GROUP
INSURANCE

YOUR GROUP INSURANCE BOOKLET

iA Financial Group

ASSOCIATION QUÉBÉCOISE DES DIRECTEURS ET DIRECTRICES D'ÉTABLISSEMENT D'ENSEIGNEMENT RETRAITÉS

Class 100

GROUP INSURANCE PLAN

Policyholder:	***ASSOCIATION QUÉBÉCOISE DES DIRECTEURS ET DIRECTRICES D'ÉTABLISSEMENT D'ENSEIGNEMENT RETRAITÉS***
Policy No.:	***28000***

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 class:

Class

100 – Retirees

Rates: Rates are available through your AQDER plan administrator.

SPECIAL PROVISIONS (cont'd)

Information regarding surviving spouse coverage (transfer to Class 300 - *Surviving spouses*):

Upon the retiree's death, the insurance may be maintained for his surviving spouse and his dependent children who were covered by the group policy at the time of the retiree's death.

In order to be eligible for transfer under Class 300, a surviving spouse must meet the following requirements:

a) He satisfies the definition of *Surviving spouse* of the group policy; and

b) He must submit an application to the insurer within 90 days following the date of the retiree's death; and

c) He must become a member in good standing of the Association Québécoise des Directeurs et Directrices d'Établissement d'Enseignement Retraités (AQDER).

The surviving spouse is then transferred to Class 300 – *Surviving spouses*.

The surviving spouse becomes a participant under this group policy and as such, is now responsible for the premium payment according to the age reached by the surviving spouse and the protection status requested for himself and his dependent children, if applicable.

GENERAL PROVISIONS

ELIGIBILITY DATE

Subject to all other provisions of the group policy, a retiree shall become eligible on day he satisfies the definition of *Retiree* indicated in the General Provisions.

PARTICIPANT'S BASIC LIFE INSURANCE

Sum Insured

$10,000

As of January 1, 2021:

A new retiree may obtain Participant's Basic Life Insurance, without evidence of insurability, up to the amount insured under his group insurance with his former insurer and subject of the maximum amount indicated under this benefit, if the application has been received by the insurer within 30 days of the participant's eligibility date.

A participant, who was not insured for life insurance previously under his former insurer's group insurance, may be covered for Participant's Basic Life Insurance under this benefit upon submission of evidence of insurability.

Amounts, which were approved and insured by the insurer before January 1, 2021, are grand-fathered.

Termination:

This benefit terminates upon the participant's death.

AS OF JANUARY 1, 2021:

PARTICIPATION TO THIS BENEFIT IS OPTIONAL.

HOWEVER, PARTICIPATION TO THIS BENEFIT BECOMES MANDATORY IF THE PARTICIPANT WANTS TO ADD A PARTICIPANT'S OPTIONAL LIFE INSURANCE AMOUNT.

PARTICIPANT'S OPTIONAL LIFE INSURANCE

Sum Insured

Units of $5,000

Minimum: $5,000

Maximum: $150,000

As of January 1, 2021:

A new retiree may obtain Participant's Optional Life Insurance, without evidence of insurability, up to the amount insured under his group insurance with his former insurer reduced by the amount insured under the Participant's Basic Life Insurance of this group policy, if the application has been received by the insurer within 30 days of the participant's eligibility.

However, evidence of insurability is required for all amounts of Participant's Optional Life Insurance which exceeds the amount previously insured with the participant's former insurer or if the application has been received by the insurer after 30 days of the participant's eligibility.

Amounts, which were approved and insured by the insurer before January 1, 2021, are grand-fathered.

Reduction:

The maximum amount of coverage available under this benefit is reduced to $75,000 on the participant's 75th birthday.

Termination:

This benefit terminates upon the participant's death.

TO BE ELIGIBLE UNDER THIS BENEFIT, A PARTICIPANT MUST BE INSURED UNDER THIS GROUP POLICY UNDER THE PARTICIPANT'S BASIC LIFE INSURANCE.

BASIC LIFE INSURANCE FOR THE PARTICIPANT'S SPOUSE AND DEPENDENT CHILDREN

Sum Insured

Spouse:	$10,000
Each child upon a live birth:	$10,000

As of January 1, 2021:

A new retiree who had an amount of life insurance for his spouse with his former insurer, may obtain Basic Life Insurance for the Participant's Spouse and Dependent Children, even if the dependent children were not initially insured with his former insurer, without evidence of insurability, up to the amount insured for his spouse and subject of the maximum amount indicated under this benefit, if the application has been received by the insurer within 30 days of the person's eligibility.

A participant, who did not have life insurance for his spouse and his dependent children previously under his former insurer's group insurance, may be covered for Basic Life Insurance for the Participant's Spouse and Dependent Children under this group policy upon submission of evidence of insurability.

Amounts, which were approved and insured by the insurer before January 1, 2021, are grand-fathered.

BASIC LIFE INSURANCE FOR THE PARTICIPANT'S SPOUSE AND DEPENDENT CHILDREN (cont'd)

Termination:

This benefit terminates upon the participant's death.

AS OF JANUARY 1, 2021:

PARTICIPATION TO THIS BENEFIT IS OPTIONAL.

HOWEVER, PARTICIPATION TO THIS BENEFIT BECOMES MANDATORY IF THE PARTICIPANT WANTS TO ADD AN OPTIONAL LIFE INSURANCE AMOUNT FOR HIS SPOUSE.

OPTIONAL LIFE INSURANCE FOR THE PARTICIPANT'S SPOUSE

Sum Insured

Units of $5,000

Minimum: $5,000

Maximum: $60,000

As of January 1, 2021:

A new retiree may obtain Optional Life Insurance for the Participant's Spouse, without evidence of insurability, up to the amount insured under his group insurance with his former insurer, reduced by the amount insured under the Basic Life Insurance for the Participant's Spouse and Dependent Children of this group policy, if the application has been received by the insurer within 30 days of the person's eligibility.

However, evidence of insurability is required for all amounts of Optional Life Insurance for the Participant's Spouse which exceeds the amount previously insured with the participant's former insurer or if the application has been received by the insurer after 30 days of the person's eligibility.

Amounts, which were approved and insured by the insurer before January 1, 2021, are grand-fathered.

Reduction:

The maximum amount of coverage available under this benefit is reduced to $30,000 on the spouse's 75th birthday.

Termination:

This benefit terminates upon the insured person's death.

TO BE ELIGIBLE UNDER THIS BENEFIT, THE SPOUSE MUST BE INSURED UNDER THE THIS GROUP POLICY UNDER THE BASIC LIFE INSURANCE FOR THE PARTICIPANT'S SPOUSE AND DEPENDENT CHILDREN.

SUPPLEMENTAL HEALTH INSURANCE

HOSPITALIZATION IN THE PROVINCE OF RESIDENCE		
Deductible: none	Reimbursement: 100%	Daily maximum: Semi-private room rate

EMERGENCY MEDICAL EXPENSES INCURRED OUTSIDE THE PROVINCE OF RESIDENCE and EMERGENCY OUT OF PROVINCE ASSISTANCE		
Deductible: none	Reimbursement: 100%	Maximum per insured person: $5,000,000 per lifetime

TRIP CANCELLATION INSURANCE		
Deductible: none	Reimbursement: 100%	Maximum per insured person: $5,000 per trip

HOME CARE		
Deductible: none	Reimbursement: 100%	Maximum per insured person: As defined under the Home Care Benefit provision

TRAVELLING EXPENSES		
Deductible: none	Reimbursement: 100%	Maximum per insured person: $500 per trip (round trip), up to a maximum of $1,000 per calendar year.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

ALL OTHER MEDICAL EXPENSES INCURRED IN CANADA	
Deductible:	None
Reimbursement	
– Drugs:	80% of the first $3,795 of eligible expenses and 100% of the excess.
– Other medical expenses:	80%, according to the maximums indicated in the following pages.
Maximum	
– Drugs:	$15,000 per calendar year, per insured person.
– Other medical expenses:	According to the maximums indicated in the following pages.

Termination:

This benefit terminates upon the participant's death.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

* **Reasonable and Customary Charges:** The maximums allocated for the following covered expenses are limited to reasonable and customary charges normally incurred for an Illness or injury of the same nature and severity in the area where the service is provided.

  However, this limitation does not apply to drugs.

Medical Expenses

Covered Expenses	Maximums Per Insured Person *
Fees for nursing care	Eligible maximum of $300 per day and an eligible maximum of $10,000 per calendar year.
Licensed ambulance service	Reasonable and customary charges.* **These expenses are reimbursed at 100%.**
Drugs (Comprehensive list)	$15,000 per calendar year.
Preventive immunization vaccines	$200 per calendar year.
Room and board in a convalescent home (with a medical recommendation)	Semi-private room; combined maximum of 120 days per disability. **These expenses are reimbursed at 100%.**
Diagnostic laboratory tests, x-rays, ultrasounds, magnetic resolution imaging (MRI), tomography, computer tomography (CT scan) and pharmacogenetic tests	$1,000 per calendar year.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

* **Reasonable and Customary Charges:** The maximums allocated for the following covered expenses are limited to reasonable and customary charges normally incurred for an Illness or injury of the same nature and severity in the area where the service is provided.

  However, this limitation does not apply to drugs.

Medical Expenses (cont'd)

Covered Expenses	Maximums Per Insured Person *
Fees for the following paramedical practitioners: psychologists, psychiatrists and social workers	Combined maximum of $750 per calendar year. **These expenses are reimbursed at 50%.**
Fees for the following paramedical practitioners: chiropractors, physiotherapists, physical rehabilitation therapists, osteopaths, podiatrists, acupuncturists, occupational therapists, naturopaths massage therapists, orthotherapists, kinesitherapists, homeopaths, dieticians, nutritionists, speech therapists, and audiologists	Eligible maximum of $50 per visit. Overall combined maximum of $1,000 per calendar year (including an eligible maximum of $60 per calendar year for x-rays by a chiropractor). One treatment per day.
Breast prostheses	$150 per period of 24 consecutive months.
Medical elastic stockings	3 pairs per calendar year.
Orthopedic shoes	$500 per calendar year.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

* **Reasonable and Customary Charges:** The maximums allocated for the following covered expenses are limited to reasonable and customary charges normally incurred for an Illness or injury of the same nature and severity in the area where the service is provided.

  However, this limitation does not apply to drugs.

Medical Expenses (cont'd)

Covered Expenses	Maximums Per Insured Person *
Intrauterine devices	Reasonable and customary charges.*
Orthopedic braces with rigid support; back supports; shoulder harnesses; head halters and cervical collars, splints, other than dental splints, casts, canes, crutches, walkers and deep massage cushion Obusforme type	$750 per calendar year.
Wigs	$500 per period of 48 months.
Sclerosing injections	Eligible maximum of $20 per day.
Therapeutic appliances	Reasonable and customary charges.*
Hearing aids	Eligible maximum of $2,000 per period of 48 consecutive months.
Drug and alcohol abuse treatment facility	Eligible maximum of $50 per day and 30 days per calendar year.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

* **Reasonable and Customary Charges:** The maximums allocated for the following covered expenses are limited to reasonable and customary charges normally incurred for an Illness or injury of the same nature and severity in the area where the service is provided.

  However, this limitation does not apply to drugs.

Medical Expenses (cont'd)

Covered Expenses	Maximums Per Insured Person *
Dental care as a result of an accidental injury	Maximum of $5,000 per accident.
Cosmetic surgery following an accident	Maximum of $15,000 per accident.

Eligible maximum:

The amount payable with respect to a claim will be the amount equal to the Eligible Maximum shown for the covered expense less any amount which is due to the application of the deductible and percentage of reimbursement, if applicable.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

HOME CARE

Covered Expenses	Maximums Per Insured Person *
Home care services	$60 per day.
Child care expenses	$25 per day, for each child.
Transportation fees	$60 per day; 3 return trips per week; Maximum of $0.25 per kilometre for the use of a private vehicle.
Overall limitation	2 periods of convalescence per calendar year.

GENERAL PROVISIONS

DEFINITIONS

Accident: A sudden, violent and unforeseeable occurrence which is external to the person and which inflicts bodily injuries directly and independently of any other cause

Age: Age as of the last birthday.

Approval of evidence of insurability: The date of approval of any evidence of insurability shall mean the date the insurer receives the last document which allows it to accept the risk on the person.

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

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

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

a) Spouse

The person who is married to or is in a civil union with the participant, or the person designated by the participant, whom he declares publicly to be his spouse and with whom he has been living on a permanent basis for at least 12 months, or less, if a child is born from their union.

A dissolution of marriage by divorce or annulment, as well as a de facto separation of more than 3 months will result in the person no longer qualifying as the participant's spouse for the purposes of the group policy.

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

b) Child

An unmarried child of the participant or of his spouse who wholly depends on the participant for support and maintenance and who meets at least one of the following conditions:

i) He is under 21 years of age; or

ii) He is 21 years of age or over but under 26 and is attending a recognized educational institution on a full-time basis with proof to the satisfaction of the insurer; or

iii) He is mentally or physically handicapped and is unable to hold a substantially gainful occupation because of such handicap provided such handicap commenced while he was a child as defined in (i) or (ii) and for which medical evidence was provided to the insurer.

Full-time resident of Canada: Has a permanent residence in Canada and resides in Canada for at least 182 days a year.

Illness: Any deterioration in health requiring regular, continuous and curative care actively provided by a physician.

Insured person: A participant or a dependent of a participant who is insured under the group policy.

Insurer: Industrial Alliance Insurance and Financial Services Inc.

Participant: Any retiree who is a full-time resident of Canada and who is insured under the group policy.

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

Retiree: Any retired director who receives a retirement pension under a pension plan for which his employer was contributing and who is an approved member of the Association Québécoise des Directeurs et Directrices d'Établissement d'Enseignement Retraités (AQDER).

Retirement date: The date on which the participant starts receiving a retirement pension under a pension plan for which his employer was contributing.

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

Surviving spouse: A spouse of a deceased retiree who was insured as a spouse under the group policy at the time of the retiree's death and who is a member in good standing of the Association Québécoise des Directeurs et Directrices d'Établissement d'Enseignement Retraités (AQDER).

CHANGES IN GOVERNMENT PLANS

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

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

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

INCONTESTABILITY

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

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

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

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

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

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

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

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

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

LAWFUL CURRENCY

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

COVERAGE ELSEWHERE

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

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

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

The application must be made within 90 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.

If the application if received after this 90-day period, the insurance will not take effect until the date on which the insurer receives and approves the retiree's or dependent's evidence of insurability.

ELIGIBILITY

Retiree

A retiree will become eligible to be insured under the group policy as a participant on the date (his "eligibility date") on which he satisfies the following conditions:

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

b) He is a full-time resident of Canada; and

c) He is covered under the provincial health plan of his province of residence.

Dependents

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 the following conditions:

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

b) He is a full-time resident of Canada; and

c) He is covered under the provincial health plan of his province of residence; and

d) The retiree of whom he is a dependent has become eligible to be insured under the group policy.

Dependent group insurance may not be effective before the retiree's group insurance becomes effective.

APPLICATION FOR GROUP INSURANCE

Any retiree who is eligible to become insured under the group policy 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

Life Insurance without evidence of insurability:

The retiree'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 30 days after such date, in regard to Life Insurance.

Life Insurance with evidence of insurability:

If the application for group insurance is received after a period of 30 days of the eligibility date, the insurance will take effect on the date on which the insurer receives and approves the evidence of insurability for the retiree and his dependents, if applicable, in regard to Life Insurance.

Supplemental Health Insurance without evidence of insurability:

The retiree's insurance and dependents' insurance, if any, will take effect on the person's eligibility date, if the application has been received by the insurer on or prior to such date, or within 90 days after such date, in regard to Supplemental Health Insurance.

Supplemental Health Insurance with evidence of insurability:

If the application is received after a period of 90 days of the eligibility date, the insurance will take effect on the date on which the insurer receives and approves the evidence of insurability for the retiree and his dependents, if applicable, in regard to Supplemental Health Insurance.

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;

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

c) The date the participant is no longer covered by his provincial health plan;

d) The date of the participant's death;

e) The date on which the participant fails to pay all of his group insurance premiums;

f) The later of the following dates:

   i) the date indicated on a written notice received from the policy-holder;

   ii) the date this notice was received by the insurer;

g) The date the participant is incarcerated after committing a criminal offence for which he was found guilty;

h) The date the participant ceases to qualify as a *Retiree* as defined in the group policy.

Dependents

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

a) The date the participant of whom he is a dependent ceases to be covered under the group policy.

b) The date the dependent ceases to be a *Dependent* as defined in the group policy;

c) The date the dependent reaches the age limit specified in the Summary of Benefits;

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

e) The date the dependent is no longer covered by the provincial health plan;

f) The later of the following dates:

   i) the date indicated on a written notice received from the policy-holder;

   ii) the date this notice was received by the insurer.

g) The date on which the participant fails to pay all of his group insurance premiums.

CLAIMS

Life Insurance:

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

Supplemental Health insurance:

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

However, if the group policy terminates, notice of claim for a Supplemental Health Insurance benefit must be submitted to the insurer within 90 days following termination of the group policy

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

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

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

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

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

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

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

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

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

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

If the participant had named a beneficiary under the Policyholder's prior group policy, such designation will be applicable to the insurance provided under 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 OF A CLAIMANT

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

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

SUBROGATION

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

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

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

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

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

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

be binding on the insurer and the insurer shall have the right to seek recovery directly from the participant or dependent in accordance with its rights under the group policy.

LIMITATION ON LEGAL ACTIONS

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

Every action or proceeding against an insurer for the recovery of insurance money payable under this 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 [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 the terms and conditions of this benefit and the group policy.

CONVERSION PRIVILEGE

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

a) his employment;

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;

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 policy will include all amounts of life insurance that the participant was covered 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;

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

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;

d) $200,000 ($400,000 for participants living in the province of Quebec).

The individual 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 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 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 insurance, the insurer shall pay an amount equal to that which he could have converted whether or not he made application for the individual 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.

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 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.

EXCLUSION

If a participant commits suicide, regardless of any impairment, illness, or state of mind, less than 24 months after the date his coverage 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 Basic Life Insurance benefit which are not inconsistent with the provisions of this benefit will form part of this benefit.

BASIC LIFE INSURANCE FOR THE PARTICIPANT'S SPOUSE AND DEPENDENT CHILDREN

Upon the death of a dependent while insured under this benefit, the insurer undertakes to pay to the participant the sum insured, as indicated in the Summary of Benefits, subject to the terms and conditions of this benefit and the group policy.

CONVERSION PRIVILEGE

A participant whose spouse's life insurance is cancelled on or prior to the earlier of (i) his 65th birthday and (ii) his spouse's 65th birthday, due to the termination of

a) his employment;

b) his group membership; or

c) the group policy and his spouse had been continuously insured under a Basic Life Insurance for the Participant's Spouse 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 is cancelled on or prior to the earlier of (i) his 65th birthday and (ii) 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;

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 policy will include all amounts of life insurance that the spouse is covered for under the group policy, 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 the spouse, if applicable;

b) the amount for which the spouse was insured immediately prior to the termination of his insurance; and

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; and

d) $200,000 ($400,000 for participants living in the province of Quebec).

The individual policy shall not include a disability benefit nor an accidental death and dismemberment benefit and the premiums shall 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 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 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 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 policy.

OPTIONAL LIFE INSURANCE FOR THE PARTICIPANT'S SPOUSE

A participant may obtain an amount of optional life insurance on his spouse if he so requests it in writing to the insurer and furnishes evidence of insurability satisfactory to the insurer.

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

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

CONVERSION PRIVILEGE

A participant whose spouse's optional life insurance is cancelled on or prior to the earlier of (i) his 65th birthday and (ii) his spouse's 65th birthday, due to the termination of

a) his employment;

b) his group membership; or

c) the group policy and his spouse had been continuously insured under a Basic Life Insurance for the Participant's Spouse benefit provided by the policyholder for at least 5 years,

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

A spouse whose optional life insurance is cancelled on or prior to the earlier of (i) his 65th birthday and (ii) 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 optional life insurance to one of the following types of insurance:

a) permanent;

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 policy will include all amounts of optional life insurance that the spouse is covered for under the group policy, a 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 the spouse, if applicable;

b) the amount for which the spouse was insured immediately prior to the termination of his insurance; and

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; and

d) $200,000 ($400,000 for participants living in the province of Quebec).

The individual policy shall not include a disability benefit nor an accidental death and dismemberment benefit and the premiums shall 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 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 optional life insurance for the participant's spouse 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 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 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 person 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.

SUPPLEMENTAL HEALTH INSURANCE

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

DEFINITIONS

As used in this benefit:

Convalescent home: Such terms designate an institution or health unit legally acknowledged as such, including senior's residence with a designated section intended for the care of bedridden patients.

Nursing homes, rest homes, rehabilitation institutions, chronic care institutions, residential and long-term care facility, drug and alcohol treatment centres are excluded.

General risk levels for countries, territories or regions: One of the 4 risk levels applied by the government of Canada to a country, territory or region and which determines the security conditions as indicated under the Travel Advice and Advisories issued by the government of Canada.

- Level 1: Exercise normal security precautions;
- Level 2: Exercise a high degree of caution;
- Level 3: Avoid non-essential travel;
- Level 4: Avoid all travel, including all travel on cruise ships.

Hospital: An institution which

a) is legally licensed by the appropriate government body;

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

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

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

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

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

HOSPITALIZATION IN THE PROVINCE OF RESIDENCE

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

a) the insured person is confined to the hospital on an in-patient basis to receive curative treatment or care related to a pregnancy, as recommended by the attending physician;

b) the insured person was hospitalized for acute care and not chronic, long-term or convalescent care; and

c) the expenses incurred are recognized up to the maximum daily cost as provided for in the fee schedule decreed by the government body concerned.

EMERGENCY MEDICAL EXPENSES INCURRED OUTSIDE THE PROVINCE OF RESIDENCE

As of January 1, 2021:

If on the date of the insured person's departure the Government of Canada has assigned a general risk level of 1, 2, or 3, for a country, territory or region:

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) **According to the Government of Canada**

The risk level is either 1 or 2:

The medical emergency occurs during the first 180 days of the insured person's absence from his province of residence, or if 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

The risk level is 3:

The medical emergency occurs during the first 30 days of the insured person's absence from his province of residence, or if 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

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

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

If on the date of the insured person's departure the Government of Canada has assigned a general risk level of 4, for a country, territory or region:

No protection is provided under this benefit for the entire duration of the absence for business, a vacation or full-time attendance at an accredited educational institution.

Change in the general risk level after the date of departure, while the insured person is outside his province of residence:

If the Government of Canada changes the general risk level assigned to a country, territory or region after the date of departure of the insured person for business, a vacation or full-time attendance at an accredited educational institution, the following conditions apply:

If the general risk level was 1 or 2 on the date of departure, and the level changes to 3:

The insured person has 14 days to return to Canada, from the date of the change in the level of risk, or if the absence is due to the insured person's full-time attendance at an accredited educational institution, the period applicable to the school year during which the insured person was enrolled in an educational institution; or

If the general risk level was 1 or 2 on the departure date, and the level changes to 4:

The insured person has 14 days to return to Canada from the date of the change in risk level.

If the general risk level was 3 on the departure date, and the level changes to 1 or 2:

The insured person has the first 180 days from the date of departure, as indicated previously under *The Risk level either 1 or 2*; or if the absence is due to the insured person's full-time attendance at an accredited educational institution, the period applicable to the school year during which the insured person was enrolled in an educational institution; or

If the general risk level was 3 on the departure date, and the level changes to 4:

The insured person has 14 days to return to Canada from the date of the change in risk level.

Failure to meet these conditions may result in the insurer limiting or denying the insured person's claim resulting, directly or indirectly, from the medical emergency.

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

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

a) Services of a physician;

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

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

d) Diagnostic, medical imaging and laboratory services;

e) Paramedical services provided during a hospital confinement;

f) Hospital out-patient services and supplies;

g) Drugs;

h) Medical appliances and supplies provided out of hospital;

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

j) Charges for the rental of wheelchairs, hospital beds or respiratory assistance devices;

k) Charges for the purchase of hernia belts, corsets, crutches, splints, other than dental splints, casts and other orthopedic devices;

l) Professional fees of a dental surgeon for accidental lesions to natural, healthy and entire teeth, following an accident occurring outside the province of residence of the insured person, up to a maximum reimbursement of $1,000 per accident. The charges shall not exceed the amount shown for the treatment in the current provincial fee schedule for general practitioners in the insured person's province of residence and the charges must be incurred within 12 months of the date of the accidental injury.

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.

TRAVELLING EXPENSES

DEFINITIONS

Collective transport means a set of modes of transport using vehicles adapted to simultaneously accommodate several people for business purposes. For the purposes of this benefit, the recognized modes of public transport are: taxi, bus, plane and boat.

TRAVELLING EXPENSES

The following expenses are covered provided they were incurred while the insured person was covered by this benefit, up to the maximums provided in the Summary of Benefits:

a) Collective transport travel expenses incurred by the insured person in order to consult or receive medically required treatment that is not

available in the public health system of the insured person's usual place of residence.

The following travel expenses are covered:

i) The cost of travel by public transport; or

ii) The cost of using a private automobile, provided that the insured person does not have easy access to a public transport service. These costs are however limited to the costs that would have been incurred if the insured person had traveled by bus, up to a maximum of $0.44 per kilometer.

Reimbursement of travelling expenses is made according to the least expensive option.

Travel costs are covered provided that:

i) The trip was made on a reasonably direct route; and

ii) The travel is medically required as certified in writing by the attending physician, other than himself; and

iii) Substantially equivalent medical care is not available within a 200 km radius of the insured person's usual place of residence; and

iv) Medical care is provided in a facility or establishment of the public health system; and

v) The travel is caused only for consultation or treatment within the province of residence.

b) The accommodation expenses covered are:

i) Living expenses for accommodation and meals in a commercial establishment where an insured person must postpone their return as certified in writing by the attending physician, subject to a maximum daily reimbursement of $150.

Accommodation expenses are covered provided, that:

i) The attending physician certifies in writing that the consultation or treatment requires a stay; and

ii) Accommodation and transportation expenses are deemed to be necessary and reasonable by the insurer; and

iii) Accommodation expenses are incurred solely by the travelling of the insured person in order to receive the specialized medical care covered by this benefit.

In addition to the exclusions and reductions listed in this benefit, Travelling Expenses do not cover the following:

a) Travelling expenses to pick up a device or medication.

b) Charges for consultations or treatments, unless it is stated that these costs are covered under this benefit.

In the event that an insured person needs to be moved while receiving benefits under this coverage, the insured person may submit a written request to the insurer for additional benefits, up to the maximums provided in the Summary of Benefits, to cover the actual expenses relating to accommodation and transport incurred by an accompanying person, provided that:

a) The attending Physician certifies in writing that the insured person is unable to travel alone to obtain medical treatment; and

b) All the conditions imposed on the insured person's travelling and accommodation expenses are met.

NOTE
These expenses may be eligible for reimbursement under a program set up by certain health and social services centres. However, this program is administered by the institution responsible for the treatment of the insured person. In order to verify the existence of such a program in his province of residence, the insured person must contact the hospital, the CLSC or the health and social services centres. Theses organizations are first payers and only the expenses which are not reimbursed by these organizations are eligible.

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) 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;

   ii) the services are medically required;

   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.

b) 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, including the cost of oxygen therapy treatments received during transportation.

c) Drugs (including preventive immunization 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, excluding prescription drugs which are listed under the Basic Prescription Drug Insurance Plan of Quebec and other products excluded under the Exclusions and Reductions provision of this benefit.

   - Drugs concerned by this clause are those listed in the current edition of the file of the Quebec Association of Proprietor Pharmacists and whose use is in accordance with indications approved by government authorities or, failing that, by the manufacturer;

   - In the case of drugs injected in the private practice of a health professional, only the injected substance is covered and not the medical act;

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

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 90 day period.

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.

d) Room and board charges made in a convalescent home provided:

- the confinement was recommended by a physician;
- the services offered are medically required;
- the confinement takes place within 14 days of a period of hospitalization.

e) Charges for diagnostic laboratory tests, x-rays, other than x-rays by a chiropractor, ultrasounds, magnetic resolution imaging (MRI), tomography, computer tomography (CT scan) and pharmacogenetic tests, provided

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

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.

f) Fees for the care provided by one of the paramedical practitioners listed in the Summary of Benefits provided the practitioner is licensed by the appropriate provincial or federal organization to practice his profession in accordance with the rules of his profession.

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

However, treatments given by a physical rehabilitation technician are only recognized by the insurer if they are given under the supervision of a physiotherapist or physiatrist.

In the case of the naturopath, only consultations aimed at obtaining dietary advice, or establishing a health check or a diet based on natural products are eligible.

g) Charges for x-rays by a chiropractor.

h) 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) breast prostheses;

   ii) medical elastic stockings prescribed for the treatment of varicose veins or required as a result of severe burns or surgery;

   iii) orthopedic shoes for which the medical necessity of was determined by a health practitioner operating within the scope of his license and which have been custom made, modified or custom molded for the insured person by a certified specialist in orthopedic footwear. Off the shelf orthopedic shoes which have not been modified for the insured person will not be eligible for coverage;

   iv) intrauterine devices, when prescribed by a physician;

   v) braces with rigid support; back supports; shoulder harnesses; head halters and cervical collars;

   vi) splints, other than dental splints, and casts;

   vii) canes, crutches, walkers and deep massage cushion Obusforme type;

   viii) sclerosing injections;

   ix) wigs.

i) The following therapeutic appliances:

   i) aerosol equipment, mist tents and nebulizers for cystic fibrosis, acute emphysema, chronic obstructive bronchitis or chronic asthma;

   ii) apnea monitors for respiratory dysrhythmias;

   iii) intermittent positive pressure breathing machine;

   iv) catheters;

   v) transcutaneous nerve stimulator;

   vi) diabetic monitoring and administration equipment (including insulin pumps), other than the insulin supplies such as needles, syringes, lancets and diagnostic testing materials;

vii) oxygen tent and supplies for oxygen administration (oxygen concentrator, portable concentrator, oxygen connector, adapter; basket cart and transport oxygen), excluding the carrying bag;

viii) colostomy and ileostomy apparatus and supplies;

ix) 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;

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

xi) artificial prostheses, including repairs and replacements.

j) Charges for the rental of, or the purchase of 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.

k) Charges made by a substance abuse treatment facility (including cost of room and board and nursing care) provided

i) the insured person is involved in a substance abuse treatment program at the facility;

ii) the facility is a legally licensed facility providing care and treatment on a regular basis to individuals who are involved with substance abuse 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.

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

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

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

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

iv) the care is received within 12 months of the date of the accidental injury.

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

m) Charges made for cosmetic surgery made necessary following an accident which occurred while the person was insured, on condition that the treatments begin within 12 months of the date of the accident and end within 24 months of this dated.

EXCLUSIONS AND REDUCTIONS

This benefit does not cover any expense:

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 resulting from civil unrest, insurrection or war, whether war be declared or not, or participation in a riot;

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

e) For an injury or illness incurred during the engagement of the insured person as an active member of the armed forces of any country;

f) For treatment or appliances to correct vertical dimension or any temporomandibular joint dysfunction, or any expenses for dental care, except if specifically mentioned as being covered under this benefit;

g) For care or treatment which is not medically required, which is given for cosmetic purposes or for any reason other than curative, which exceeds the normal care or treatment given in accordance with current therapeutic practice, or is of an experimental nature;

h) 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;

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

j) 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;

k) 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;

l) For rest cures or travel for reasons of health;

m) For eye examinations, eyeglasses and contact lenses;

n) For care or treatment related to fertility or infertility;

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 any services or supplies which are for the sole purpose of facilitating the insured person's participation in sports or recreational activities and not for daily living activities;

q) For preventive immunization vaccines or the administration of serums, vaccines and injectable medications, except if mention is made that these expenses are covered under this benefit;

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

s) 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, sunscreens*;
- toilet products including soaps and emollients;
- skin softeners and protectors;
- vitamins, vitamin supplements or multivitamins;
- minerals;
- homeopathic or so-called ''natural'' products;
- anabolic steroids;

* *Sunscreens may be covered when needed to treat people with illnesses requiring such products.*

t) For drugs listed under the Basic Prescription Drug Insurance Plan of Quebec;

u) For any contribution to the cost of drugs and pharmaceutical services which must be paid by the insured person under the Basic Prescription Drug Insurance Plan of Quebec;

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;

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

x) 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;

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

z) For any care or treatment received outside of the province of residence due to a medical emergency, if on the date of the insured person's departure, the Government of Canada had assigned a general risk level of 4, for a country, a territory or region;

aa) 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 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.

CONVERSION PRIVILEGE

A participant whose coverage 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 coverage to an individual insurance contract without having to submit evidence of insurability to the insurer.

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

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

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

SUPPLEMENTAL HEALTH INSURANCE – HOME CARE

The insurer undertakes to reimburse the expenses for the care and services defined herein **following hospitalization or day surgery in Canada which results in a period of convalescence** subject to the terms and conditions specified below and in the group policy, provided (i) the insured person is unable to perform at least one of the basic activities of daily living and (ii) the insured person's attending physician provides medical information concerning the surgery or hospitalization and the date it was scheduled.

DEFINITIONS

As used in this benefit:

Basic activities of daily living:

a) **feeding**: preparing and eating meals;

b) **dressing**: gathering clothes and getting dressed (for example, tying shoes or buttoning a shirt);

c) **using the toilet**;

d) **moving (from the bed to a chair)**: laying down in bed and getting up from bed or sitting down in a chair and getting up from it. An insured person who is only able to move with the help of a cane or walker will be considered to be unable to move; and

e) **personal hygiene**: getting in or out of the bathtub or shower and washing.

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.

Home care services provider: An individual working for remuneration for a co-operative or incorporated or registered agency specializing in home care, as well as any self-employed worker receiving a contract from such co-operative or agency.

Hospitalization: Occupancy of a hospital room as an admitted bedridden patient where a room and board charge has been made in connection with the confinement. Day surgery will be considered to be a period of hospitalization.

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

COVERED EXPENSES

The expenses for the following services will be covered if they are incurred after the date the insured person became insured under this benefit:

a) Home care services:

The following services are covered, up to the maximum specified in the Summary of Benefits:

i) assistance to accomplish a basic daily activity;

ii) household maintenance (regular maintenance of the home, including cleaning, dishes and laundry);

iii) regular maintenance outside the home (snow removal, lawn mowing);

iv) preparation of meals; and

v) accompanying the insured person to medical appointments.

The services provided by a supplier must be dispensed at the home of the insured person.

b) Child care expenses for children 13 years of age and under:

Fees to care for the dependent children of the participant, at the participant's home or in a day-care, up to the daily maximum specified in the Summary of Benefits. The individual who provides the child care services must not be a member of the insured person's immediate family and must not normally live with him.

Only the fees in excess of those that were being incurred by the participant or the participant's spouse before the period of convalescence of the insured person will be covered under this benefit.

c) Transportation fees:

Transportation fees incurred by the insured person in order for him to receive medical care or to attend a medical follow-up subsequent to the hospital stay or day surgery, up to the maximum specified in the Summary of Benefits.

The transportation fees that will be covered are:

i) the cost for transportation in a public conveyance or taxi; or

ii) the cost of using a private automobile plus parking expenses.

EXCLUSIONS AND REDUCTIONS

In addition to the exclusions and reductions outlined in the Exclusions and Reductions provision of the Supplemental Health Insurance benefit, this benefit does not cover the following:

a) Any expenses incurred following a hospitalization or day surgery scheduled before the effective date of this benefit.

b) Any expenses incurred while the insured person is able to perform the basic activities of daily living or after he has returned to work.

c) Any expenses incurred following a hospitalization for childbirth, except where the insured person remained in hospital for a period of 7 days or more after delivery on the recommendation of the attending physician.

d) Any expenses for services that are rendered more than 60 days after the insured person was released from the hospital or underwent day surgery, whichever is applicable.

SUPPLEMENTAL HEALTH INSURANCE – EMERGENCY OUT OF PROVINCE ASSISTANCE

As of January 1, 2021:

If on the date of the insured person's departure the Government of Canada has assigned a general risk level of 1, 2, or 3, for a country, territory or region:

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

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

b) **According to the Government of Canada**

The risk level is either 1 or 2:

The medical emergency occurs during the first 180 days of the insured person's absence from his province of residence, or if 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

The risk level is 3:

The medical emergency occurs during the first 30 days of the insured person's absence from his province of residence, or if 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) In case of a medical emergency, the emergency is covered under the Emergency Medical Expenses Incurred Outside the Province of Residence section of the Supplemental Health Insurance benefit.

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

If on the date of the insured person's departure the Government of Canada has assigned a general risk level of 4, for a country, territory or region:

No protection is provided under this benefit for the entire duration of the absence for business, a vacation or full-time attendance at an accredited educational institution.

Change in the general risk level after the date of departure, while the insured person is outside his province of residence:

If the Government of Canada changes the general risk level assigned to a country, territory or region after the date of departure of the insured person for business, a vacation or full-time attendance at an accredited educational institution, the following conditions apply:

If the general risk level was 1 or 2 on the date of departure, and the level changes to 3:

The insured person has 14 days to return to Canada, from the date of the change in the level of risk, or if the absence is due to the insured person's full-time attendance at an accredited educational institution, the period applicable to the school year during which the insured person was enrolled in an educational institution; or

If the general risk level was 1 or 2 on the departure date, and the level changes to 4:

The insured person has 14 days to return to Canada from the date of the change in risk level.

If the general risk level was 3 on the departure date, and the level changes to 1 or 2:

The insured person has the first 180 days from the date of departure, as indicated previously under *The Risk level either 1 or 2*; or if the absence is due to the insured person's full-time attendance at an accredited educational institution, the period applicable to the school year during which the insured person was enrolled in an educational institution; or

If the general risk level was 3 on the departure date, and the level changes to 4:

The insured person has 14 days to return to Canada from the date of the change in risk level.

Failure to meet these conditions may result in the insurer limiting or denying the insured person's claim resulting, directly or indirectly, from the medical emergency.

DEFINITION

As used in this benefit:

General risk levels for countries, territories or regions: One of the 4 risk levels applied by the government of Canada to a country, territory or region and which determines the security conditions as indicated under the Travel Advice and Advisories issued by the government of Canada.

- Level 1: Exercise normal security precautions;
- Level 2: Exercise a high degree of caution;
- Level 3: Avoid non-essential travel;
- Level 4: Avoid all travel, including all travel on cruise ships;

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

MEDICAL EMERGENCY ASSISTANCE SERVICES

The following services will be provided during a medical emergency:

a) 24 Hour Telephone Access

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

b) Medical Care

The Medical Assistance Service provider will:

- If the insured person is unable to locate a physician or hospital, provide a referral to a physician or an appropriate hospital;
- Upon request of the insured person, organize consultations with general practitioners or specialists in order to obtain the best medical care available in the area;
- Provide assistance with admittance to a hospital;
- Confirm to doctors and hospitals that the insured person's group policy will cover the insured person's medical expenses.

c) Medical Transportation

The Medical Assistance Service provider will:

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

d) Payment of Medical Expenses and Cash Advance

- The Medical Assistance Service provider will make the necessary arrangements to pay medical expenses which are covered under the Emergency Medical Expenses Incurred Outside of Province section of the Supplemental Health Insurance benefit;

- When necessary in order for the insured person to obtain needed medical treatment, the Medical Assistance Service provider will advance up to $10,000 (Canadian), after consultation with the insurer.

e) Return of Deceased

- Should the insured person die, the Medical Assistance Service provider will make all arrangements and pay all expenses associated with returning the body of the deceased person to the place of burial in his province of residence, up to a maximum of $5,000. Funeral expenses will not be covered.

f) Return of Dependent Children

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

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

- The Medical Assistance Service provider will organize the return of the insured person and/or a member of the insured person's immediate family who has lost the use of his return ticket due to the insured person's hospitalization or death. The Medical Assistance Service provider will arrange and pay for economy transportation to return the insured person and/or member of the immediate family to his usual place of residence. If the return tickets are still valid, only the additional cost incurred for the return transportation, after deducting the value of the tickets, will be paid.

h) Visit from a friend or a Member of the Immediate Family

- The Medical Assistance Service provider will arrange and pay for round-trip economy class transportation for a friend or 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 friend or 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 $200 per person, and an overall maximum of $1,600.

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

j) Vehicle Return

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

k) Emergency Drugs

- Should an insured person require drugs for the treatment of a medical condition and such drugs are not available locally, the Medical Assistance Service provider will co-ordinate a search for the drugs and once located arrange for the delivery of the drugs. The insured person will be responsible for the cost of the drugs unless they are covered under the Supplemental Health Insurance benefit.

PERSONAL EMERGENCY TRAVEL ASSISTANCE SERVICES

The following services will be provided during a personal emergency:

a) Telephone Interpretation Service

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

b) Messages

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

c) Legal Assistance

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

d) Travel Information

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

e) Lost Baggage or Travel Documents

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

EXCLUSIONS

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

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

REIMBURSEMENT

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

If a cash advance to cover an expense had been made or an expense had been paid and (i) such expense is not a covered expense under the Emergency Medical Expenses Incurred Outside the Province of Residence section of the Supplemental Health Insurance benefit or (ii) the amount advanced or paid was in excess of the insurer's responsibility under the group policy, the participant will be responsible for reimbursing the insurer the cash advancement or the excess amount, whichever is applicable, within 90 days of the insured person returning to his province of residence. Should the participant fail to pay back the cash advance or excess amount, the insurer will have the right to reduce future health claims or any other claims by the participant or his dependents under the group policy by the amount owing.

SUPPLEMENTAL HEALTH INSURANCE – TRIP CANCELLATION INSURANCE

The insurer undertakes to reimburse all eligible expenses defined herein which are incurred after the insured person became insured under this benefit and result from the cancellation or interruption of a covered trip, **up to a maximum of $5,000 per insured person, per covered trip,** subject to the terms and conditions of this benefit and the group policy.

The expenses are covered only if the insured person, at the time of making the final arrangements for the covered trip, was not aware of any event that could reasonably have led to the cancellation or interruption of the covered trip.

DEFINITIONS

As used in this benefit:

Business meeting: A private meeting related to the insured person's full-time occupation which has been organized in advance and which constitutes the sole reason for the trip. A business meeting may not, under any circumstances, include symposiums, conventions, assemblies, fairs, shows, seminars or board of directors meetings.

Carrier: A public airplane, bus, train or boat (provided the latter is used to travel, and not for a stay).

Covered trip: A trip

a) which will result in the insured person being absent from his normal place of residence for at least 2 consecutive nights, and

b) for which the destination is at least 400 kilometres from the insured person's normal place of residence.

Destination: The city or country to which the insured person is travelling.

General risk levels for countries, territories or regions: One of the 4 risk levels applied by the government of Canada to a country, territory or region and which determines the security conditions as indicated under the Travel Advice and Advisories issued by the government of Canada.

- Level 1: Exercise normal security precautions;
- Level 2: Exercise a high degree of caution;
- Level 3: Avoid non-essential travel;
- Level 4: Avoid all travel, including all travel on cruise ships.

Host at destination: The person who provides accommodation for the insured person in his home.

Member of the family: The spouse, child, father, mother, brother, sister, daughter-in-law, son-in-law, mother-in-law, father-in-law, grandparent, grandchild, half-brother, half-sister, brother-in-law, sister-in-law, uncle, aunt, nephew and niece of the insured person.

Travelling companion: A person who shares the financial travel arrangements with the insured person, up to a maximum of 4 persons, including the insured person.

INSURABLE RISKS

The cancellation or interruption of the covered trip must result from one of the following causes:

a) The illness, injury or death of the insured person, a member of the insured person's family, a travelling companion, or a member of the travelling companion's family;

b) The illness, injury or death of a business associate, or of the insured person's host at destination;

c) The illness, injury or death of a person for whom the insured person is the legal guardian;

d) The death of a person for whom the insured person is the estate executor;

e) The notification of the insured person to report for jury duty or to serve as a witness in a trial taking place during the covered trip, except if the insured person is a law enforcement officer;

f) The quarantine of the insured person;

g) The hijacking of a carrier on which the insured person is travelling;

h) Any event which renders the insured person's principal residence uninhabitable;

i) The cancellation of a business meeting due to the illness, injury or death of the person with whom the arrangements for the meeting were made beforehand (written proof of the arrangements will be required);

j) A recommendation from the Canadian government, following the issuance of a general risk level of 3 or 4, advising its citizens against travelling to the destination, if such recommendation was issued after the insured person had made the arrangements for the covered trip and this recommendation is still in effect at the time of the beginning of the covered trip;

k) The transfer of the insured person by his employer, which requires the insured person to move more than 100 kilometres from his current place of residence within 30 days prior to the date of departure;

l) The missing of a scheduled connection or a delayed departure due to (i) a delay of the carrier responsible for ensuring the connection provided the delay is caused by atmospheric conditions or mechanical failure or (ii) a traffic accident involving the insured person's private or rented automobile or the taxi in which the insured person was travelling.

ELIGIBLE EXPENSES

The following expenses are covered:

a) In the event of a cancellation before departure

   i) The prepaid, non-refundable portion of the travel expenses;

ii) The additional expenses for a higher hotel rate which are incurred by the insured person who elects to proceed with a covered trip when a travelling companion is required to cancel due to one of the insurable risks. The additional expenses shall be reimbursed up to an amount not to exceed the cancellation penalty of the hotel which is applicable at the time the travelling companion is required to cancel his covered trip.

b) If the return is early or delayed

i) The additional cost of an available one-way economy fare return ticket to the point of departure;

ii) The unused, non-refundable portion of the expenses for any pre-paid travel arrangements;

iii) Living expenses for commercial accommodation and meals when an insured person has to postpone his return due to a change in a general risk level of 3 or 4, and this, as long as no means of transportation is then available to ensure the insured person's return or due to an illness or injury sustained by himself or by a member of his family accompanying him, or by a travelling companion, subject to a daily maximum of $200 per insured person, and to an overall maximum of $1,600 for a participant and his insured dependents;

Living expenses for commercial accommodation and meals when an insured person has to anticipate his return due to a change in a general risk level of 3 or 4, which results in a stopover because a direct flight is not available, subject to a daily maximum of $200 per insured person, and to an overall maximum of $1,600 for a participant and his insured dependents;

If the insured person has similar coverage under another benefit of the group policy, the maximum amount payable under the group policy may not exceed the maximum amount indicated under this benefit.

c) Delayed departure or missed connection

i) The additional cost of a one-way, economy fare ticket to the scheduled destination, required by a carrier when a connection is

missed or a departure is delayed due to one of the insurable risks;

For the benefit to be payable, the insured person must have planned to arrive at the point of departure at least 2 hours prior to the scheduled time of departure.

ii) The unused, non-refundable portion of the insured person's prepaid travel expenses, if the insured person elected not to proceed with his covered trip due to an interruption of at least 30% of the scheduled duration of such trip which resulted from atmospheric conditions preventing him from making a scheduled connection with another carrier.

EXCLUSIONS

No benefit will be payable under this benefit if the cause of the cancellation or interruption of a covered trip was due to one of the following:

a) Abuse of drugs or alcohol, or from drug use;

b) Suicide or attempted suicide, or self-inflicted injury unless medical evidence establishes that the injury was directly related to a mental health illness;

c) Commission of or attempted commission of a criminal offence or the provoking of an assault;

d) Civil unrest, insurrection or war, whether declared or undeclared, or participation in a riot;

e) Pregnancy, false labour, delivery or resulting complications, if these events occur within 2 months prior to the expected delivery date;

f) An injury or illness that occurs while taking part in a professional sporting event, or in any kind of motorized vehicle competition or speed trial, or in any dangerous activity such as, but not limited to, hang gliding or sail-flying, mountaineering, parachuting or bungee jumping;

g) An injury or illness resulting from service in the armed forces;

h) The insured person's medical condition was not stable at the time of making the final arrangements for the covered trip. 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:

   i) Medical status;

   ii) Medical treatment, examination, consultation or hospitalization;

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

   iv) Change in medical treatment or in medication;

   v) 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 the final arrangements for that covered trip.

No benefit will be payable under this benefit if

a) A travel credit is offered to the insured person and the insured person refuses it.

   However, if the insured person can demonstrate that it will be impossible for him to use a travel credit before its expiry due to one of the following the causes:

   i. The deterioration of his state of health, which was stable at the time of finalizing the travel arrangements; or
   ii. The occurrence of one of the causes of cancellation or interruption recognized by this benefit.

   The insured person may submit a request for reimbursement of the said travel credit to the insurer;

b) The covered trip was taken for the purpose of receiving medical or paramedical care or hospital services;

c) The covered trip was taken to visit or assist a person who was ill or who had suffered an injury and whose state of health or subsequent death

causes the insured person to change the originally scheduled return date;

d) The covered trip was to visit or assist a person who was ill or who had suffered an injury and whose state of health or death caused the insured person to cancel such trip.

Also, no benefit will be payable under this benefit for any payment or deposit paid when the general risk level was 4, at the time the expense was incurred.

However, an insured person who purchases a covered trip when the general risk level is 3 could be reimbursed for a cancellation resulting from an insured risk other than the general alert level (see the Insurable Risks section).

SPECIAL PROVISIONS

a) When an event listed under the Insurable Risks provision occurs prior to the date of departure, the insured person must contact the travel agency or carrier, as the case may be, within 48 hours following the event to cancel the covered trip, and must advise the insurer at the same time.

b) In order to submit a claim under this benefit, the insured person must provide one or more of the following documents, as the case may be:

   i) The original, unused transportation tickets;

   ii) The official receipts for additional transportation expenses;

   iii) The receipts for ground arrangements and other disbursements. The receipts must include contracts that were officially issued through the travel agency or an accredited company, and must indicate the amounts not refundable in the event of cancellation;

   iv) An official document stating that an insurable risk was in fact the cause of the cancellation. If the cancellation is due to medical reasons, the insured person must provide a medical certificate from the duly qualified attending physician practising in the region where the illness or injury took place and the medical supervision must have started on or prior to the insured person's scheduled date of departure or return, as the case may be. The medical certificate must indicate the full diagnosis confirming the need to cancel, delay or interrupt the covered trip;

v) In case of a traffic accident, a police report.

COPY OF CONTRACT AND ENROLLMENT MATERIAL

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

Health 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

514 499-3800 (Montreal area)
1 877 422-6487 (toll free)

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

416 585-8921 (Toronto area)
1 877 422-6487 (toll free)

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.

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 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

MEDICAL SECOND OPINION SERVICE

A participant will be able to access the Medical Second Opinion service on behalf of himself or a dependent, if the participant or the dependent is diagnosed with a covered serious medical condition, provided that the participant and his dependents are covered under the Supplemental Health Insurance benefit of the group policy.

SERVICE

Upon identification of a covered serious medical condition, this service allows the participant or the dependent to quickly obtain a second opinion from leading medical specialists affiliated with renowned Canadian medical teaching institutions. These medical specialists are connected to global resources and clinical expertise, facilitating consultation with other world-class experts when required.

COVERED SERIOUS MEDICAL CONDITIONS [1]

The covered serious medical conditions for which a participant or a dependent can access the Medical Second Opinion service are:

◆ AIDS	◆ Any disease requiring amputation
◆ Benign brain tumour	◆ Cancer
◆ Cardiovascular conditions, including heart attack (myocardial infarction), coronary bypass surgery, or aortic surgery	◆ Coma
◆ Complications of diabetes	◆ Deafness
◆ Emphysema	◆ Hip and knee replacement
◆ Loss of speech	◆ Loss of eyesight
◆ Major lung and bone disorders	◆ Major trauma
◆ Motor neuron diseases	◆ Neuro-degenerative diseases (e.g. Alzheimer's disease, Multiple Sclerosis, Parkinson's disease…)
◆ Paralysis	◆ Renal insufficiency or kidney failure
◆ Severe burns	◆ Stroke (Cerebrovascular accident) and related conditions
◆ Thrombophlebitis and embolism	◆ Vital organ transplants

[1] This list is not exhaustive. The participant or dependent needs to contact Second Medical Opinion to verify the eligibility of any life-threatening illness.

NOTE: If the specialist cannot confirm a diagnosis based on the participant's or dependent's file, he may recommend that additional test(s) or physical consultation be considered to help further refine the diagnosis. Once these test(s) or physical consultations have been completed, the specialist will re-evaluate the participant's or dependent's request for a medical second opinion.

A FAST, RELIABLE SIX-STEP PROCESS

1. The participant or dependent calls Medical Second Opinion to confirm his eligibility at 1 855 422-4622 to validate its eligibility;
2. A coordinator of the Medical Second Opinion team opens a file and gathers the medical records with the consent of the participant or dependent;
3. The coordinator provides the specialist from Medical Second Opinion with the medical records;
4. The specialist reviews the case and prepares the final report;
5. The coordinator from Medical Second Opinion sends the final report to the participant or dependent. upon agreement with the participant or dependent, the coordinator forwards a copy of the final report to the attending physician;
6. The attending physician consults with the specialist from Medical Second Opinion, if required.

TREATMENT OPTIONS

Upon confirming the diagnosis, the participant or dependent is offered the best treatment options and enhanced access to advanced knowledge within the Canadian healthcare system. Effective treatment is often available near home.

Sometimes, Medical Second Opinion specialists may recommend that the participant or dependent considers treatment in another part of Canada, or even in another country. Should the recommended treatment be available only outside the province of residence, Medical Second Opinion will make all necessary arrangements on behalf of the participant or dependent by coordinating transportation, admission to the medical institution and repatriation. (2)

(2) The eligible participant or dependent is responsible for all costs for transportation, hospitalization and treatment, unless such costs are covered by the group policy and/or the provincial health plan. The participant or dependent should contact Industrial Alliance and the provincial health plan to determine what costs, if any, are covered.

MEDICAL SECOND OPINION SERVICE

CONFIDENTIALITY

Medical Second Opinion's privacy policy complies with requirements under the Personal Information Protection and Electronic Documents Acts (PIPEDA), as well as provincial privacy legislation.

HOW TO ACCESS MEDICAL SECOND OPINION

To obtain a second medical opinion after a diagnosis of a covered serious medical condition, the participant or dependent has to call 1 855 422-4622.

You may contact your plan administrator to obtain a Medical Second Opinion brochure.

TERMINATION OF MEDICAL SECOND OPINION SERVICE

A participant's ability to access the Medical Second Opinion service on behalf of himself or a Dependent will terminate on the date the participant is no longer insured under the Supplemental Health Insurance benefit of the group policy.

In addition, if the agreement between Industrial Alliance and Medical Second Opinion service should terminate, the participant and his dependents will no longer be able to access the Medical Second Opinion service.

NOTES