Insurance amount is increased at the Participant's request, but only for the additional amount of insurance.

ADDITIONAL PROVISIONS

Any provisions of the Participant’s Life Insurance benefit which are not inconsistent with the provisions of this benefit will form part of this benefit.

REDUCTIONS

The sum insured is reduced as indicated in the Summary of Benefits. The sum insured is also subject to any applicable reductions indicated in this benefit or in the General Provisions of the group policy.

TERMINATION

The insurance under this benefit terminates as indicated in the Summary of Benefits, or such other earlier date indicated in this benefit or in the General Provisions of the group policy.

DEPENDENTS' OPTIONAL LIFE INSURANCE

A Participant may obtain an amount of optional life insurance on his Dependents if he so requests it in writing to the insurer and furnishes evidence of insurability satisfactory to the insurer and the insurer provides Approval of Evidence of Insurability.

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

Upon the death of the Dependent while insured under this benefit the insurer undertakes to pay to the Participant the sum insured at the time of death, subject to all of the terms and conditions of this benefit and the group policy.

WAIVER OF PREMIUMS

A Participant whose life insurance premiums are waived in accordance with the Waiver of Premiums provision of the Participant's Life Insurance benefit will also be entitled to have the premiums for this benefit waived, under the same terms and conditions.

CONVERSION PRIVILEGE

A Participant whose Spouse's life insurance under this benefit is cancelled on or prior to the earlier of his 65th birthday or his Spouse's 65th birthday, due to the termination of:

a) His employment; or

b) His group membership; or

c) The group policy and his Spouse had been continuously insured under a Dependents' Life Insurance benefit provided by the Policyholder for at least 5 years,

will be able to convert all or part of his Spouse's life insurance to an individual life insurance policy without having to provide evidence of insurability.

A Spouse whose life insurance under this benefit is cancelled on or prior to the earlier of his 65th birthday or the 65th birthday of the Participant, due to the death of the Participant, will be able to convert all or part of his life insurance to an individual life insurance policy without having to provide evidence of insurability.

The Participant or Spouse, if applicable, will be able to convert the life insurance to one of the following types of insurance:

a) Permanent; or

b) Term to age 65; or

c) One year term convertible into permanent term or term to age 65 at the end of the one year.

The amount that can be converted to an individual life policy will include all amounts of life insurance and optional life insurance that the Spouse is insured for under this policy, and any other group insurance policy issued by the insurer, and will not exceed the lesser of:

a) The amount selected by the Participant or the Spouse, if applicable; or

b) The amount for which the Spouse was insured immediately prior to the termination of his insurance; or

c) The difference between the amount for which the Spouse was insured immediately prior to the termination of his insurance and the amount for which he is eligible under a new group insurance policy; or

d) $200,000 ($400,000 for Participants living in the Province of Quebec).

The individual life policy will not include a disability benefit nor an accidental death and dismemberment benefit and the premiums will be based on the insurer’s rates in effect which apply to the type and amount of such policy, based on the Spouse’s sex and attained age.

The individual life policy will only be issued if the insurer receives a written request to that effect, together with a deposit covering the monthly premium for a one year term policy, within 31 Days of the date of the termination of the Spouse’s life insurance and will take effect only at the expiration of that period.

Should the Spouse die during the period of 31 Days following the termination of his life insurance, the insurer shall pay an amount equal to that which could have been converted to the Participant, or the Participant’s estate if he is no longer living, whether or not application had been made for the individual life policy.

NON-SMOKER STATUS

If the insurer provides reduced premium rates for non-smokers, the Spouse must provide a non-smoker statement on the application card to receive such rates.

Misrepresentation of Non-Smoker Status

A Spouse who states that he is a non-smoker on the application card or on his last evidence of insurability declaration, if it is more recent, when he is a smoker, will be considered to have made a misrepresentation.

If it is proven, after the Spouse's death, that he had made a misrepresentation, the optional life insurance of the Spouse will become null and void and no optional life insurance will be payable under this benefit.

Proof of Status

The insurer reserves the right to request new proof of the Spouse's non-smoker status each time evidence of insurability may be required.

EXCLUSION

If a Dependent insured for optional life insurance commits suicide, regardless of any impairment, Illness, or state of mind, less than 24 months after the date his Optional Life Insurance commenced under this benefit no benefit will be payable by the insurer. The insurer will refund to the Participant the premiums paid in respect of such person and the refund will constitute a full discharge of the insurer's liability under this benefit.

The 24 month period starts anew on the date:

a) The Optional Life Insurance is reinstated; or

b) The Optional Life Insurance amount is increased at the Participant's request, but only for the additional amount of insurance.

REDUCTIONS

The sum insured is subject to any applicable reductions indicated in this benefit or in the General Provisions of the group policy.

TERMINATION

The insurance under this benefit terminates as indicated in the Summary of Benefits, or such other earlier date indicated in this benefit or in the General Provisions of the group policy.

If a Participant becomes Totally Disabled while insured under this benefit and while he is Actively at Work, the insurer will undertake to pay the Participant the amount of the Long-Term Disability benefit specified in the Summary of Benefits for each month or part of a month during which such Total Disability lasts, subject to all of the terms and conditions of this benefit and the group policy.

DEFINITIONS

As used in this benefit:

Total Disability and Totally Disabled means that, during the Participant's Elimination Period and the first 24 months following the Elimination Period, the Participant is, due to an Illness or Accident, continuously unable to perform all the essential duties of his Regular Occupation with his own Employer and is also continuously unable to perform all those same duties of his Regular Occupation with any other employer, all of which shall be determined by the insurer.

After the Elimination Period and the first 24 months following the Elimination Period, **Total Disability and Totally Disabled** means that the Participant is, due to an Illness or Accident, continuously unable to perform any Gainful Employment, as determined by the insurer.

Except as specifically permitted by the Rehabilitation Program provision of the group policy or specifically approved by the insurer, if a Participant engages in any occupation, any employment, or any other activity for compensation or profit, he will be deemed to no longer be Totally Disabled.

The following will not be taken into consideration in determining the Total Disability:

a) The availability of the Regular Occupation or any Gainful Employment; and

b) The loss, revocation, withdrawal, or non renewal of a professional or occupational, license, permit or any other certification required to perform such Regular Occupation or Gainful Employment.

Gainful Employment means any occupation, any employment or any other activity for compensation or profit, for which the Participant is reasonably qualified, or may so become, by training, education or experience, and from which the Participant would be able to earn at least 70% of his Indexed Pre-Total Disability Gross Monthly Earnings.

Regular Occupation means the occupation that the Participant was regularly performing immediately before the date of Total Disability.

Elimination Period means the period specified in the Summary of Benefits during which the Participant must be continuously absent from work due to a Total Disability before he can begin to receive Long-Term Disability benefits.

Satisfactory Application means that the Participant has made an application and has taken all necessary steps to appeal any denial of that application to the highest level of appeal, all within the time limits prescribed for such application or appeal.

PARTICULARS

Beginning of Benefit Payments

Payment of the Long-Term Disability benefit begins following completion of the Elimination Period specified in the Summary of Benefits.

Amount of Benefit Payments

The amount of the Long-Term Disability benefit payable is determined according to the formula set forth in the Summary of Benefits and will not exceed the monthly maximum amount specified.

However, legal holidays are excluded, unless otherwise advised by the Policyholder.

REDUCTION OF BENEFIT PAYMENTS

Satisfactory Application

The Participant is required to make a Satisfactory Application for all Direct and Indirect Reductions to which, in the opinion of the insurer, he is or may become entitled.

Direct Reductions

The Long-Term Disability benefit payable by the insurer will be reduced by the following amounts which are payable or which would have been payable to the Participant had a Satisfactory Application been made under:

a) The Quebec or Canada Pension Plan disability benefits, excluding benefits payable on behalf of a Dependent Child; and

b) Workers' compensation benefits and any other similar benefits; and

c) Income loss or replacement benefits payable under provincial automobile insurance legislation; and

d) Benefits payable under provincial crime victims compensation legislation.

Indirect Reductions

The Long-Term Disability benefit payable by the insurer will be further reduced so that the total amount of all income, compensation, profit, indemnities and benefits from All Sources, which is payable to the Participant, or which would have been payable to the Participant had a Satisfactory Application been made, does not exceed:

a) 80% of the Participant’s Pre-Total Disability Gross Monthly Earnings, if the Long-Term Disability benefit is taxable; or

b) 80% of the Participant’s Pre-Total Disability Net Monthly Earnings, if the Long-Term Disability benefit is non-taxable.

All Sources means:

a) The Long-Term Disability benefit under the group policy; and

b) Any of the Direct Reductions listed above; and

c) Any indemnity and benefits which the Participant would or could receive, due to his disability, from:

    i) the Policyholder,

    ii) his Employer,

    iii) any government body,

    iv) a franchise or association insurance plan,

    v) any group insurance or pension plan to which the Policyholder or Employer contributes,

    vi) a third party in the form of damages for loss of income.

Lump Sum Payments

Should any of the amounts listed in subparagraphs b) and c) of the All Sources definition included in the Indirect Reductions section be paid to the Participant as a lump sum, the insurer shall be entitled to reduce the Long-Term Disability benefit payment, whether retroactively or in the future, by the monthly amount that would have been payable to the Participant had the lump sum been paid on a monthly basis. The insurer shall be entitled to calculate such monthly amount that would have been payable based on the period of time the lump sum represents. Where no period of time is stipulated for the lump sum, the insurer shall have the right to determine a reasonable period of time.

Rehabilitation Program Reductions

If the Participant is participating in a Rehabilitation Program approved by the insurer, the amount of the Long-Term Disability benefit payable by the insurer will be further reduced so that the total amount of all income, compensation, profit, indemnities and benefits which are payable or which would have been payable to the Participant had a Satisfactory Application been made from (i) any of the All Sources; and (ii) the approved Rehabilitation Program, does not exceed

a) 100% of the Participant's Pre-Total Disability Gross Monthly Earnings if the Long-Term Disability benefit is taxable; or

b) 100% of the Participant's Pre-Total Disability Net Monthly Earnings if the Long-Term Disability benefit is non-taxable.

Further Reductions

After the first reductions made from any of the amounts listed in subparagraphs b) and c) of All Sources as defined above, future cost of living adjustments made to amounts payable from such sources will not bring about further reductions.

TERMINATION OF BENEFIT PAYMENTS

The Long-Term Disability benefit payments cease on the earliest of the following dates:

a) The date the maximum benefit payment period specified in the Summary of Benefits has been reached; or

b) The date on which the Participant ceases to be Totally Disabled; or

c) The date on which the Participant reaches the termination age specified in the Summary of Benefits for the Long-Term Disability benefit; or

d) The date on which the Participant retires or reaches the normal retirement age under the Employer's pension plan; or

e) The date of the Participant's death; or

f) The date on which the Participant fails to submit to an examination in accordance with the group policy, as required by the insurer; or

g) The date on which the Participant fails to provide any evidence of Total Disability required by the insurer; or

h) The date on which the Participant refuses to actively and continuously participate and cooperate in a Rehabilitation Program, as required by the insurer; or

i) The date on which the Participant pleads guilty or is found guilty of an offence for which he is confined in a penitentiary, prison, correctional facility, forensic psychiatric facility or any similar institution; or

j) The date a Participant engages in any occupation, any employment, or any other activity for compensation or profit, except as specifically permitted by the Rehabilitation Program provision of the group policy and specifically approved by the insurer.

SUCCESSIVE PERIODS OF TOTAL DISABILITY

During the Elimination Period

If a Participant who was Totally Disabled returns Actively at Work before the end of his Elimination Period, and then becomes Totally Disabled again while his insurance under this benefit is in force, such successive period of Total Disability will be considered to be a recurrence of the previous Total Disability only if:

a) It is due to the same cause or related causes as the previous Total Disability; and

b) The Participant was Actively at Work for less than 31 consecutive Days from the end of the previous Total Disability.

After the Elimination Period

If a Participant who was Totally Disabled returns Actively at Work after the end of his Elimination Period, and then becomes Totally Disabled again while his insurance under this benefit is in force, such successive period of Total Disability will be considered to be a recurrence of the previous Total Disability only if:

a) It is due to the same cause or related causes as the previous Total Disability; and

b) The Participant was Actively at Work for less than 6 consecutive months from the end of the previous Total Disability.

Recurrence of the Previous Total Disability

When a successive period of Total Disability is determined by the insurer to be a recurrence of the previous Total Disability according to this provision, the Elimination Period will not have to be satisfied in full again. If the Elimination Period was not satisfied in full during the previous Total Disability, only that portion of the Elimination Period that was not satisfied will be applied.

The Long-Term Disability benefit payable for a recurrence of the previous Total Disability will be determined in accordance with all of the terms and conditions of the group policy based on the Participant's Earnings as at the date of the previous Total Disability. Benefits for all recurrences will not be paid for a combined period longer than the maximum benefit period applicable to the previous Total Disability as shown in the Summary of Benefits.

New Total Disability

If the insurer determines that a successive period of Total Disability is not a recurrence of the previous Total Disability according to this provision, such successive period of Total Disability will be considered to be a new Total Disability and a new Elimination Period will apply.

EXCLUSIONS

No Long-Term Disability benefit will be payable for a Total Disability resulting directly or indirectly from, or which is in any manner or degree associated with or occasioned by, any of the following causes:

a) Participation to a civil unrest, insurrection or war, whether war be declared or not, or a riot, unless these events occur while the Participant performs his functions.

b) Self-inflicted injury unless medical evidence establishes that the injury was directly related to a mental health Illness.

c) Care, surgery or treatment which is not Medically Required.

d) Care, surgery or treatment for infertility.

e) Care, surgery or treatment for cosmetic purposes, except when such care, surgery or treatment is Medically Required as a direct result of an Illness or Accident.

f) Committing or attempting to commit any offence under any criminal code or similar law in any jurisdiction, if the Participant has been charged or convicted.

g) The operation, care or control by the Participant of any vehicle or vessel with a blood alcohol concentration in excess of the limit permitted by the law, or while under the influence of any drug, whether prescribed or not, or while under the influence of any intoxicating or addictive substance.

h) Any addiction, including but not limited to drugs and alcohol, unless for such addiction, the Participant is actively participating and co-operating in an in-patient medical treatment program.

i) The dangerous operation, care or control of any vehicle or vessel by the Participant, if the Participant has been convicted.

j) **For all Employees and, with the Policyholder's approval, for Expatriate Employees**, any Participant who leaves Canada and the United States for a period of over 90 consecutive Days **after the beginning of benefit payments** will no longer be entitled to indemnity under the present benefit and such entitlement will be restored only upon the Participant's return, subject to all other provisions of the present benefit.

k) A Pre-existing Condition, where the Total Disability begins within 12 months after the date on which the Participant became insured under this benefit.

Pre-existing Condition means an Illness or Accident or the symptoms of an Illness, or symptoms arising out of an Accident, whether diagnosed or not:

i) For which the Participant sought or received (or for which he was advised to seek or receive) any treatment, advice consultation, diagnostic tests, or any care or services, from any medical healthcare provider; or

ii) For which the Participant was prescribed or took medication,

during the 3 months prior to the date on which the Participant became insured under this benefit.

However, if the group policy is issued in replacement of a policy of a prior insurer, the Long-Term Disability benefits will be payable for a Total Disability due to a Pre-existing Condition, provided that the Participant satisfies the following requirements:

i) Was insured under the prior insurer's policy on the date it was terminated; and

ii) Became insured under this benefit on the effective date of the group policy; and

iii) Was Actively at Work on the effective date of the group policy; and

iv) Satisfies the Pre-existing Condition exclusion period under the group policy, giving consideration towards continuous time insured under both policies, or the prior policy giving consideration towards continuous time insured under both policies.

The Long-Term Disability benefits payable to the Participant will be determined in accordance with this benefit, but in no case will it exceed the maximum amount and duration of the Long-Term Disability benefits of the prior insurer.

LIMITATIONS

The Long-Term Disability benefit will not be payable during any of the following periods:

a) The Participant is not under continuous and curative care actively provided by a Physician who is a Specialist in the field of medicine which is applicable to his Total Disability.

b) The Participant is not undergoing medical treatment which, in the opinion of the insurer, is required.

c) The Participant is out of Canada for a period of 90 consecutive Days or more.

d) The Participant is confined in a penitentiary, prison, correctional facility, forensic psychiatric facility or any similar institution by order of a court or review board.

e) The Participant is on a leave taken in accordance with any provincial or federal legislation, including but not limited to, maternity, parental or family-related leave.

f) The Participant is on a leave of absence, that was approved by the Employer.

g) The Participant is on any other type of leave not already mentioned in this provision.

h) The Participant is suspended with or without pay.

TOTAL DISABILITY THAT BEGINS WHILE A PARTICIPANT IS NOT ACTIVELY AT WORK

No benefits will be payable for a Total Disability that begins while a Participant is not Actively at Work except as expressly set out in this provision.

If a Participant is not Actively at Work due to one of the Absences specified in this provision, Long-Term Disability benefits for a Total Disability that begins during such Absence will only be payable if all of the Conditions set out in this provision are satisfied:

As used in this provision, Absence means:

A leave taken in accordance with any provincial or federal legislation including but not limited to maternity, parental or family-related leave.

As used in this provision, Conditions means:

a) The Participant's insurance under this benefit was:

   i) In force as of the date of Total Disability; and

   ii) Kept in force during the entire Absence in accordance with the terms and conditions for extending such insurance under this benefit and policy, including but not limited to the Termination of Insurance provision of the group policy; and

b) Any premiums due for the Participant during the Absence were paid to the insurer; and

c) Had the Participant not been on the Absence he would have otherwise been able to satisfy the definition of Actively at Work; and

d) The Participant satisfies all of the terms and conditions of this benefit and the group policy during the Absence and as of the date of Total Disability.

If the Conditions set out above are satisfied, any Long-Term Disability benefits that are payable to a Participant will only commence on the latest of:

a) The date the Elimination Period is satisfied; or

b) The date the Participant was scheduled to return Actively at Work following the scheduled end of his Absence.

REHABILITATION PROGRAM

The insurer may, at its sole discretion, require a Participant who is Totally Disabled to participate in a Rehabilitation Program, for a maximum period of 24 months after completion of his Elimination Period.

Rehabilitation Program means any program or activity that, in the opinion of the insurer, would assist a Totally Disabled Participant in being able to return to his Regular Occupation or any Gainful Employment. Such Rehabilitation Program must be approved in advance and in writing by the insurer.

A Rehabilitation Program may include any form of the following activities or programs:

a) Work hardening or return to work program on a gradual, modified, trial or part-time basis.

b) Functional or occupational assessments, services for job placements or job searches.

c) Treatment or access to healthcare services or assistive devices or any other equipment.

d) Skills or knowledge development or upgrading, training, retraining or educational courses.

e) Any other programs or activities that the insurer, at its sole discretion, determines to be appropriate and reasonable as a Rehabilitation Program taking into account factors such as the nature and expected duration of the Participant's Total Disability, his training, education or experience, and the nature, scope and cost of the program or activity.

The approval of a Rehabilitation Program by the insurer does not constitute an ongoing approval of such Program into the future. The insurer may, therefore and at its sole discretion, terminate a Rehabilitation Program at any time and for any reason.

Rehabilitation Expenses

Any expenses for a Rehabilitation Program must be approved by the insurer in advance and in writing. If the insurer does approve such expenses he may limit them to a cumulative total of 3 times the Participant's Long-Term Disability benefit.

Active and Continuous Participation Required

The Participant must actively and continuously participate and cooperate in the Rehabilitation Program. Long-Term Disability benefits will terminate if, in the opinion of the insurer, a Participant is not actively or continuously participating or cooperating in such a Rehabilitation Program.

WAIVER OF PREMIUMS

A Participant whose life insurance premiums are waived in accordance with the Waiver of Premiums provision of the Participant's Life Insurance benefit will also be entitled to waiver of premiums for this benefit, under the same conditions.

COST OF LIVING ADJUSTMENT

The amount of the Long-Term Disability benefit payable will be adjusted on the first Day of January of each year according to the Canadian Consumer Price Index, up to the maximum cost of living adjustment rate indicated in the Summary of Benefits.

TERMINATION

The insurance under this benefit terminates as indicated in the Summary of Benefits, or such other earlier date indicated in this benefit or in the General Provisions of the group policy.

Includes Prescription Drugs for Residents of Provinces Outside Quebec

The insurer undertakes to reimburse the medical expenses defined herein which are due to an injury, Illness or pregnancy and which are incurred by an Insured Person after the Insured Person became insured under this benefit subject to all of the terms and conditions of this benefit and the group policy.

DEFINITIONS

As used in this benefit:

Day Surgery: Surgery which is performed in a Hospital or out-patient clinic affiliated with a Hospital and requiring local, regional or general anaesthesia, but will not include minor surgery that can be performed in the Physician's office.

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.

General Dental Practitioner: A licensed dentist who practices dentistry without specialization.

Hospitalization or Hospitalized: The occupancy of a Hospital room as an admitted bedridden patient where a room and board charge has been charged in connection with the confinement. A stay of more than 24 hours under observation in a Hospital, even if no charge is made, is considered a Hospitalization. Day Surgery is considered to be a period of Hospitalization.

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

Medically Required means broadly accepted and recognized by the Canadian medical profession, and where applicable the Canadian dental profession as effective, appropriate and essential in the treatment of an Illness or injuries, including injuries due to an Accident, in accordance with Canadian medical standards, or where applicable Canadian dental standards.

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.

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 and stethoscopes.

HOSPITALIZATION IN THE PROVINCE OF RESIDENCE

Room and board charges made by a Hospital in the Insured Person's 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; and

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.

Day surgery will be considered to be a period of Hospitalization.

EMERGENCY MEDICAL EXPENSES INCURRED OUTSIDE THE PROVINCE OF RESIDENCE

A Participant who opted for the Exemption Option will benefit from this coverage only if his absence was due to business travel.

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 Insured Person is insured under the Supplemental Health Insurance at the time of the Medical Emergency; and

b) The Medical Emergency occurs during the first 90 consecutive Days of the Insured Person's absence from his province of residence.

If, however, the absence is due to his 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; and

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

d) The services and supplies had to be provided before the Insured Person could return 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 of benefit specified in the Hospitalization in The Province of Residence provision;

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

d) Diagnostic, medical imaging and laboratory services;

e) Paramedical services provided during a Hospitalization;

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;

j) Fees for dental surgeons for emergency dental treatments required following an external trauma resulting in damage to whole, healthy and natural teeth or when it is necessary to reduce a fracture or following dislocation of the jaw. Treatment must begin while the Insured Person is covered and end within 6 months of the Accident. The maximum reimbursement is $2,000 per Accident, per Insured Person.

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 of 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 medical factors, such as but not limited to 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.

Extension of coverage for Emergency Medical Expenses Incurred Outside the Province of Residence

This benefit is extended, automatically and at no cost, at the end of the maximum period of 90 consecutive Days per trip:

a) Up to 24 hours when the return home of the Insured Person is postponed due to a delay by the carrier or following an Accident or a mechanical problem to the Insured Person's private vehicle while in it and while returning to the starting point (claim must be supported by vouchers); or

b) During Hospitalization and 24 hours following the Insured Person's discharge from the hospital; or

c) Up to 72 hours when the return home is delayed due to an Insured Person's Illness that began within 24 hours before the scheduled return date and requiring emergency medical care.

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

The following medical expenses are covered, up to the maximums specified in the Summary of Benefits:

a) Drugs (including anti-smoking aids, oral contraceptives, injectable drugs, drugs for the treatment of fertility or infertility, anti-addiction drugs, anesthetics, serums and vaccines) 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 law 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 Quebec Prescription Drug Insurance benefit.

Dispensing Limitations

The quantity of drugs which may be dispensed for any one prescription will be limited to that amount sufficient for up to a 100 Day period.

Some drugs, commonly called "RAMQ exception drugs", are covered only if they meet the conditions and therapeutic indications determined by the regulations applying to the Basic Prescription Drug Insurance Plan of Quebec. Prior authorization for an exception drug must be received from the insurer.

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 the group policy or a material change in risk for the insurer in general.

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:

i) An alternative drug to the Original Drug deemed interchangeable by law; or

ii) A subsequent entry biologic.

b) Services rendered at the Insured Person's home by a registered nurse or certified nursing assistant provided:

i) The services were prescribed by a Physician and pre-approved by the insurer; and

ii) The services are Medically Required; and

iii) The services fall within the scope of services provided by a registered nurse or certified nursing assistant; and

iv) The registered nurse or certified nursing assistant is unrelated to the Insured Person and does not normally reside with him.

c) Physician's fees to complete a medical certificate or provide additional information, during an absence due to an Illness, in relation to a claim made under the Long-term Disability Insurance benefit of the group policy, if applicable. Expenses are reimbursed from the second medical certificate and the date of the receipt must be different from the date of the onset of disability.

d) 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.

e) 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; and

ii) The confinement was recommended by a Physician; and

iii) The confinement takes place within 14 Days of a period of Hospitalization; and

iv) 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.

f) Charges for diagnostic laboratory tests and medical imaging services (such as, but not limited to x-rays, tomodensitometry, ultrasounds, magnetic resonance imaging, including *Procrea* tests and electrocardiograms) other than x-rays by a paramedical practitioner, provided:

i) Coverage for the tests and services is not prohibited by provincial legislation; and

ii) The tests and services are performed in a facility licensed to perform such tests and services; and

iii) The tests and services are required for the diagnosis of an Illness or injury or to determine the effectiveness of the treatment being prescribed or received.

g) Charges for the rental of, or at the insurer's option, the purchase of the following medical appliances and supplies provided they are prescribed by a Physician:

i) Oxygen, oxygen tent and oxygen supplies

ii) Aerosol equipment, mist tents and nebulizers for cystic fibrosis, acute emphysema, chronic obstructive bronchitis or chronic asthma

iii) Artificial eyes, including repairs and replacements

iv) Artificial arm, hand and foot, excluding myoelectric and electric prostheses, including repairs and replacements

v) Manual wheelchairs or electric wheelchairs when the Insured Person is incapable of operating a manual wheelchair due to a medical condition

vi) 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

vii) Apnea monitors for respiratory dysrhythmias

viii) Diabetic monitoring (dextrometers, glucometers, reflectometers) and administration equipment (insulin pumps) other than the insulin supplies such as needles, syringes, lancets and diagnostic testing materials

ix) Percutaneous or transcutaneous nerve stimulator

x) Tensiometers

xi) Intermittent positive pressure breathing machine

xii) Continuous positive pressure breathing machine

xiii) Breast prostheses

xiv) Surgical brassieres

xv) Medical elastic stockings (of 15mmHg or more) prescribed for the treatment of varicose veins

xvi) Orthopedic shoes which are Medically Required by a health practitioner operating within the scope of his license and which have been custom made, custom modified or custom molded for the Insured Person by a certified specialist in orthopedic footwear, Off the shelf orthopedic shoes which have not been custom made, modified or molded for the Insured Person will not be eligible for coverage

xvii) Foot orthoses which are Medically Required 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, including arch supports added to regular shoes or to orthopedic shoes and alterations. Off the shelf foot orthoses which have not been specifically designed and constructed for the Insured Person will not be eligible for coverage

xviii) Intrauterine devices

xix) Diaphragms

xx) Glasses following cataract surgery

xxi) Contact lenses following cataract surgery

xxii) Intraocular lenses following cataract surgery

xxiii) Braces with rigid support; back supports; shoulder harnesses; head halters and cervical collars

xxiv) Splints, other than dental splints, and casts

xxv) Canes, crutches and walkers

xxvi) Hernia belts

xxvii) Wigs required as a result of chemotherapy

xxviii) Sclerosing injections (excluding administration)

xxix) Colostomy, ileostomy and urostomy apparatus and supplies

xxx) Catheters

h) Dental care given out of Hospital by a General Dental Practitioner which is required as a result of an Accident to whole, healthy, natural teeth, provided:

i) The Accident occurs while the Insured Person is insured under this benefit; and

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

iii) The charges do not exceed the amount shown for the treatment in the current provincial fee schedule for General Dental Practitioners in the Participant's province of residence; and

iv) The care is received within 12 months of the date of the Accident.

Any charges for dental care which are not directly related to the Accident will not be covered.

i) 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 or an audiologist.

j) Charges made by a treatment facility treating drug addiction, alcoholism or gambling addictions (including cost of room and board and nursing care) provided

i) The Insured Person is involved in a treatment program treating drug addiction, alcoholism or gambling addiction in the facility;

ii) the facility is a legally licensed facility providing care and treatment on a regular basis to individuals who are involved with drug addiction, alcoholism or gambling addictions and is operating in accordance with the laws of the jurisdiction in which it is located, and

iii) the insurer has approved the facility prior to the charges being incurred.

k) Charges for eye examinations when performed by an ophthalmologist or an optometrist.

l) Charges for eyeglasses (including sunglasses and safety glasses), when prescribed by an ophthalmologist or an optometrist.

m) Charges for contact lenses, when prescribed by an ophthalmologist or an optometrist.

n) Charges for corrective laser surgery, when prescribed by an ophthalmologist or an optometrist.

o) Charges for eyeglasses, when prescribed by an ophthalmologist or an optometrist following the treatment of a keratoconus.

p) Charges for contact lenses, when prescribed by an ophthalmologist or an optometrist following the treatment of a keratoconus.

q) Fees for cosmetic surgery needed following an Accident, which occurred while the person was insured, provided treatments started within 12 months following the date of the Accident and ended within 36 months following the date of the Accident.

r) Fees for the care (including charges for x-rays, if specifically mentioned as being covered under the Summary of Benefits) 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.

EXCLUSIONS AND REDUCTIONS

This benefit does not cover any of the following expenses:

a) Payable or reimbursable under a workers' compensation act or would have been payable if the claim had been submitted.

b) For 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.

c) For an Illness or injury or any expenses resulting, directly or indirectly, from civil unrest, insurrection or war, whether war be declared or not, or participation in a riot, invasion, acts or attacks from foreign enemies, hostilities or conflicts between nations, guerrilla, campaign or military operation, rebellion, insurrection, agitation or people's uprising, disorder, piracy, terrorism or conspiracy;

   However, the events previously described are covered for Participants travelling on business for the Employer, subject to a maximum of $600,000 per event for all Participants involved in such event.

   Moreover, if the Participant travelling on business for the Employer in a country for which the Canadian government has issued a recommendation to the effect that Canadians should not travel in such country, the stay is covered up to a maximum of $600,000 per trip for all Participants involved.

d) For an Illness or injury or any expenses resulting, directly or indirectly, from the commission of an offence under any criminal code or similar law in any jurisdiction, if the Insured Person has been charged or convicted.

e) For treatment or appliances to correct vertical dimension or any temporomandibular joint dysfunction.

f) For care or treatment which is not Medically Required, or which is given for cosmetic purposes, or for any reason other than curative, or which exceeds the normal care or treatment given in accordance with current therapeutic practice, or is of an experimental nature.

g) For any 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.

h) For care or treatment of an Illness or injury that is not recognized as normal, customary and common practice for such Illness or injury.

i) For 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.

j) For any care or treatment rendered free of charge or which would have been free of charge were it not for insurance coverage or which is not chargeable to the Insured Person.

k) For rest cures or travel for reasons of health.

l) For eye examinations, except if specifically mentioned as being covered under this benefit.

m) For eyeglasses and contact lenses, except if specifically mentioned as being covered under this benefit.

n) For care or treatment related to fertility or infertility, except if specifically mentioned as being covered under this benefit.

o) For the purchase or rental of any comfort or massage apparatus, and of domestic accessories that are not exclusively required for medical purposes.

p) For the purchase of food or nutritional supplements, whether or not these are prescribed for a medical reason, except if mention is made that these expenses are covered under this benefit.

q) For any services or supplies which are for the sole purpose of facilitating the Insured Person's participation in sports, or for fitness and training (except if specifically mentioned as being covered under this benefit), or recreational activities and not for daily living activities.

r) For care or treatment of (including breaking the addiction to) such conditions as, but not limited to, obesity, smoking, drug addiction, alcoholism and gambling, except if specifically mentioned as being covered under this benefit.

s) For preventive immunization vaccines or the administration of serums, vaccines and injectable medications, except if specifically mentioned as being covered under this benefit.

t) For contraceptives (other than oral), except if specifically mentioned as being covered under this benefit.

u) 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;
- natural products (NPN);
- anabolic steroids.

v) For any drugs which are considered lifestyle drugs such as, but not limited to, drugs for the treatment of infertility, erectile dysfunction, loss of hair or lack of growth, except if specifically mentioned as being covered under this benefit.

w) For expenses incurred by any Insured Person who has entered the armed forces of any country on a full-time basis

x) Expenses incurred for a vasectomy or a uterine tubes ligating, as well as services or supplies relating to any appliance worn in the practice of a sport

y) Expenses incurred for periodic health examination, examinations required for the use of a third party, or travel for health

z) Expenses incurred for physician's charges for his time spent travelling, broken appointments, transportation costs, room rental charges or advice given by telephone or any other means of telecommunication

aa) For any drugs which are excluded from coverage by the insurer under the Dispensing Limitations provision of this benefit.

bb) 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.

cc) For any care or treatment received outside of the province of residence due to a Medical Emergency which is related to (i) a pregnancy, false labour, delivery or resulting complications, if the Medical Emergency occurs after the 32nd week of gestation; or (ii) the deliberate inducement of a miscarriage.

dd) For any care or treatment received outside of the province of residence due to a Medical Emergency which is related to an Accident occurring while the Insured Person is participating in a sport for remuneration, any kind of motor vehicle or any kind of speed contest, gliding or hang-gliding, mountain climbing (trails graded 4 or 5 according to the Fédération québécoise de la montagne et de l'escalade), skydiving or free fall as well as bungee jumping.

ee) For any care or treatment received outside of the province of residence due to drug abuse or drug use, as well as driving a motor vehicle, an aircraft or a boat while the Insured Person is under the influence of any drug or with an alcohol level exceeding 80 milligrams per 100 milliliters of blood.

ff) 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.

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 Insured 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

If the Participant dies while insured under this benefit and prior to any extension of insurance as provided for under the Extension of Benefits provision, insurance under this benefit shall continue for his Dependents who were insured under this benefit at the time of his death, without payment of premiums, until the earliest of:

a) 3 months after the Participant's death; or

b) The date on which the Dependents' insurance would have terminated had the Participant then been living; or

c) The termination date of this benefit.

EXTENSION OF BENEFITS

If on the date an Insured Person's insurance under this benefit is discontinued, the Insured Person is Disabled, a benefit will be payable for covered health care expenses directly related to the Disability provided:

a) The expenses are incurred within 90 Days of the date the insurance was discontinued; and

b) This benefit is in force when the expenses are incurred.

As used in this provision, Disabled and Disability mean:

a) With respect to a Participant, his complete incapacity due to an Illness or injury to perform any work for which he is reasonably qualified by education, training or experience; and

b) With respect to a Dependent, that the Dependent, due to a medically determinable physical or mental impairment, is confined to a Hospital or is receiving treatment by a Physician.

CONVERSION PRIVILEGE

A Participant whose insurance under the group policy is cancelled due to termination of:

a) His employment; or

b) His group membership,

will be able to convert his Supplemental Health Insurance 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 policy. 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.

TERMINATION

The insurance under this benefit terminates as indicated in the Summary of benefits, or such other earlier date indicated in this benefit or in the General Provisions of the group policy.

SUPPLEMENTAL HEALTH INSURANCE – EMERGENCY OUT OF PROVINCE ASSISTANCE

A Participant who opted for the Exemption Option under the Supplemental Health Insurance will benefit from this coverage only if his absence was due to business travel.

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 insured under the Supplemental Health Insurance at the time of the Medical Emergency or personal emergency; and

b) The Medical Emergency or personal emergency occurs during the first 90 consecutive Days of the Insured Person's absence from his province of residence.

   If, however, 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; and

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

d) The services and supplies had to be provided before the Insured Person could return to his province of residence without endangering his health; and

e) 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.

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.

The insurer has the right to refuse a claim if the Insured Person has not contacted the medical assistance service as soon as possible in the case of a medical consultation or a Hospitalization.

In the absence of medical contraindication, the insurer may request that the Insured Person be repatriated or treated elsewhere. Repatriation must be recommended and planned by the medical assistance service provider. If an

Insured Person refuses to follow a recommendation for repatriation, the insurer accepts no responsibility for expenses incurred thereafter.

DEFINITIONS

As used in this benefit:

Day Surgery: Surgery which is performed in a Hospital or out-patient clinic affiliated with a Hospital and requiring local, regional or general anaesthesia, but will not include minor surgery that can be performed in the Physician's office.

Immediate Family: The Insured Person's Spouse, father, mother, Child, brother or sister.

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

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 hotline, 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 Physicians or Specialists in order to obtain the best medical care available in the area;
- Provide assistance with admittance to a Hospital;
- Confirm to Physicians and Hospitals the medical expenses that are covered under the Insured Person's group policy.

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;
- 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.
- The medical assistance service provider will pay for charges incurred due to a Hospitalization (such as parking, television rental, telephone calls, etc.), on presentation of vouchers, up to a maximum of $100 per Hospitalization.
- The medical assistance service provider will pay medical fees for a Dental Surgeon for emergency treatment required to relieve pain, up to a maximum of $200 per Insured Person.

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, cremation or burial on site, up to a maximum of $7,500. Funeral expenses will not be covered.

- The medical assistance service provider will arrange and pay for round-trip economy class transportation for a Family member to identify the deceased, where required, prior to transportation, cremation or burial on site.

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 Immediate Family

- The medical assistance service provider will organize the return of the Insured Person and/or a member of the 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 $3,000 (maximum of 20 Days).

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 the drugs are covered under the Supplemental Health Insurance.

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 AND REDUCTIONS

In addition to the exclusions and reductions outlined in the Exclusions and Reductions provision of the Supplemental Health Insurance, the Medical Emergency Assistance Services provided under this benefit will be subject to the limitations, exclusions and terms and conditions that are applicable under the Emergency Medical Expenses Incurred Outside the Province of Residence provision of the Supplemental Health Insurance.

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 Physicians, 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 Physicians, 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 by the insurer or its medical assistance provider to cover a charge that had been made, or if a charge was paid by the insurer or its medical assistance provider, and the Participant submits such charge as a covered expense under the Supplemental Health Insurance at a later date, the Participant will only be reimbursed the difference between the eligible amount of the covered expense and the amount of the cash advance or the amount already paid by the insurer or its medical assistance provider, subject to the Deductible and Reimbursement level that are 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 Emergency Medical Expenses Incurred Outside the Province of Residence provision of the Supplemental Health Insurance 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.

AUTOMATIC EXTENSION

This benefit will be automatically extended at no cost at the end of the maximum period of 90 consecutive Days per trip:

- Up to 24 hours when the return home is postponed due to a delay by the carrier or the result of an accident or a mechanical problem to the Insured

Person's private vehicle while in it and while returning to the starting point (claim must be supported by vouchers); or

- During Hospitalization and 24 hours following the Insured person's discharge from the hospital; or
- Up to 72 hours when the return home is delayed due to an Insured Person's illness that began within 24 hours before the scheduled return date and requiring emergency medical care.

DENTAL CARE INSURANCE

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

DEFINITIONS

As used in this benefit:

General Dental Practitioner: A licensed dentist who practices dentistry without specialization.

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

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

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.

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

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

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

Medically Required means broadly accepted and recognized by the Canadian medical profession, and where applicable the Canadian dental profession, as effective and appropriate and essential in the treatment of an Illness or injuries, including injuries due to an Accident, in accordance with Canadian medical standards, or where applicable Canadian dental standards.

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.

DENTAL EXPENSES

Only those items included below which are specified in the Summary of Benefits will be considered “eligible expenses” provided they were rendered by a General Dental Practitioner, a Dental Specialist on the recommendation of a General Dental Practitioner or by a Dental Hygienist.

Preventive and Basic Treatments

a) Examinations and Diagnoses
   i) Complete oral examination
   ii) Recall examination (every 6 months)
   iii) Specific oral examination
   iv) Treatment plan
   v) Emergency and unusual services
   vi) Consultation
   vii) House call, institutional call and office visit

b) Tests and Laboratory Examinations
   i) Bacteriologic cultures
   ii) Biopsy
   iii) Cytological examination
   iv) Pulp vitality tests
   v) Diagnostic casts

c) X-rays
   i) Complete series - periopical (every 24 months)
   ii) Occlusal
   iii) Interproximal (every 6 months)
   iv) Extra-oral
   v) Sialography
   vi) Panoramic (every 24 months)

vii) Radiopaque dyes

d) Preventive services

i) Light scaling (2 units of time per Calendar Year)

ii) Dental prophylaxis (polishing of coronal portion of teeth) (every 6 months)

iii) Topical fluoride application (every 6 months)

iv) Caries control

v) Oral hygiene instructions (once per lifetime)

vi) Pit and fissure sealants

vii) Interproximal discing of teeth

viii) Plaque control program (under certain conditions)

ix) Prophylactic odontotomy

e) Restorative

i) Polycarbonate crowns for primary teeth

ii) Removal of crown or of an inlay or onlay

iii) Recementation of crown

iv) Amalgam

v) Silicate

vi) Acrylic or composite resin (In Quebec, composite restorations are covered for persons of age 10 and over only)

vii) Stainless steel crown for primary teeth

f) Space maintainers following primary tooth loss

g) Endodontics

i) Pulp capping

ii) Pulpotomy

iii) Root canal therapy

iv) Periapical treatments

v) Emergency procedures

vi) Root amputation

vii) Alveolectomy

viii) Banding of tooth to maintain sterile operating field

ix) Hemisection

x) Canal or pulp chamber enlargement

xi) Intentional removal, apical filling and reimplantation

xii) Removal of root filling material

xiii) Pulp mommification

xiv) Recontouring and polishing of traumatized tooth

xv) Relieving traumatic occlusion

xvi) Reimplantation of luxated tooth

xvii) Repositionning of traumatically displaced tooth

xviii) Laboratory procedure done in the dentist’s office

h) Periodontics

i) Non-surgical services

ii) Surgical services

iii) Post-surgical treatments

iv) Occlusal equilibration (8 units of time per Calendar Year)

v) Deep scaling (8 units of time per Calendar Year)

vi) Root planing and curretage

These expenses are covered up to a maximum of 6 sextants or 4 quadrants or up to 28 teeth per Calendar Year. They must be done entirely by the dentist and is only covered if testing of periodontal pockets indicates 4 mm or more. In all cases, appropriate x-rays and periodontal chart must be submitted.

vii) Special periodontal appliances (mouthguard)

viii) Provisional splint

- ix) Any treatment or device used to prevent bruxism

i) Dentures
- i) Repairs
- ii) Addition of teeth
- iii) Relining and rebasing

j) Surgical procedures
- i) Removal (uncomplicated)
- ii) Surgical removal and surgical repositionning of tooth
- iii) Alveoloplasty
- iv) Excision
- v) Incision
- vi) Frenectomy
- vii) Dislocations
- viii) Miscellaneous surgical services
- ix) General anesthesia
- x) Removal of impacted teeth
- xi) Removal of cysts

k) Anesthesia (excluding general anesthesia)
- i) Sedation

l) Removable dentures
- i) Remount with equilibration
- ii) Denture cleaning and polishing
- iii) Adjustments to dentures

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

Major Treatments

a) The following reasonable and customary charges:

   i) Crowns, inlays and onlays
      - deep metal inlays and onlays
      - crowns
      - retentive pins for deep inlays and onlays and for crowns
      - deep porcelain inlays and onlays, under certain conditions
      - provisional acrylic crowns
      - provisional metal crowns (chairside), under certain conditions
      - cast post

   ii) Fixed bridges
      - pontics
      - abutments
      - intra-oral brace for welding
      - retentive pins in abutments
      - adjustment or splint

   iii) Removable complete and partial dentures
      - complete dentures
      - partial dentures
      - provisional complete dentures
      - provisional partial dentures
      - equilibrated dentures

   iv) Repairs and adjustments
      - remaking of partial removable denture
      - bridge repairs

v) Surgery

- tuberoplasty
- fracture reduction

vi) Complementary services

- therapeutic injections

b) Replacement of a removable denture, of a bridge, of a crown, of an inlay or onlay, if the removable denture, the bridge, the crown or the inlay or onlay was installed at least 5 years before the replacement

c) Replacement of a bridge or a removable denture if the bridge or the denture is temporary and is permanently replaced within 12 months from the date of installation

d) Laboratory fees

e) Excluding partial dentures, initial fixed or removable dentures are covered in the case of teeth extracted while the person was insured under a similar benefit in another group insurance plan that covered the replacement of partial dentures and initial fixed or removable dentures.

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

Orthodontic Treatments

Reasonable expenses incurred for orthodontic treatment given by an orthodontist to correct malocclusion and dental irregularities.

Orthodontic treatments are available to any Insured Person.

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

EXCLUSIONS AND REDUCTIONS

In addition to the exclusions and reductions outlined in the Exclusions and Reductions provision of the Supplemental Health Insurance, if such a benefit is included in the group policy, the Dental Care Insurance does not cover any expenses:

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

b) Related to any appliance which is to be worn by the Insured Person during his participation in sports or recreational activities;

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

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

e) For services and supplies resulting, directly or indirectly, from civil unrest, insurrection or war, whether war be declared or not, or a riot;

f) For services and supplies which are not Medically Required, which are given for cosmetic purposes or for any reason other than curative, or which exceed the normal services and supplies given in accordance with current therapeutic practice;

g) For services and supplies 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;

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

i) For services and supplies or any expenses resulting, directly or indirectly, from the commission of an offence under any criminal code or similar law in any jurisdiction, if the Insured Person has been charged or convicted;

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

TREATMENT PLAN

If the total cost of a course of treatment is expected to exceed $500, a Treatment Plan should be submitted to the insurer who will determine, before commencement of the treatment, the amount of eligible expenses.

Treatment Plan means a written description of the course of treatment which, in the opinion of the General Dental Practitioner, will be required, including x-rays in support of such opinion, and specification of the probable date and cost of the treatment.

PAYMENT OF BENEFITS

Fees

Eligible expenses will be reimbursed according to the appropriate Fee Guide of the year specified in the Summary of Benefits, subject to any limits stated in the benefit.

Expenses Incurred in Canada, other than expenses related to services provided by a Denturist, will be limited to the normal rate suggested for General Dental Practitioners, for the Versatility Option and for a specialist, for the Comfort and Serenity Options in the province where the expenses were incurred.

Expenses Incurred for services provided by a Denturist are limited to the normal suggested fee for Denturists in the province where the expenses were incurred.

Expenses Incurred outside Canada are limited to the normal rate suggested for General Dental Practitioners in the Participant's province of residence.

Proof

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

Alternative Treatment Plan

If more than one type of treatment exists for the dental condition of the Insured Person, the insurer will limit Reimbursement to the least expensive treatment

that will produce a professionally adequate result with respect to the Insured Person's condition.

CALCULATION OF REIMBURSEMENT

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 eligible 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 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 dental care or treatment, the coverages will be co-ordinated to ensure that payment by all the coverages do not exceed the actual expenses incurred. The term "coverage" will mean any coverage providing care, services or supplies under:

i) Any group, individual or family insurance, travel insurance, creditor's or savings insurance plan; and

ii) Any government-sponsored plan; and

iii) Any non-insured employee benefit plan.

SURVIVOR BENEFIT

If the Participant dies while insured under this benefit and prior to any continuation of insurance as provided under the Extension of Benefits provision, insurance under this benefit shall continue for his Dependents who were insured under this benefit at the time of his death, without payment of premiums, until the earlier of:

a) 3 months after the Participant's death; or

b) The date on which the Dependent's insurance would have terminated had the Participant then been living; or

c) The termination date of this benefit.

EXTENSION OF BENEFITS

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

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

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

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

CONVERSION PRIVILEGE

A Participant whose insurance under the group policy is cancelled due to termination of:

a) His employment; or

b) His group membership,

will be able to convert his Dental Care Insurance to an individual insurance contract without having to submit evidence of insurability to the insurer, provided

he is also converting his Supplemental Health Insurance. Failure to convert his Supplemental Health Insurance will prevent the Participant from converting his Dental Care Insurance.

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

The Participant must make application and pay all required premiums for the individual insurance contract within 60 Days of the termination date of his insurance under the group policy. 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.

TERMINATION

The insurance under this benefit terminates as indicated in the Summary of Benefits, or such other earlier date indicated in this benefit or in the General Provisions of the group policy.

HEALTH SPENDING ACCOUNT COVERAGE

SUMMARY OF COVERAGE
CREDITED AMOUNT PER EMPLOYEE

The Employees are covered under this Health Spending Account ("HSA") Agreement No. 28770 as follows:

Class(es): 567

Health Spending Account Year ("HSA Year"):	June 1, 2020 to the December 31, 2020 and from January 1, to December 31, each year thereafter
For Employees covered under the previous HSA:	**Options:** Exemption; Versatility; Comfort; Serenity Flexible credits transferred from previous HSA plus new flexible credit allocation as chosen by the Employee.
For Employees not covered with previous carrier who become eligible on the HSA Effective Date May 1, 2020	**Options:** Exemption; Versatility; Comfort; Serenity Flexible credit allocation as chosen by the Employee.
For Employees who become eligible during the HSA Year:	**Options:** Exemption; Versatility; Comfort; Serenity Flexible credit allocation as chosen by the Employee.

SUMMARY OF COVERAGE
CREDITED AMOUNT PER EMPLOYEE (cont'd)

Class(es): 567

For all Employees eligible on the first day of the HSA Year:	**Options:** Exemption; Versatility; Comfort; Serenity New flexible credit allocation as chosen by the Employee. On the first day of the HSA Year, an Employee may change his flexible credit allocation.
Carryover Type:	Credits Carryover

DEFINITIONS

Administrator means Industrial Alliance Insurance and Financial Services Inc.

Dependent means a person who is considered an eligible Dependent of the Employee for a medical expense tax credit claim under the Income Tax Act.

Expenses means the health and dental expenses that the Administrator considers eligible under this HSA Agreement.

To be eligible the expenses must:

a) Be listed as medical expenses under the Income Tax Act, its regulations and Interpretation Bulletins; and

b) Not be eligible for reimbursement under any other plan (group, government or private).

Group Policy means group insurance policy no 28770 issued by Industrial Alliance Insurance and Financial Services Inc.

Health Spending Account Effective Date: June 1, 2020

ELIGIBLE EMPLOYEES

Subject to all of the terms and conditions of the HSA Agreement, an Employee shall become eligible for coverage on the latest of the following dates:

a) The Effective Date of the HSA, if he is then an Employee covered under the Group Policy; or

b) On the date the Employee is covered under the Group Policy.

CARRYOVER TYPE – CREDIT CARRYOVER

Coverage

The credits credited to each Employee's HSA will be used to reimburse the Expenses submitted. The Employee will be able to submit and be reimbursed for Expenses for himself or any Dependent.

Utilization of the credits and grace period

Credits allocated to an Employee's HSA for a HSA Year may be carried forward into the next HSA Year.

The Employee has a grace period of 90 Days at the end of the HSA Year during which the credits were carried forward to utilize the unused credits. After that period, the credits will be forfeited from the Employee's HSA.

During that 90 Day period, the credits must be used to reimburse expenses which were incurred during the HSA Year to which these credits were carried forward.

Expenses and grace period

Expenses incurred during a HSA Year must be submitted during this same HSA Year.

The Employee has a grace period of 90 Days at the end of this HSA Year to submit the expenses that were not submitted. After that period, the expenses are not reimbursed.

During that 90 Day period, the expenses must be reimbursed from the credits of the HSA Year in which these expenses were incurred.

Sufficient credits

There must be sufficient credits in the Employee's HSA for expenses to be reimbursed.

If an Employee submits expenses and there are insufficient credits in the Employee's HSA, the Employee will be reimbursed up to the extent of the credits available in his HSA.

If an Employee submits expenses and there are no credits in the Employee's HSA, no expenses will be reimbursed.

TERMINATION OF HSA COVERAGE

The Employee's HSA coverage automatically terminates on the earliest of the following dates:

a) The date the HSA Agreement is terminated; or

b) The date on which the Employee retires; or

c) The date the Employee is no longer covered under the Group Policy; or

d) The date the Accountholder terminates coverage under the HSA Agreement for the Employee.

NOTICE AND PROOF OF HSA CLAIM

Notice and proof of any claim must be submitted to the Administrator in the format required by the Administrator. The proof of claim must include all information that the Administrator requires and deems necessary. The Administrator is not liable for any claim that is not submitted in accordance with this Agreement.

Claims must be submitted within the prescribed period in the provision Carryover Type under the section Health Spending Account Coverage.

HSA CLAIMS IN CASE OF TERMINATION OF EMPLOYMENT

The Employee has 90 Days from the date his HSA coverage terminates to submit any claims incurred prior to such date. After that period, the credits are forfeited from the Employee's HSA and the Expenses are not reimbursed.

HSA CLAIMS IN CASE OF HSA AGREEMENT TERMINATION

If the HSA Agreement and the Group Policy are terminated, the Administrator will not be responsible for claims submitted after the date the HSA terminates.

However, if the HSA Agreement is terminated but the Group Policy is still in force, claims for Expenses incurred on or prior to the HSA termination date can be submitted within 90 Days from that date.

The Administrator will not be responsible for claims submitted after the end of 90 Day period.

If the Group Policy is terminated before the end of the 90 Day period, the Administrator will not be responsible for claims submitted after the date the Group Policy terminates.

MODIFICATION TO HSA CREDITS DUE TO LIFE EVENT

If during a HSA Year, the Employee should experience a life event (change in matrimonial status, birth or adoption of a first Child, end of eligibility of the last Dependent Child, change of eligibility of the Spouse to his employer's group policy, death of the Spouse or return to an accredited educational institution on a full-time basis of a Dependent Child who is over 22 years of age but under 26 years of age after no more Dependent Children are eligible), which results in a change of his HSA coverage and additional credits become available, these additional credits can be transferred to the Employee's HSA.

If, however, as a result of the change, credits should be reduced, this reduction in credits will not reduce the credits initially allocated to the HSA.

The additional credits are calculated in proportion to the number of months remaining in the current HSA Year.

SUMMARY OF COVERAGE
CREDITED AMOUNT PER EMPLOYEE

The Employees are covered under this Wellness Account Agreement Agreement No. 28770 as follows:

Class(es): 567

Wellness Account Year:	June 1, 2020 to the December 31, 2020 and from January 1, to December 31, each year thereafter
For Employees covered under the previous Wellness Account:	**Options:** Exemption; Versatility; Comfort; Serenity Flexible credits transferred from previous Wellness Account plus new flexible credit allocation as chosen by the Employee.
For Employees not covered with previous carrier who become eligible on the Wellness Account Effective Date:	**Options:** Exemption; Versatility; Comfort; Serenity Flexible credit allocation as chosen by the Employee.
For Employees who become eligible during the Wellness Account Year:	**Options:** Exemption; Versatility; Comfort; Serenity Flexible credit allocation as chosen by the Employee.
For all Employees eligible on the first day of the Wellness Account Year:	**Options:** Exemption; Versatility; Comfort; Serenity New flexible credit allocation as chosen by the Employee. On the first day of the Wellness Account Year, an Employee may change his flexible credit allocation.

SUMMARY OF COVERAGE
CREDITED AMOUNT PER EMPLOYEE (cont'd)

Class(es): 567

Carryover Type: Credits Carryover

WELLNESS ACCOUNT COVERAGE

DEFINITIONS

Administrator means Industrial Alliance Insurance and Financial Services Inc.

Dependent means a person who is considered an eligible dependent of the employee for a medical expense tax credit claim under the Income Tax Act.

Expenses means the expenses considered as being eligible or not eligible under the Wellness Agreement according to the Accountholder.

Group Policy means group insurance policy no 28770 issued by Industrial Alliance Insurance and Financial Services Inc.

Wellness Account Effective Date: June 1, 2020

ELIGIBLE EMPLOYEES

Subject to all of the terms and conditions of the Wellness Account Agreement, an Employee shall become eligible for coverage on the latest of the following dates:

a) The Effective Date of the Wellness Account Agreement, if he is then an Employee covered under the Group Policy; or

b) On the date the Employee is covered under the Group Policy.

ELIGIBLE EXPENSES

The Administrator is not responsible for determining whether expenses are eligible for reimbursement. The Accountholder determines which expenses are eligible or ineligible for reimbursement under the Wellness Account.

The credits allocated to each Employee's Wellness Account are used by the Administrator to reimburse the eligible Expenses submitted.

CARRYOVER TYPE – CREDIT CARRYOVER

Coverage

The credits credited to each Employee's Wellness Account will be used to reimburse the eligible Expenses submitted. The Employee will be able to submit and be reimbursed for eligible Expenses for himself or any Dependent.

Utilization of the credits and grace period

Credits allocated to an Employee's Wellness Account for a Wellness Account Year may be carried forward into the next Wellness Account Year.

The Employee has a grace period of 90 Days at the end of the Wellness Account Year during which the credits were carried forward to utilize the unused credits. After that period, the credits will be forfeited from the Employee's Wellness Account.

During that 90 Day period, the credits must be used to reimburse expenses which were incurred during the Wellness Account Year to which these credits were carried forward.

Expenses and grace period

Expenses incurred during a Wellness Account Year must be submitted during this same Wellness Account Year.

The Employee has a grace period of 90 Days at the end of this Wellness Account Year to submit the expenses that were not submitted. After that period, the expenses are not reimbursed.

During that 90 Day period, the expenses must be reimbursed from the credits of the Wellness Account Year in which these expenses were incurred.

Sufficient Credits

There must be sufficient credits in the Employee's Wellness Account for expenses to be reimbursed.

If an Employee submits expenses and there are insufficient credits in the Employee's Wellness Account, the Employee will be reimbursed up to the extent of the credits available in his Wellness Account.

If an Employee submits expenses and there are no credits in the Employee's Wellness Account, no expenses will be reimbursed.

TERMINATION OF WELLNESS ACCOUNT COVERAGE

The Employee's Wellness Account coverage automatically terminates on the earliest of the following dates:

a) The date the Wellness Account Agreement is terminated; or

b) The date on which the Employee retires; or

c) The date the Employee is no longer covered under the Group Policy; or

d) The date the Accountholder terminates coverage under this Wellness Account Agreement for the Employee.

NOTICE AND PROOF OF WELLNESS ACCOUNT CLAIM

Notice and proof of any claim must be submitted to the Administrator in the format required by the Administrator. The proof of claim must include all information that the Administrator requires and deems necessary. The Administrator is not liable for any claim that is not submitted in accordance with this Agreement.

Claims must be submitted within the prescribed period in the provision Carryover Type under the section of the Wellness Account Coverage.

WELLNESS ACCOUNT CLAIMS IN CASE OF TERMINATION OF EMPLOYMENT

The Employee has 90 Days from the date his Wellness Account coverage terminates to submit any claims incurred prior to such date. After that period, the credits are forfeited from the Employee's Wellness Account and the Expenses are not reimbursed.

WELLNESS ACCOUNT CLAIMS IN CASE OF WELLNESS ACCOUNT AGREEMENT TERMINATION

If the Wellness Account Agreement and the Group Policy are terminated, the Administrator will not be responsible for claims submitted after the date the Wellness Account Agreement terminates.

However, if the Wellness Account Agreement is terminated but the Group Policy is still in force, claims for Expenses incurred on or prior to the Wellness Account Agreement termination date can be submitted within 90 Days from that date.

The Administrator will not be responsible for claims submitted after the end of 90 Day period.

If the Group Policy is terminated before the end of the 90 Day period, the Administrator will not be responsible for claims submitted after the date the Group Policy terminates.

MODIFICATION TO THE WELLNESS ACCOUNT CREDITS DUE TO A LIFE EVENT

If during a Wellness Account Year, the Employee should experience a life event (change in matrimonial status, birth or adoption of a first Child, end of eligibility of the last Dependent Child, change of eligibility of the Spouse to his employer's group policy, death of the Spouse or return to an accredited educational institution on a full-time basis of a Dependent Child who is over 22 years of age but under 26 years of age after no more Dependent Children are eligible), which results in a change of his Wellness Account coverage and additional credits become available, these additional credits can be transferred to the employee's Wellness Account.

If, however, as a result of the change, credits should be reduced, this reduction in credits will not reduce the credits initially allocated to the Wellness Account.

The additional credits are calculated in proportion to the number of months remaining in the current Wellness Account Year.

COPY OF CONTRACT AND ENROLLMENT MATERIAL

A Participant may request from the insurer a copy of the group 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.

Health and Dental Claims

To benefit from an accelerated processing, a Participant may submit claims in any of the following ways, if offered as part of his group insurance plan:

- **on our secure website *My Client Space* accessible via *ia.ca*; or**
- **via *iA Mobile***

The Participant may also submit a completed claim form with the original receipts (if applicable) to the following address:

For Participants residing in Quebec

Industrial Alliance Insurance and Financial Services Inc.
Group Insurance
Health/Dental Claims Department
P.O. Box 800 - Station Maison de la Poste
Montreal, Quebec, H3B 3K5

For Participants residing outside Quebec

Industrial Alliance Insurance and Financial Services Inc.
Group Insurance
Health/Dental Claims Department
P.O. Box 4643, Station "A"
Toronto, Ontario, M5W 5E3

It is important that Participants keep photocopies of their receipts. In addition, Participants should keep a copy of the Explanation of Benefits (EOB) which will be attached to their claim cheques. Participants may need these documents to co-ordinate benefits with another insurer or for their income tax returns.

Disability Claims

The Participant must submit a completed claim form to the following address:

For Participants residing in Quebec

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

For Participants residing outside Quebec

Industrial Alliance Insurance and Financial Services Inc.
Group Insurance
Disability Claims Department
522 University Ave., Suite 400
Toronto, Ontario, M5G 1Y7

IMPORTANT NOTICE
For Persons Hospitalized Outside their Province of Residence

The Insured Person is required to contact Industrial Alliance Insurance and Financial Services Inc. (hereafter "the Company") Medical Assistance Service Provider at the following number as soon as the person is reasonably able to do so after the commencement of Hospitalization. Failure to do so may result in the Company limiting or denying the Insured Person's claim.

From within Canada or the United States	1 800 203-9024	(toll free)
From outside Canada or the United States	514 499-3747	(collect)

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's 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

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Policy No. 100012339 issued by iA Special Markets, a division of Industrial Alliance Insurance and Financial Services Inc.

Classes 563, 567, 572

COVERAGE

You are covered for any injury sustained as the result of an accident anywhere in the world - 24 hours per day - on or off the job.

AMOUNT OF INSURANCE

Your amount of insurance (Principal Sum) is an amount equal to the amount of your current Basic Group Life Insurance.

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

BENEFITS

Accidental Death, Dismemberment and Specific Loss Indemnity

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

Loss	Benefit
Life	100%
Both Arms or Both Hands	100%
Both Feet	100%
Entire Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and Entire Sight of One Eye	100%
One Foot and Entire Sight of One Eye	100%
Speech and Hearing in both Ears	100%
One Arm or One Leg	80%
One Hand or One Foot	75%
Entire Sight of One Eye	75%
Speech or Hearing in both Ears	75%
Hearing in One Ear	66 2/3%
Thumb and Index Finger of Either Hand	33 1/3%
Four Fingers of Either Hand	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%

Bereavement Benefit ($1,000)

If an injury results in loss of life, the Company will pay the reasonable and necessary expenses actually incurred by the Spouse and Dependent Children for up to six (6) sessions of grief counselling, by a professional counsellor.

Comatose Benefit

If an injury does not cause loss of life but results in a coma or comatose state within 12 months after the date of the accident, the Company will pay 1% of the principal sum (less any sum paid under the Accidental Death, Dismemberment and Specific Loss Indemnity) for each month the coma or comatose state continues. Payments commence at the end of the waiting period of 31 days and are subject to a maximum of 100 consecutive months.

Continuation of Coverage

Coverage can be continued while the insured is on an approved leave of absence, maternity/parental leave, lay-off, strike/lockout or disability as per the Policyholder's current Group Life policy, subject to continued payment of premiums.

Conversion Option

Upon termination of active employment with the Policyholder, an insured may convert his/her insurance 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 90 days. Premiums become payable annually in advance. This benefit is restricted to Canadian residents only.

Cosmetic Disfigurement Benefit ($25,000)

If an insured suffers a third degree burn, the Company will pay a percentage of the principal sum, depending on the area of the body which was burned according to the following table:

Cosmetic Disfigurement Benefit ($25,000) (cont'd)

Body Part	Area Classification (A)	Maximum Allowable Percentage for Area Burned (B)	Maximum Percentage of Principal Sum Payable (C)
		%	%
Face, Neck, Head	11	9.0	99.0
Hand and Forearm	5	4.5	22.5
Either Upper Arm	3	4.5	13.5
Torso (front or back)	2	18.0	36.0
Either Thigh	1	9.0	9.0
Either Lower Leg (below knee)	3	9.0	27.0

The maximum percent of principal sum payable (C) is determined by multiplying the area classification (A) by the maximum allowable percent for area burned (B). This table only represents the maximum percent of the principal sum payable for any one accident. If the insured suffers burns in more than one area, as a result of any one accident, benefits will not exceed the maximum amount stated above.

Day Care Benefit ($5,000)

If injury results in loss of life, 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, or within 12 months following the accident.

Education Benefit ($5,000)

If injury results in loss of life, the Company will pay 5% of the principal sum for each year 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, none of the dependent children are eligible for the Education Benefit, the Company shall pay an additional amount of $2,500 to the designated beneficiary.

Exposure and Disappearance

If, as the result of an accident, an insured is unavoidably exposed to the elements and if, as a result of such exposure and within 12 months after the date of the accident, the insured suffers a loss for which indemnity would otherwise have been payable hereunder, such loss will be deemed to be the result of injury.

Where, due to the accidental wrecking, sinking or disappearance of a conveyance in which an insured was riding, the insured disappears, and if the body of the insured is not found within 12 months after the date of such wrecking, sinking or disappearance, it will be presumed, subject to there being no evidence to the contrary and subject to all other terms and conditions of the policy, that the insured suffered loss of life as a result of injury.

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 100 km from the insured'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 insured. 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.

Funeral Expense Benefit ($5,000)

If injury results in loss of life, an additional amount is payable for funeral expenses actually incurred.

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 insured's principal residence and/or the cost of modification to one motor vehicle utilized by the insured, provided such injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity.

Hospital Indemnity Expense ($2,500)

A daily benefit of 1/30 of 1% of the insured's principal sum, subject to the above-mentioned monthly maximum, will be payable when the insured 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.

Identification Benefit ($5,000)

If injury results in loss of life, and requires body identification, the Company will pay the expenses actually incurred by a member of the immediate family for lodging, board and transportation by the most direct route, provided the body is located not less than 150 kilometres from the member of the immediate family's residence and the identification of the body is required by the police or a similar law enforcement agency having authority over such matters. If transportation occurs in a vehicle or device other than one operated under the 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.

Permanent Total Disability

If an injury totally and permanently disables an insured within 12 months of the date of the accident, preventing the insured from engaging in any and every occupation, the Company will pay, provided such disability has continued for a period of 12 consecutive months and is total, continuous and permanent at the end of this period, the principal sum less any amounts already paid under the Accidental Death, Dismemberment and Specific Loss Indemnity as the result of the same accident.

Psychological Therapy Benefit ($5,000)

If injury results in a loss payable to an insured under the Accidental Death, Dismemberment and Specific Loss Indemnity and results in the insured requiring psychological therapy, as prescribed by a physician, the Company will pay the reasonable and necessary expenses actually incurred.

Rehabilitation Benefit ($15,000)

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

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.

Seat Belt Benefit ($50,000)

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 insured was driving or riding in a vehicle and wearing a properly fastened seat belt.

Spousal Retraining Benefit ($15,000)

If injury results in loss of life, 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.

Waiver of Premium

In the event of total disability and waiver of premium 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.

Workplace Modification and Accommodation Benefit ($5,000)

If injury requires special adaptive equipment and/or workplace modification for an insured to return to active full-time employment, the Company will pay the cost provided the policyholder agrees in writing to provide such modification and accommodation to the workplace for the purpose of making it accessible and adaptable to the needs of such insured; and the policyholder acknowledges in writing that the performance of the essential duties of such insured's occupation may be altered.

Aircraft Coverage (Passenger)

Coverage is extended to include 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 any fixed-wing 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.

The extended insurance afforded by this part does not apply to any loss fatal or non-fatal, caused by or resulting from Injury sustained while the Insured Person is:

(a) flying in any aircraft while it is being used for or in connection with acrobatic or stunt flying or racing;

(b) flying in any aircraft while it is being used for or in connection with crop dusting or seeding or spraying, pipe or power line inspection, any form of hunting, bird or fowl herding, banner towing, unless previously consented to in writing by the Company.

The above-noted exclusions do not apply to endurance tests, demonstration or any test for experimental purpose, nor to carry passengers for hire and for any flight which requires a special permit or waiver from the authority having jurisdiction over civil aviation, even though granted.

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; 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; being struck by; or making a forced landing with or from any aircraft owned, operated or leased by the policyholder.

EXCLUSIONS

- 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 parts titled “Limited Air Travel Coverage” and “Aircraft Coverage”.

TERMINATION OF INSURANCE

Coverage will terminate immediately on the earliest of:

(a) the policy termination date;

(b) the premium due date if the Policyholder fails to pay the insured’s premium, except as a result of an inadvertent error;

(c) the premium due date coinciding with or immediately following the date an insured retires;

(d) the premium due date next following the date an insured is ineligible for coverage, except as provided under the part titled “Continuation of Coverage”.

BENEFICIARY

Indemnity payable in the event of the loss of life of an insured is payable to the beneficiary or beneficiaries designated in writing by the insured on his enrollment card on file with the Policyholder, or if there is no such beneficiary designation with respect to the insured, such indemnity is payable in accordance with the beneficiary designation in effect under the Policyholder's current Basic Group Life insurance policy and if there is no such beneficiary designation with respect to the insured, such indemnity is payable to the estate of the insured. All other indemnities payable are payable to the insured, with the exception of indemnities payable under the following parts:

- Bereavement Benefit
- Day Care Benefit
- Education Benefit
- Family Transportation Benefit
- Funeral Expense Benefit
- Identification Benefit
- Repatriation Benefit
- Spousal Retraining Benefit
- Workplace Modification and Accommodation Benefit

In the situation where the policy replaces an existing policy issued to the Policyholder, the designation recorded under the replaced policy will be deemed to be valid and of full force and effect under this policy 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. The 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 iA Special Markets, a division of Industrial Alliance Insurance and Financial Services Inc., not this summary.

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Policy No. 100012340 issued by iA Special Markets, a division of Industrial Alliance Insurance and Financial Services Inc.

Classes 563, 567, 572

COVERAGE

If you elect to participate, you will be covered for injuries sustained as the result of an accident anywhere in the world - 24 hours per day - on or off the job. You may also elect to insure your family.

AMOUNT OF INSURANCE

You may select any principal sum of insurance from a minimum of $5,000 in units of $5,000 to a maximum of $1,650,000 for yourself, combined with your Basic Accidental death and dismemberment Group insurance.

You may select any principal sum of insurance from a minimum of $5,000 in units of $5,000 to a maximum of $400,000 for your spouse
You may select any principal sum of insurance from a minimum of $5,000 in units of $5,000 to a maximum of $50,000 for each of your dependent children.

BENEFITS

Accidental Death, Dismemberment and Specific Loss Indemnity

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

Loss	Benefit
Life	100%
Both Arms or Both Hands	100%
Both Feet	100%
Entire Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and Entire Sight of One Eye	100%
One Foot and Entire Sight of One Eye	100%
Speech and Hearing in both Ears	100%
One Arm or One Leg	80%
One Hand or One Foot	75%
Entire Sight of One Eye	75%
Speech or Hearing in both Ears	75%
Hearing in One Ear	66 2/3%
Thumb and Index Finger of Either Hand	33 1/3%
Four Fingers of Either Hand	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%

Bereavement Benefit

If an injury results in loss of life of a participant, the Company will pay the reasonable and necessary expenses actually incurred by the spouse and dependent children of the participant for up to six (6) sessions of grief counselling, by a professional counsellor. The maximum amount payable is $1,000 if the participant has selected single coverage. The maximum amount payable is $2,000.00 per family if the participant has selected coverage for his spouse and /or dependent children.

Comatose Benefit

If an injury does not cause loss of life but results in a coma or comatose state within 12 months after the date of the accident, the Company will pay 1% of the principal sum (less any sum paid under the Accidental Death, Dismemberment and Specific Loss Indemnity) for each month the coma or comatose state continues. Payments commence at the end of the waiting period of 31 days and are subject to a maximum of 100 consecutive months.

Continuation of Coverage

Coverage can be continued as described under the Policyholder's current Group Life policy, subject to continued payment of premiums.

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 90 days. Premiums become payable annually in advance. This benefit is restricted to Canadian resident Participants only.

Cosmetic Disfigurement Benefit ($25,000)

If an insured suffers a third degree burn, the Company will pay a percentage of the principal sum, depending on the area of the body which was burned according to the following table:

Cosmetic Disfigurement Benefit ($25,000) (cont'd)

Body Part	Area Classification (A)	Maximum Allowable Percentage for Area Burned (B)	Maximum Percentage of Principal Sum Payable (C)
		%	%
Face, Neck, Head	11	9.0	99.0
Hand and Forearm	5	4.5	22.5
Either Upper Arm	3	4.5	13.5
Torso (front or back)	2	18.0	36.0
Either Thigh	1	9.0	9.0
Either Lower Leg (below knee)	3	9.0	27.0

The maximum percent of principal sum payable (C) is determined by multiplying the area classification (A) by the maximum allowable percent for area burned (B). This table only represents the maximum percent of the principal sum payable for any one accident. If the insured suffers burns in more than one area, as a result of any one accident, benefits will not exceed the maximum amount stated above.

Day Care Benefit ($5,000)

If injury results in 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, or within 12 months following the accident.

Education Benefit ($5,000)

If injury results in loss of life of a participant, the Company will pay 5% of the principal sum for each year 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, none of the dependent children are eligible for the Education Benefit, the Company shall pay an additional amount of $2,500.00 to the designated beneficiary.

Exposure and Disappearance

If, as the result of an accident, an insured is unavoidably exposed to the elements and if, as a result of such exposure and within 12 months after the date of the accident, the insured suffers a loss for which indemnity would otherwise have been payable hereunder, such loss will be deemed to be the result of injury.

Where, due to the accidental wrecking, sinking or disappearance of a conveyance in which an insured was riding, the insured disappears, and if the body of the insured is not found within 12 months after the date of such wrecking, sinking or disappearance, it will be presumed, subject to there being no evidence to the contrary and subject to all other terms and conditions of the policy, that the insured suffered loss of life as a result of injury.

Extended Family Benefit

If an injury results in loss of life of a participant, and his/her spouse and dependent children are insured under this plan at the time of the death, this insurance may be continued for the insured spouse and insured dependent children for up to 6 months with no further payment or premium.

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 100 km from the insured’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 insured. 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.

Funeral Expense Benefit ($5,000)

If injury results in loss of life, an additional amount is payable for funeral expenses actually incurred.

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 insured's principal residence and/or the cost of modification to one motor vehicle utilized by the insured, provided such injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity.

Hospital Indemnity Expense ($2,500)

A daily benefit of 1/30 of 1% of the insured's principal sum, subject to the above-mentioned monthly maximum, will be payable when the insured 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.

Identification Benefit ($5,000)

If injury results in loss of life, and requires body identification, the Company will pay the expenses actually incurred by a member of the immediate family for lodging, board and transportation by the most direct route, provided the body is located not less than 150 kilometres from the member of the immediate family's residence and the identification of the body is required by the police or a similar law enforcement agency having authority over such matters. If transportation occurs in a vehicle or device other than one operated under the 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.

Permanent Total Disability

If an injury totally and permanently disables an insured within 12 months of the date of the accident, preventing the insured from engaging in any and every occupation, the Company will pay, provided such disability has continued for a period of 12 consecutive months and is total, continuous and permanent at the end of this period, the principal sum less any amounts already paid under the Accidental Death, Dismemberment and Specific Loss Indemnity as the result of the same accident.

Psychological Therapy Benefit ($5,000)

If injury results in a loss payable to an insured under the Accidental Death, Dismemberment and Specific Loss Indemnity and results in the insured requiring psychological therapy, as prescribed by a physician, the Company will pay the reasonable and necessary expenses actually incurred.

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 within three years of the date of the accident, provided such injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity.

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.

Seat Belt Benefit ($50,000)

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 insured was driving or riding in a vehicle and wearing a properly fastened seat belt.

Spousal Retraining Benefit ($15,000)

If injury results in 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.

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.

Workplace Modification and Accommodation Benefit ($5,000)

If injury requires special adaptive equipment and/or workplace modification for a participant to return to active full-time employment, the Company will pay the cost provided the policyholder agrees in writing to provide such modification and accommodation to the workplace for the purpose of making it accessible and adaptable to the needs of such participant; and the policyholder acknowledges in writing that the performance of the essential duties of such participant's occupation may be altered.

Aircraft Coverage (Passenger)

Coverage is extended to include 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 any fixed-wing 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.

The extended insurance afforded by this part does not apply to any loss fatal or non-fatal, caused by or resulting from Injury sustained while the Insured Person is:

(a) flying in any aircraft while it is being used for or in connection with acrobatic or stunt flying or racing;

(b) flying in any aircraft while it is being used for or in connection with crop dusting or seeding or spraying, pipe or power line inspection, any form of hunting, bird or fowl herding, banner towing, unless previously consented to in writing by the Company.

Aircraft Coverage (Passenger) (Cont'd)

The above-noted exclusions do not apply to endurance tests, demonstration or any test for experimental purpose, nor to carry passengers for hire and for any flight which requires a special permit or waiver from the authority having jurisdiction over civil aviation, even though granted.

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; 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; being struck by; or making a forced landing with or from any aircraft owned, operated or leased by the policyholder.

EXCLUSIONS

- 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 parts titled “Limited Air Travel Coverage” and “Aircraft Coverage”.

TERMINATION OF INSURANCE

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 70; (d) the premium due date next following the date a participant is ineligible for coverage, except as provided under the part titled "Continuation of 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.

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 enrolment card on file with the Policyholder, or if there is no such beneficiary designation with respect to the participant, such indemnity is payable in accordance with the beneficiary designation in effect under the Policyholder's current Basic Group Life insurance policy and 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:

- Bereavement Benefit
- Day Care Benefit
- Education Benefit
- Family Transportation Benefit
- Funeral Expense Benefit
- Identification Benefit
- Repatriation Benefit
- Spousal Retraining Benefit
- Workplace Modification and Accommodation Benefit

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

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. The 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 iA Special Markets, a division of Industrial Alliance Insurance and Financial Services Inc., not this summary.

BUSINESS TRAVEL ACCIDENT GROUP INSURANCE

Policy No.100012341 issued by iA Special Markets,
a division of Industrial Alliance Insurance and Financial Services Inc.

Classes 563, 567, 572

COVERAGE AND AMOUNT OF INSURANCE

You are covered for a principal sum of $200,000 if an injury is sustained as the result of an accident while travelling on business of the Policyholder.

Coverage begins at the start of a business trip when you leave your home or your place of regular employment - whichever happens last - and continues until you return home or to your place of employment - whichever happens first. During this time, you are covered against all accidents 24 hours a day. *Everyday travel to and from work and bona fide leave of absence or vacations are excluded.* Benefits are payable in addition to any other insurance you may have.

BENEFITS

Accidental Death, Dismemberment and Specific Loss Indemnity

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

Life	100%
Both Arms or Both Hands	100%
Both Feet	100%
Entire Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and Entire Sight of One Eye	100%
One Foot and Entire Sight of One Eye	100%
Speech and Hearing in both Ears	100%
One Arm or One Leg	75%
One Hand or One Foot	66 2/3%
Entire Sight of One Eye	66 2/3%
Speech or Hearing in both Ears	66 2/3%
Hearing in One Ear	33 1/3%
Thumb and Index Finger of Either Hand	33 1/3%
Four Fingers of Either Hand	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%

Aircraft Coverage (Passenger)

Coverage is extended to include 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 any fixed-wing 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.

The extended insurance afforded by this part does not apply to any loss fatal or non-fatal, caused by or resulting from Injury sustained while the Insured Person is:

(a) flying in any aircraft while it is being used for or in connection with acrobatic or stunt flying or racing;

(b) flying in any aircraft while it is being used for or in connection with crop dusting or seeding or spraying, pipe or power line inspection, any form of hunting, bird or fowl herding, banner towing, unless previously consented to in writing by the Company.

The above-noted exclusions do not apply to endurance tests, demonstration or any test for experimental purpose, nor to carry passengers for hire and for any flight which requires a special permit or waiver from the authority having jurisdiction over civil aviation, even though granted.

Exposure and Disappearance

If, as the result of an accident, an insured is unavoidably exposed to the elements and if, as a result of such exposure and within 12 months after the date of the accident, the insured suffers a loss for which indemnity would otherwise have been payable hereunder, such loss will be deemed to be the result of injury.

Where, due to the accidental wrecking, sinking or disappearance of a conveyance in which an insured was riding, the insured disappears, and if the body of the insured is not found within 12 months after the date of such wrecking, sinking or disappearance, it will be presumed, subject to there being no evidence to the contrary and subject to all other terms and conditions of the policy, that the insured suffered loss of life as a result of injury.

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; 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; being struck by; or making a forced landing with or from any aircraft owned, operated or leased by the policyholder.

Permanent Total Disability

If an injury totally and permanently disables an insured within 12 months of the date of the accident, preventing the insured from engaging in any and every occupation, the Company will pay, provided such disability has continued for a period of 12 consecutive months and is total, continuous and permanent at the end of this period, the principal sum less any amounts already paid under the Accidental Death, Dismemberment and Specific Loss Indemnity as the result of the same accident.

EXCLUSIONS

- 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 parts titled “Limited Air Travel Coverage” and “Aircraft Coverage”.

TERMINATION OF INSURANCE

Coverage will terminate immediately on the earliest of:

(a) the policy termination date;

(b) the premium due date if the Policyholder fails to pay the insured's premium, except as a result of an inadvertent error;

(c) the date an insured retires;

(d) the date an insured is ineligible for coverage.

BENEFICIARY

Indemnity payable in the event of the loss of life of an insured is payable to the beneficiary or beneficiaries designated in writing by the insured on his enrollment card on file with the Policyholder, or if there is no such beneficiary designation with respect to the insured, such indemnity is payable in accordance with the beneficiary designation in effect under the Policyholder's current Basic Group Life insurance policy and if there is no such beneficiary designation with respect to the insured, such indemnity is payable to the estate of the insured. All other indemnities payable are payable to the insured.

In the situation where the policy replaces an existing policy issued to the Policyholder, the designation recorded under the replaced policy will be deemed to be valid and of full force and effect under this policy 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. The 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 iA Special Markets, a division of Industrial Alliance Insurance and Financial Services Inc., not this summary.

VOLUNTARY GROUP CRITICAL ILLNESS INSURANCE

Policy No. 100012342 issued by Industrial Alliance Insurance and Financial Services Inc.

Classes 563, 567, 572

BENEFIT SCHEDULE

You, your Spouse and Dependent Children are insured for benefits as communicated by the Administrator of this policy.

BENEFIT AMOUNT

Voluntary Group Critical Illness insurance is available to you and your spouse in units of $25,000, to a maximum of 10 units or $250,000. Evidence of insurability is required for all amounts except for applications submitted during an Annual Enrolment Offer, a New Employee Offer or a Qualifying Life Event Offer. During such offers, you and your spouse may apply for up to $75,000 non-evidence maximum.

You may also apply for $5,000 of Dependent Child Critical Illness Insurance for each your Dependent Children.

PLAN DESCRIPTION – EMPLOYEE OR SPOUSE COVERAGE

Covered Condition Benefit

If an Insured Employee or Insured Spouse is diagnosed by a Specialist with a Covered Condition while his Voluntary Group Critical Illness Insurance is in force and survives for 30 days following the Date of Diagnosis or such longer period as described in certain Covered Conditions, the Company will pay such Insured Employee or Insured Spouse the Benefit Amount in force with respect to such Insured Person (the "**Covered Condition Benefit**"). The Date of Diagnosis must be later than the effective date of coverage. With respect to new or increased coverage issued as a result of a New Employee Offer or a Qualifying Life Event Offer only, the Date of Diagnosis of the Covered Condition must be later than the date on which the Insured Person's application for Voluntary Group Critical Illness Insurance is received by the Administrator.

In the case of cancer recurrences or metastases: no benefit will be payable for any recurrence or metastases of a cancer if that cancer was originally diagnosed prior to the Issue Date of the Insured Person's coverage, regardless of the date of the recurrence or metastases. With respect to new or increased coverage issued as a result of a New Employee Offer or a Qualifying Life Event Offer only, no benefit will be payable for any recurrent or metastases of a cancer if that cancer was originally diagnosed prior to the date on which the Insured Person's application for coverage is received by the Administrator.

If the Insured Person dies before the approved Covered Condition Benefit is paid, the Company will pay the Covered Condition Benefit to the Insured Person's estate.
Payment of the Covered Condition Benefit for Voluntary Group Critical Illness Insurance is limited to only the first Covered Condition to occur.

Once a Covered Condition Benefit has become payable under this Policy or under the Previous Plan as a result of an injury, accident, illness or disease, the Insured Person will not be covered under the MEC Benefit described below for another claim that is:

i) Caused by, contributed to or occurs as a result of the same injury, accident, illness or disease, or
ii) A result of any medical or surgical treatment for that same injury, accident, illness or disease.

AdvanceCare Benefit

If an Insured Employee or Insured Spouse is diagnosed by a Specialist with an AdvanceCare Benefit Condition while his Voluntary Group Critical Illness Insurance is in force, the Company will pay to such Insured Employee or Insured Spouse a benefit equivalent to 10% of the Benefit Amount in force with respect to such Insured Person (the **"AdvanceCare Benefit"**). The Date of Diagnosis of the AdvanceCare Benefit Condition must be later than the effective date of coverage. With respect to new or increased coverage issued as a result of a New Employee Offer or a Qualifying Life Event Offer only, the Date of Diagnosis of the AdvanceCare Benefit Condition must be later than the date on which the Insured Person's application for Voluntary Group Critical Illness Insurance is received by the Administrator.

If the Insured Person dies before the approved AdvanceCare Benefit is paid, the AdvanceCare Benefit will be paid to the estate of such Insured Person. The AdvanceCare Benefit is a one-time benefit which the Company will pay for one AdvanceCare Benefit Condition only.

Payment of the AdvanceCare Benefit in respect of an Insured Person will not affect the amount of benefit payment under a subsequent Covered Condition Benefit for such person.

Voluntary Group Critical Illness Insurance for an Insured Person will continue in force during the adjudication of an AdvanceCare Benefit and following the payment of an AdvanceCare Benefit providing premiums continue to be paid as required.

Multiple Event Coverage Benefit

If an Insured Employee or Insured Spouse receives a Covered Condition Benefit under the Group Policy, and then diagnosed with a different Covered Condition in a different Multiple Event Coverage Benefit grouping (**"MEC Grouping"**) the Company will pay to such Insured Person the Benefit Amount in force with respect to such Insured Employee or Spouse (the **"Multiple Event Coverage Benefit"**), subject to the terms and conditions of the Group Policy. Notwithstanding the above, an Employee or Spouse who receives a Covered Condition Benefit or Multiple Event Coverage Benefit for Stroke will be ineligible for a subsequent Multiple Event Coverage Benefit for all Covered Conditions in MEC Grouping – Group 2 and MEC Grouping – Group 3.

The Insured Person must survive for 30 days following the Date of Diagnosis or such longer period as described in certain Covered Conditions to qualify for this benefit. The Date of Diagnosis must be after the Date of Diagnosis of the prior Covered Condition. In addition, with respect to increases in coverage issued as a result of a Qualifying Life Event Offer only, the Date of Diagnosis must be on or after the date the Insured Person's application for Voluntary Group Critical Illness Insurance is received by the Administrator.

If the Insured Employee or Spouse dies before the approved Multiple Event Coverage Benefit is paid, the Multiple Event Coverage Benefit will be paid to the estate of such Insured Person.

MEC Grouping	Covered Condition
Group 1	Cancer (Life-Threatening)
Group 2	Aortic Surgery, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Replacement or Repair, Stroke
Group 3	Bacterial Meningitis, Benign Brain Tumour, Coma, Dementia including Alzheimer's Disease, Loss of Independent Existence, Loss of Speech, Motor Neuron Disease, Multiple Sclerosis, Paralysis, Parkinson's Disease and Specified Atypical Parkinsonian Disorders, Stroke
Group 4	Aplastic Anemia, Kidney Failure, Major Organ Failure on Waiting List, Major Organ Transplant
Group 5	Blindness
Group 6	Deafness
Group 7	Severe Burns
Group 8	Loss of Limbs
Group 9	Occupational HIV Infection

LIMITATIONS

a) Cancer (Life-Threatening) and Benign Brain Tumour

An Insured Employee or Insured Spouse will not be entitled to a Covered Condition Benefit for Cancer (Life-Threatening) or Benign Brain Tumour if, within 90 days following the issue date of an insured's Voluntary Group Critical Illness Insurance coverage, such Insured Person has a diagnosis of Cancer (Life-Threatening) or Benign Brain Tumour, or has any signs, symptoms or investigations leading to the Diagnosis of Cancer (Life-Threatening) or Benign Brain Tumour, regardless of when the Diagnosis is actually made. In the event of any such Diagnosis, the applicable Covered Condition Benefit will not be paid. If the Insured Person continues to satisfy the Eligibility provisions for coverage under the Policy, Voluntary Group Critical Illness Insurance will remain in force but Cancer (Life-Threatening) or Benign Brain Tumour will no longer be considered a Covered Condition for such Insured Person.

b) AdvanceCare Benefit

An Insured Employee or Insured Spouse will not be entitled to an AdvanceCare Benefit for Early Stage Cancer if, within 90 days following the issue date of an insured's Voluntary Group Critical Illness Insurance coverage, such Insured Person has a diagnosis of Early Stage Cancer, or has any signs, symptoms or investigations leading to the diagnosis of Early Stage Cancer, regardless of when the Diagnosis is made. In the event of any such Diagnosis, Voluntary Group Critical Illness Insurance will remain in force but Early Stage Cancer will be removed as an AdvanceCare Benefit Condition for such Insured Person.

EXCLUSIONS

In addition to the exclusions included within the definition of certain Covered Conditions, the following exclusions also apply:

a) No benefit will be paid if a Covered Condition results from any Covered Condition or AdvanceCare Benefit Condition diagnosed prior to the effective date of an Insured Employee's or Insured Spouse's Voluntary Group Critical Illness Insurance;
b) No benefit will be paid if an AdvanceCare Benefit Condition results from any AdvanceCare Benefit Condition diagnosed prior to the effective date of an Insured Employee's or Insured Spouse's Voluntary Group Critical Illness Insurance;
c) No benefit will be paid if a Covered Condition or AdvanceCare Benefit Condition results directly or indirectly from any one or more of the following:
    i) attempted suicide;
    ii) taking poison or inhaling gas, whether voluntarily or involuntarily, not connected with the employment of the Insured Employee or Insured Spouse;
    iii) taking any drug other than as prescribed by a licensed physician;
    iv) war or full-time active service in the armed forces of any country;
    v) flying as a student pilot or flying as a privately licensed pilot for less than 25 hours or more than 400 hours per year;
    vi) participation in a criminal act or any attempt to commit a criminal offense, including but not limited to operating a motor vehicle while the concentration of alcohol in 100 millilitres of the Insured Employee's or Insured Spouse's blood exceeds 80 milligrams;

vii) intentionally self-inflicted injury, while sane or insane.

d) With respect to Voluntary Group Critical Illness Insurance issued to an Employee or Spouse as a result of an Annual Enrolment Offer, New Employee Offer or Qualifying Life Event Offer, in addition to the exclusions described above, no benefit will be paid if a Covered Condition or AdvanceCare Benefit Condition results directly or indirectly from any illness, disease, mental, nervous or psychiatric condition or disorder for which any one of medical advice, treatment, service, prescribed medication, diagnosis or consultation, including consultation to investigate and/or diagnose (where diagnosis has not yet been made) was received by the Insured Employee or Insured Spouse or would have been received by a prudent individual within the 24 months immediately preceding the effective date of such person's coverage. This exclusion applies for the 24 months following the effective date of the Insured Employee's or Insured Spouse's Voluntary Group Critical Illness Insurance coverage under the Annual Enrolment Offer, New Employee Offer and Qualifying Life Event Offer.

NOTE 1: The pre-existing condition exclusion noted above will be removed in the event an Insured Employee or Insured Spouse applies for additional Voluntary Group Critical Illness Insurance coverage that is subject to evidence of insurability, and such coverage is approved by the Company.

NOTE 2: If an Insured Employee and/or Insured Spouse was insured under a Previous Plan, the 24/24 pre-existing condition exclusion in d) above will apply from the original date of coverage under the Previous Plan for all Covered Conditions.

In addition, no benefit will be paid if the Insured Employee or Insured Spouse suffer Blindness, Coma, Deafness, Loss of Limbs, Paralysis, Severe Burns or Stroke as a result, directly or indirectly, from amateur or professional boxing, bungee jumping, B.A.S.E. jumping, cliff diving, mountain climbing, motor vehicle racing or speed competition on land and/or water, parachuting or underwater activities, including scuba diving and snuba diving.

Conversion Privilege

If the Voluntary Group Critical Illness Insurance of an Insured Employee or Insured Spouse terminates as a result of such Insured Person ceasing to be eligible for insurance under the Group Policy and the Insured is not in receipt of an AdvanceCare Benefit from the Company, the Insured Person may, on or before such Insured Person's 65th birthday and without evidence of insurability, convert their terminated Voluntary Group Critical Illness Insurance to a separate critical illness policy (the "**Converted Policy**"), issued by the Company subject to the following conditions:

a) the minimum amount of insurance in force with respect to the Insured Person on the date of termination must be $5,000;
b) the maximum amount of insurance under the Converted Policy will be limited to the lesser of $100,000 and the amount of coverage in force with respect to the Insured Person on the date of termination;
c) the Insured Person must reside in Canada at the time of application and submit a completed application and the first premium to the Company within 31 days of the date of termination of such Insured Person's insurance;
d) the Converted Policy will be of a type then issued by the Company providing term insurance to age 75;
e) the Converted Policy will be issued without waiver of premium benefit, return of premium benefit, paid-up benefit or guaranteed increase benefit;
f) the premium rates for the Converted Policy will be those then in effect for such policy;
g) the premium rates will be based on the Insured Person's gender, smoker status and age at the time of conversion; and
h) if a special provision, exclusion and/or limitation had been imposed on the Voluntary Group Critical Illness Insurance, then a comparable special provision, exclusion and/or limitation will be imposed on the Converted Policy.

PLAN DESCRIPTION – DEPENDENT CHILD COVERAGE

Dependent Child Covered Condition Benefit

If an Insured Dependent Child is diagnosed by a Specialist with a Covered Condition while his Dependent Child Critical Illness Insurance is in force and survives for 30 days following the Date of Diagnosis or such longer period as described in certain Covered Conditions, the Company will pay to the Insured Employee the Benefit Amount in force with respect to such Insured Dependent Child (the **"Dependent Child Covered Condition Benefit"**), subject to the terms and conditions of the Policy. The Date of Diagnosis must be later than the effective date. With respect to new or increased coverage issued as a result of a New Employee Offer or a Qualifying Life Event Offer only, the Date of Diagnosis of the Covered Condition must be later than the date on which the Employee's application for Dependent Child Critical Illness Insurance is received by the Administrator.

In the case of cancer recurrences or metastases: no benefit will be payable for any recurrence or metastases of a cancer if that cancer was originally diagnosed prior to the Issue Date of the Insured Dependent Child's coverage, regardless of the date of the recurrence or metastases. With respect to new or increased coverage issued as a result of a New Employee Offer or a Qualifying Life Event Offer only, no benefit will be payable for any recurrent or metastases of a cancer if that cancer was originally diagnosed prior to the date on which the Employee's application for Dependent Child Critical Illness Insurance is received by the Administrator.

If the Insured Dependent Child dies before the approved Dependent Child Covered Condition Benefit is paid, the Company will pay the Dependent Child Covered Condition Benefit to the Insured Employee.

The Company will pay the Dependent Child Covered Condition Benefit in respect of any Insured Dependent Child for one Covered Condition only.

Notwithstanding the foregoing, with respect to an Insured Dependent Child who is a natural child of the Insured Employee born on or after the effective date of Dependent Child Critical Illness Insurance coverage under the Company policy:

a) if such Insured Dependent Child, while in the womb, is diagnosed by a Specialist with a Covered Condition, excluding Cancer (Life-Threatening) and Benign Brain Tumour, and such Insured Dependent

Child survives for 30 days following the effective date of Dependent Critical Illness Insurance in respect of such Dependent Child, the Company will pay the Dependent Child Covered Condition Benefit in force to the Insured Employee;

b) if such Insured Dependent Child, while in the womb, is diagnosed by a Specialist with Cancer (Life-Threatening) or Benign Brain Tumour, the terms described in Limitation section a) below will apply.

In addition, with respect to an Insured Dependent Child who is a natural child of the Insured Employee born on or after the effective date of coverage under the Company policy, the terms described in Limitations section b) below will apply.

LIMITATIONS

a) Cancer (Life-Threatening) and Benign Brain Tumour
An Insured Dependent Child will not be entitled to a Dependent Child Covered Condition Benefit for Cancer (Life-Threatening) or Benign Brain Tumour and coverage will be void if such Dependent Child has a diagnosis of Cancer (Life-Threatening) or Benign Brain Tumour, or has any signs, symptoms or investigations leading to such diagnosis, regardless of when the diagnosis is made, which are initiated within 90 days following the effective date of an Insured Dependent Child's coverage.

In addition, an Insured Dependent Child who is a natural child of an Insured Employee born on or after the effective date of such Employee's Dependent Child Critical Illness Insurance coverage is not entitled to a Dependent Child Covered Condition Benefit for Cancer (Life-Threatening) or Benign Brain Tumour and coverage will be void if Cancer (Life-Threatening) or Benign Brain Tumour was diagnosed while such Dependent Child was in the womb.

In the event that such Insured Dependent Child is the only Insured Dependent Child of the Employee, then applicable premiums paid for Dependent Child Critical Illness Insurance will be refunded.

b) <u>All Covered Conditions excluding Cancer (Life-Threatening) and Benign Brain Tumour</u>

An Insured Dependent Child who is a natural child of an Insured Employee born in the 10 month period immediately following the effective date of such Employee's Dependent Child Critical Illness Insurance coverage, will not be entitled to a Dependent Child Covered Condition Benefit if, within 30 days of birth such Insured Dependent Child has any of the following:

1. a diagnosis of a Covered Condition or
2. the child's parent or physician notices or becomes aware of any sign, symptom, condition or medical problem that leads to a diagnosis of a Covered Condition at any time in the future.

In the event of any such Diagnosis with respect to the Insured Dependent Child, of a Covered Condition other than Cancer (Life-Threatening) or Benign Brain Tumour, the Dependent Critical Illness Insurance will remain in force but the applicable diagnosed Covered Condition will no longer be considered a Covered Condition for such Dependent Child.

<u>EXCLUSIONS</u>

In addition to the exclusions included within the definitions of certain Covered Conditions, the following exclusions will also apply.

No benefit will be paid if a Dependent Child's Covered Condition results directly or indirectly from any one or more of the following:

a) any Covered Condition diagnosed prior to the effective date of such child's Dependent Child Critical Illness Insurance coverage.
b) attempted suicide;
c) taking any drug other than as prescribed by a licensed physician;
d) taking poison or inhaling gas, whether voluntarily or involuntarily, not connected with the employment of the Insured Dependent Child;
e) war or full-time active service in the armed forces of any country;
f) participation in a criminal act or any attempt to commit a criminal offense, including, but not limited to, operating a motor vehicle while the concentration of alcohol in 100 millilitres of the Insured Dependent Child's blood exceeds 80 milligrams;
g) flying as a student pilot or flying as a privately licensed pilot for less than 25 hours or more than 400 hours per year;

h) intentionally self-inflicted injury, while sane or insane.

In addition, no benefit will be paid if the Insured Dependent Child suffers Blindness, Coma, Deafness, Loss of Limbs, Paralysis, Severe Burns or Stroke, as a result, directly or indirectly, from amateur or professional boxing, bungee jumping, B.A.S.E. jumping, cliff diving, mountain climbing, motor vehicle racing or speed competition on land and/or water, parachuting or underwater activities, including scuba diving and snuba diving.

With respect to Dependent Child Critical Illness Insurance, in addition to the exclusions described above, no benefit will be paid if a Covered Condition results directly or indirectly from any illness, disease, mental, nervous or psychiatric condition or disorder for which any one of medical advice, treatment, service, prescribed medication, diagnosis or consultation, including consultation to investigate and/or diagnose (where diagnosis has not yet been made) was received by the Insured Dependent Child or would have been received by a prudent individual or prudent parent of a Dependent Child within the 24 months immediately preceding the effective date of an Insured Dependent Child's coverage. This exclusion applies for the 24 months following the effective date of such Insured Dependent Child's coverage. This exclusion does not apply to a Dependent Child who is a natural child of an Insured Employee born on or after the effective date of such Employee's Dependent Child Critical Illness Insurance coverage.

Notwithstanding the foregoing paragraph, if the Insured Dependent Child was insured under the Previous Plan, the 24/24 pre-existing condition exclusion described above will apply from the original date of coverage for all Covered Conditions.

DEFINITIONS

POLICY DEFINITIONS

"Administrator" means Telus.

"AdvanceCare Benefit Conditions" are medical conditions for which an AdvanceCare Benefit is paid under the Group Policy with respect to an Insured Employee or Insured Spouse. These are Coronary Angioplasty or Early Stage Cancer as defined in this document.

"Annual Enrolment Offer" (when applicable) means Voluntary Group Critical Illness Insurance and Dependent Child Critical Illness Insurance available to

eligible Employees, their Spouses and/or Dependent Children on a guaranteed issue basis during a 60-days open enrolment period in which such Employees can elect to change their coverage options under the employer's group insurance program.

"Benefit Amount" means the amount of Voluntary Group Critical Illness Insurance issued to the Insured Person.

"Covered Conditions" with respect to an Insured Employee, Insured Spouse or Insured Dependent Child are Aortic Surgery, Aplastic Anemia, Bacterial Meningitis, Benign Brain Tumour, Blindness, Cancer (Life-Threatening), Coma, Coronary Artery Bypass Surgery, Deafness, Dementia including Alzheimer's Disease, Heart Attack, Heart Valve Replacement or Repair, Kidney Failure, Loss of Independent Existence, Loss of Limbs, Loss of Speech, Major Organ Failure on Waiting List, Major Organ Transplant, Motor Neuron Disease, Multiple Sclerosis, Occupational HIV Infection, Paralysis, Parkinson's Disease and Specified Atypical Parkinsonian Disorders, Severe Burns and Stroke, as defined in the section titled *Definitions of Covered Conditions – All Insured Persons*.

"Covered Conditions" with respect to an Insured Dependent Child only are Cerebral Palsy, Congenital Heart Disease, Cystic Fibrosis, Down Syndrome, Muscular Dystrophy and Type 1 Diabetes, as defined in the section titled *Definitions of Covered Conditions – Dependent Children Only.*

"Date of Diagnosis" means the date on which a Specialist diagnoses the Insured Person with one of the Covered Conditions or one of the AdvanceCare Benefit Conditions.

"Dependent Child" means any natural child, step-child or legally adopted child of an Employee who is under 23 years of age, unmarried and receives full parental support and maintenance, or 23 years of age or over but under 26 years of age, unmarried and receives full parental support and maintenance for reason of full-time attendance at a recognized school, college or university.

"Diagnosis" means the certified diagnosis of the Insured Person with a Covered Condition or AdvanceCare Benefit Condition by a Specialist.

"Employee" means an employee as defined in the Group Policy.

"Insured Dependent Child" means an Insured Person who is a Dependent Child.

"Insured Employee" means an Insured Person who is an Employee.

"Insured Person" means a person who is eligible and insured under the Group Policy.

"Insured Spouse" means an Insured Person who is a Spouse.

"Issue Date" means the date that insurance for an Insured Person becomes effective.

"Life Event" means one of the following events in the life of an Employee:

- Change in matrimonial status
- Birth or adoption of a first Child
- Last Dependent Child's cessation of eligibility
- Spouse's change of eligibility to his employer's group policy
- Death of the Spouse
- Return to an accredited educational institution on a full-time basis of a Dependent Child who is over 22 years of age but under 26 years of age after no more Dependent Children are eligible.

"Life Event Offer" (when applicable) means Voluntary Group Critical Illness Insurance and Dependent Child Critical Illness Insurance available to an Employee going through Life Events during a specified enrolment period.

"New Employee Offer" (when applicable) means Voluntary Group Critical Illness Insurance and Dependent Child Critical Illness Insurance available to a new Employee, their Spouse and/or Dependent Children on a guaranteed issue basis during a specified enrolment period following completion of any required eligibility waiting period.

"Previous Plan" means the Voluntary group critical illness insurance available to eligible Employees, Spouses and Dependent Children provided to the Policyholder under policy no. 100012037 issued to Bombardier Inc. by the Company, existing until midnight of the day preceding the effective date of Voluntary Group Critical Illness Insurance and Dependent Child Critical Illness Insurance under this Policy.

"Specialist" means a licensed medical practitioner who

- has been trained in the specific area of medicine relevant to the Covered Condition or AdvanceCare Benefit Condition for which a benefit is being claimed;
- has been certified by a specialty examining board; and
- Is currently practicing in their area of specialty in Canada or the United States of America

Specialist includes but is not limited to: cardiologist, neurologist, nephrologist, oncologist, ophthalmologist, burn specialist and internist. The Specialist must not be the Insured Person, a relative or business associate of the Insured Person.

In the absence or unavailability of a Specialist, and as approved by the Company, a Covered Condition or AdvanceCare Benefit Condition may be diagnosed by a qualified medical practitioner practicing in Canada or the United States of America.

"Spouse" means the legal or common-law spouse of an Employee. Legal spouse is a person who is legally married and cohabiting with the Employee and with whom there is no formal or informal agreement of separation. Common-law spouse is a person who has been cohabiting in a marriage-like relationship with the Employee for a period of not less than twelve consecutive months.

"You or your" refers to the Insured Person.

DEFINITIONS OF COVERED CONDITIONS – ALL INSURED PERSONS

Aortic Surgery means the undergoing of surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta refers to the thoracic and abdominal aorta but not its branches.

The surgery must be determined to be medically necessary by a Specialist.

Exclusion: No benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Aplastic Anemia means a definite Diagnosis of a chronic persistent bone marrow failure, confirmed by biopsy, which results in anemia, neutropenia and

thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following:

- marrow stimulating agents
- immunosuppressive agents
- bone marrow transplantation

The Diagnosis of Aplastic Anemia must be made by a Specialist.

Bacterial Meningitis means a definite Diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least 90 days from the date of Diagnosis.

The Diagnosis of Bacterial Meningitis must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for viral meningitis.

Benign Brain Tumour means a definite Diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgical or radiation treatment or cause irreversible objective neurological deficit(s).

The Diagnosis of Benign Brain Tumour must be made by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition if, within the first 90 days following the later of the Issue Date of coverage, or the last reinstatement date of coverage, an insured has any of the following:

- *signs, symptoms or investigations that lead to a Diagnosis of Benign Brain Tumour (covered or excluded under the Policy), regardless of when the Diagnosis is made; or*
- *a Diagnosis of Benign Brain Tumour (covered or excluded under the Policy).*

Medical Information about the Diagnosis and any signs, symptoms or investigations leading to the Diagnosis must be reported to the Company within 6 months of the Date of Diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for Benign Brain Tumour or any Critical Illness caused by any Benign Brain Tumour or its treatment.

No benefit will be payable under this condition for pituitary adenomas less than 10mm.

Blindness means a definite Diagnosis of the total and irreversible loss of vision in both eyes, evidenced by:

- the corrected visual acuity being 20/200 or less in both eyes; or,
- the field of vision being less than 20 degrees in both eyes.

The Diagnosis of Blindness must be made by a Specialist.

Cancer (Life-Threatening) means a definite Diagnosis of a tumour, which must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Types of cancer include carcinoma, melanoma, leukemia, lymphoma, and sarcoma. The Diagnosis of Cancer (Life Threatening) must be made by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition if, within the first 90 days following the later of the Issue Date of an Insured Employee's coverage, or the last Reinstatement Date of an Insured Employee's coverage, such Insured Employee has any of the following:

- *signs, symptoms or investigations that lead to a Diagnosis of cancer (covered or excluded under the Policy), regardless of when the Diagnosis is made; or*
- *a Diagnosis of cancer (covered or excluded under the Policy).*

Medical Information about the Diagnosis and any signs, symptoms or investigations leading to the Diagnosis must be reported to the Company within 6 months of the Date of Diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for Cancer (Life Threatening) or any Critical Illness caused by any cancer or its treatment.

No benefit will be payable for the following:

- lesions described as benign, pre-malignant, uncertain, borderline, non-invasive, carcinoma in-situ (Tis), or tumours classified as Ta;
- malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- any non-melanoma skin cancer, without lymph node or distant metastasis;
- prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;
- papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis;
- chronic lymphocytic leukemia classified less than Rai stage 1; or

- malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC Stage 2.

Coma means a definite Diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours and for which period the Glasgow coma score must be 4 or less. The Diagnosis of Coma must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for:

- *a medically induced coma; or,*
- *a coma which results directly from alcohol or drug use; or,*
- *a diagnosis of brain death.*

Coronary Artery Bypass Surgery means the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s).

The surgery must be determined to be medically necessary by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Deafness means a definite Diagnosis of the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz.

The Diagnosis of Deafness must be made by a Specialist.

Dementia, including Alzheimer's Disease means a definite Diagnosis of dementia, which must be characterized by a progressive deterioration of memory and at least one of the following areas of cognitive function:

- aphasia (a disorder of speech)
- apraxia (difficulty performing familiar tasks);
- agnosia (difficulty recognizing objects); or
- disturbance in executive functioning (e.g. inability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behavior), which is affecting daily life.

The Insured Person must exhibit

- Dementia of at least moderate severity, which must be evidenced by a Mini Mental State Exam of 20/30 or less, or equivalent score on another generally medically accepted test or tests of cognitive function; and
- Evidence of progressive worsening in cognitive and daily functioning either by serial cognitive tests or by history over at least a 6 month period.

The Diagnosis of Dementia, including Alzheimer's Disease must be made by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition for affective or schizophrenic disorders, or delirium.

Heart Attack means a definite Diagnosis of the death of heart muscle due to obstruction of blood flow, that results in a rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following:

- heart attack symptoms
- new electrocardiogram (ECG) changes consistent with a heart attack
- development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

The Diagnosis of Heart Attack must be made by a Specialist.

Exclusions: No benefit will be payable under this condition for:

- *elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves, or*
- *ECG changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as described above.*

Heart Valve Replacement or Repair means the undergoing of surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities. The surgery must be determined to be medically necessary by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition for angioplasty, inter-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Kidney Failure means a definite Diagnosis of chronic irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation is initiated.

The Diagnosis of Kidney Failure must be made by a Specialist.

Loss of Independent Existence means a definite Diagnosis of the total inability to perform, by oneself, at least 2 of the following 6 Activities of Daily Living for a continuous period of at least 90 days with no reasonable chance of recovery.

The Diagnosis of Loss of Independent Existence must be made by a Specialist.

Activities of Daily Living are:

- bathing – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of assistive devices;
- dressing – the ability to put on and remove necessary clothing, braces, artificial limbs or other surgical appliances with or without the aid of assistive devices;
- toileting – the ability to get on and off the toilet and maintain personal hygiene with or without the aid of assistive devices;
- bladder and bowel continence – the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained;
- transferring – the ability to move in and out of a bed, chair or wheelchair, with or without the aid of assistive devices; and
- feeding – the ability to consume food or drink that already has been prepared and made available, with or without the use of assistive devices.

Loss of Limbs means a definite Diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation.

The Diagnosis of Loss of Limbs must be made by a Specialist.

Loss of Speech means a definite Diagnosis of the total and irreversible loss of the ability to speak as a result of physical injury or disease, for a period of at least 180 days.

The Diagnosis of Loss of Speech must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for all psychiatric related causes.

Major Organ Failure on Waiting List means a definite Diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Failure on Waiting List, the Insured Person must become enrolled as the recipient in a recognized transplant center in Canada or the United States of America that performs the required form of transplant surgery. For the purpose of the Survival Period, the Date of Diagnosis is the date of the Insured Person's enrolment in the transplant centre.

The Diagnosis of the major organ failure must be made by a Specialist.

Major Organ Transplant means a definite Diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow and transplantation must be medically necessary. To qualify under Major Organ Transplant, the Insured Person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities.

The Diagnosis of the major organ failure must be made by a Specialist.

Motor Neuron Disease means a definite Diagnosis of one of the following: amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy, and limited to these conditions.

The Diagnosis of Motor Neuron Disease must be made by a Specialist.

Multiple Sclerosis means a definite Diagnosis of at least one of the following:

- two or more separate clinical attacks, confirmed by a magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination; or
- well-defined neurological abnormalities lasting more than 6 months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination; or
- a single attack, confirmed by repeated MRI imaging of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart.

The Diagnosis of Multiple Sclerosis must be made by a Specialist.

Occupational HIV Infection means a definite Diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Insured Person's normal occupation, which exposed the person to HIV contaminated body fluids. The accidental injury leading to the infection must have occurred after the effective date of such Insured Person's insurance coverage.

Payment under this condition requires satisfaction of all of the following:

- The accidental injury must be reported to the Company within 14 days of the accidental injury;
- A serum HIV test must be taken within 14 days of the accidental injury and the result must be negative;
- A serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;
- All HIV tests must be performed by a duly licensed laboratory in Canada or the United States of America;
- The accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States of America workplace guidelines.

The Diagnosis of Occupational HIV Infection must be made by a Specialist.

Exclusion: No benefit will be payable under this condition if:

- *the Insured Person has elected not to take any available licensed vaccine offering protection against HIV; or,*
- *a licensed cure for HIV infection has become available prior to the accidental injury; or*
- *HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use.*

Paralysis means a definite Diagnosis of the total loss of muscle function of two or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event.

The Diagnosis of Paralysis must be made by a Specialist.

Parkinson's Disease and Specified Atypical Parkinsonian Disorders means a definite Diagnosis of either a) Parkinson's Disease or b) Specified Atypical Parkinsonian Disorders, as defined below.

a) **"Parkinson's Disease"** means a definite Diagnosis of primary Parkinson's disease, a permanent neurological condition which must be characterized by bradykinesia (slowness of movement) and at least one of the following: muscular rigidity or rest tremor. The Insured Person must exhibit objective signs of progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's Disease.

b) **"Specified Atypical Parkinson's Disorders"** means a definite Diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.

The Diagnosis of Parkinson's Disease or a Specified Atypical Parkinsonian Disorder must be made by a Specialist.

Exclusions: No benefit will be payable for Parkinson's Disease or Specified Atypical Parkinsonian Disorders if, within the first year following the later of the Issue Date or the latest Reinstatement Date of an Insured Person's coverage, such Insured Person has any of the following:

- signs, symptoms or investigations that lead to a Diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism, regardless of when the Diagnosis is made; or
- a Diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of Parkinsonism.

Medical information about the Diagnosis and any signs, symptoms or investigations leading to the Diagnosis must be reported to the Company within 6 months of the Date of Diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for Parkinson's Disease or Specified Atypical Parkinsonian Disorders or its treatment.

No benefit will be payable under Parkinson's Disease and Specified Atypical Parkinsonian Disorders for any other type of Parkinsonism.

Severe Burns means a definite Diagnosis of third-degree burns over at least 20% of the body surface.

The Diagnosis of Severe Burns must be made by a Specialist.

Stroke (Cerebrovascular Accident) means a definite Diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism from an extra-cranial source with:

- acute onset of new neurological symptoms, and
- new objective neurological deficits on clinical examination,

persisting for more than 30 days following the Date of Diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging testing.

The Diagnosis of Stroke must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for:

- *Transient Ischaemic Attacks; or*
- *Intracerebral vascular events due to trauma; or*
- *Lacunar infarcts which do not meet the definition of stroke as described above.*

DEFINITIONS OF ADVANCECARE BENEFIT CONDITIONS – EMPLOYEES AND SPOUSES ONLY

Coronary Angioplasty means the undergoing of an interventional procedure to unblock or widen a coronary artery that supplies blood to the heart to allow an uninterrupted flow of blood. The procedure must be determined to be medically necessary by a Specialist.

Early Stage Cancer refers to one of the following conditions:

- malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- any non-melanoma skin cancer, without lymph node or distant metastasis;
- prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;
- papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis;
- chronic lymphocytic leukemia classified less than Rai stage 1;
- malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC Stage 2; or
- Ductal Carcinoma in situ of the Breast

The Diagnosis of an Early Stage Cancer must be made by a Specialist.

DEFINITIONS OF COVERED CONDITIONS – DEPENDENT CHILDREN ONLY

Cerebral Palsy means a non-progressive neurological defect characterized by spasticity and incoordination of movements.

Congenital Heart Disease means a Diagnosis of one of the following heart conditions following a 30 day survival period from Diagnosis or birth, whichever comes later. The Diagnosis must be made by a qualified pediatric cardiologist and supported by appropriate cardiac imaging.

- Atresia of any heart valve
- Coarctation of the Aorta
- Double Inlet Ventricle
- Double Outlet Left Ventricle
- Ebstein's Anomaly
- Eisenmenger Syndrome
- Hypoplastic Left Heart Syndrome
- Hypoplastic Right Ventricle
- Single Ventricle
- Tetralogy of Fallot
- Total Anomalous Pulmonary Venous Connection
- Transposition of the Great Vessels
- Truncus Arteriosus

Exclusion: Trans-catheter procedures such as balloon valvuloplasty or percutaneous Atrial Septal Defect closure are excluded. All other congenital cardiac conditions are excluded.

Cystic Fibrosis means a definitive Diagnosis of Cystic Fibrosis with evidence of chronic lung disease and pancreatic insufficiency.

Down Syndrome means a definitive Diagnosis of Down Syndrome supported by chromosomal evidence of Trisomy 21.

Muscular Dystrophy means a definitive Diagnosis of Muscular Dystrophy, characterized by well defined neurological abnormalities, confirmed by electromyography and muscle biopsy.

Type 1 Diabetes means a Diagnosis of type 1 mellitus, characterized by absolute insulin deficiency and continuous dependence on exogenous insulin for survival. The Diagnosis must be made by a qualified pediatrician or

endocrinologist licenced and practicing in Canada or the United States of America and there must be evidence of dependence on insulin for a minimum of three months.

CLAIMS AT TUGO

As an insured person under a Company critical illness insurance plan, you are eligible to access **Claims at** TuGo. **Claims at** TuGo is a service that provides assistance in obtaining specialized, private medical treatment at claim time. With access to treatment centres around the world, **Claims at** TuGo coordinates medical appointments and procedures with specialists and surgeons, and arranges travel and lodging, if required, at special pricing discounts.

For assistance in accessing this service, please visit **www.tugo.com/tms**. Note that utilization fees may apply.

GENERAL PROVISIONS

TERMINATION OF INSURANCE IN RESPECT OF AN INSURED PERSON

An Insured Employee's insurance will terminate automatically on the earliest of the following dates:

a) the termination date of the Group Policy;
b) the date of death of the insured Employee;
c) the end of the month coincident with or next following the date on which the Employee's employment terminates or changes so that the Employee ceases to be eligible for insurance under the Group Policy;
d) the end of the month coincident with or next following an Employee's 75th birthday;
e) the due date of any unpaid premiums;
f) the date that the Administrator receives written notice from the Employee requesting cancellation of all or part of the insurance;
g) the end of the month coincident with or next following the date on which a leave of absence has expired and the Employee is not actively at work.

An Insured Spouse's Insurance will terminate automatically on the earliest of the following dates:

a) the termination date of the Group Policy;

b) the date of death of the Employee or Insured Spouse;
c) the end of the month coincident with or next following the date on which the Employee's employment terminates or changes so that the Employee ceases to be eligible for insurance under the Group Policy;
d) the end of the month coincident with or next following a Spouse's 75th birthday;
e) the due date of any unpaid premiums;
f) the date that the Administrator receives written notice from the Employee requesting cancellation of all or part of the Spouse's insurance;
g) the end of the month coincident with or next following the date on which a leave of absence has expired and the Employee is not actively at work;
h) the end of the month coincident with or next following the date on which he/she no longer qualifies as a Spouse.

The Dependent Child Critical Illness Insurance in respect of an Insured Dependent Child will terminate automatically on the earliest of the following dates:

a) the termination date of the Group Policy;
b) the date that the Dependent Child Covered Condition Benefit is paid with respect to that Insured Dependent Child;
c) the date of death of the insured Employee or Insured Dependent Child;
d) the end of the month coincident with or next following the date on which the Employee's employment terminates or changes so that the Employee ceases to be eligible for Dependent Child Critical Illness Insurance under the Group Policy;
e) the due date of any unpaid premiums;
f) the date that the Administrator receives written notice from the Employee requesting cancellation of the Dependent Child Critical Illness Insurance coverage;
g) the end of the month coincident with or next following the date on which a leave of absence has expired and the Employee is not actively at work;
h) the end of the month coincident with or next following the date on which an Insured Dependent Child no longer qualifies as a Dependent Child.

CLAIMS PROCEDURES

Before paying a benefit under the Group Policy, claims forms must be duly completed and sent to the Company.

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. Insurance Act means the applicable insurance legislation in the applicable provincial jurisdiction.

Note: All claims will be adjudicated according to the definition at the time of Diagnosis of the Covered Condition or the applicable AdvanceCare Benefit Condition.

This Insurance Benefits Summary is designed to outline the Voluntary Group Critical Illness Insurance benefits which are available to you and your dependents under a Group Policy no. 100012342 issued to MHI RJ Aviation ULC by Industrial Alliance Insurance and Financial Services Inc. ("the Company").This Group Policy contains a provision removing or restricting the right of the insured person to designate persons to whom or for whose benefit insurance money is payable. In the event of any variation between this document and the provisions of the Group Policy, the latter will prevail. All rights with respect to the benefits of an Insured Person will be governed solely by the Group Policy which may be amended from time to time.

NOTES