# GROUP INSURANCE PLAN

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|---|---|
| *Policyholder:* | ***QUÉBEC PROVINCIAL ASSOCIATION OF TEACHERS*** |
| *Policy No.:* | ***97,000 / 97,001*** |

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# INTRODUCTION

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

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

**New Participant**

To participate in the present plan, you have to fill out the form *Participation Request F54-018A(16)*, indicate the chosen benefits and transmit it to your school board. This form is available at your school board.

**Modification to the Coverage**

Any modification to the coverage of a participant should be transmitted to your school board on the form *Participation Request F54-018A(16)*. This form is available at your school board.

**Claims**

**a) Life Insurance**

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

**b) Waiver of Premiums and Long-term Disability**

You have to present a proof of your disability within five (5) months following the beginning of the disability. You have to fill out the form *Claim Request F54-360A* and transmit it to your school board. This form is available at your school board.

**c) Health Insurance**

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

ii) **Other expenses**: Fill out the form *Claim Request F54-326 (16)*, available at your school board or at your school.

All claims should be sent to the following address :

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

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

**Administration Department**

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

(514) 499-3800
or
1-800-363-3540

**Claims Department**

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

(514) 499-3800
or
1-800-363-3540

# SUMMARY OF BENEFITS

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

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

## SPECIAL PROVISIONS

You are covered under one of the following classes:

**Classes**

Full-time Teachers

Part-time Teachers

# GENERAL PROVISIONS

## ELIGIBILITY DATE

Subject to all other provisions, you become eligible on one of the following dates:

a) on the effective date of the plan, if you are then in the employer's service,

or

b) if you are not in the employer's service:

    i) on the scheduled date of the beginning of service if your contract takes effect between the first working day and the last working day of the work year;

    or

    ii) on the date of the first working day of the work year, if your employment contract takes effect before or on the first working day of the work year.

## NORMAL RETIREMENT AGE

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

## YOUR LIFE INSURANCE

### Full-time and Part-time Teachers

Sum Insured

1 to 6 units of $25,000, at your choice.

Maximum: $75,000 without evidence of insurability (if the application is submitted within 60 days of the eligibility), or $150,000 with evidence of insurability.

This benefit terminates on the date of your retirement.

**PARTICIPATION IN THIS BENEFIT IS OPTIONAL.**

## LIFE INSURANCE FOR YOUR DEPENDENTS

### Full-time and Part-time Teachers

Spouse: $10,000

Each child aged

- less than 24 hours: None
- 24 hours and more: $5,000

This benefit terminates on the date of your retirement.

**PARTICIPATION IN THIS BENEFIT IS OPTIONAL.**

## YOUR ADDITIONAL LIFE INSURANCE

### Full-time and Part-time Teachers

Sum Insured

Units of: $25,000

Maximum: $100,000 with evidence of insurability

To submit an application for participation in the present benefit, you should have the maximum amount of insurance with evidence of insurability under the PARTICIPANT'S LIFE INSURANCE BENEFIT of the present plan.

This benefit terminates on the first day of the month coinciding with or following your 65th birthday or upon retirement, if earlier.

**PARTICIPATION IN THIS BENEFIT IS OPTIONAL.**

## LONG-TERM DISABILITY INCOME INSURANCE

### Full-time and Part-time Teachers

Monthly Indemnity

50% of the basic monthly salary, the result being rounded to the next dollar.

However, the overall maximum must not exceed 90% of the net monthly salary determined at the onset of disability.

Elimination Period: 104 weeks

Maximum Benefit Period: To your 65th birthday

Maximum Annual Indexation Rate: 3%

Benefits are not taxable.

This benefit terminates on your 65th birthday or upon retirement, if earlier.

**PARTICIPATION IN THIS BENEFIT IS MANDATORY FOR FULL-TIME TEACHERS AND OPTIONAL FOR PART-TIME TEACHERS.**

## HEALTH INSURANCE

| HOSPITALIZATION IN CANADA | |
|---|---|
| Deductible: | none |
| Reimbursement: | 100% |
| Daily Maximum: | Semi-private room without limit as to the number of days |

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

| OTHER MEDICAL EXPENSES IN CANADA | |
|---|---|
| Deductible if protection is: | |
| • for you only: | $25 |
| • for you and your spouse: | $50 |
| • for you and your children: | $50 |
| • for you, your children and your spouse: | $50 |
| Reimbursement | |
| • drugs: | 80% of the first $5,400 (for year 2011) * per certificate and 100% of the excess |
| • other expenses: | 80% (except if otherwise specified in the Summary of Benefits) |
| Maximum: | Unlimited |

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

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

This benefit terminates on the date of your retirement.

**PARTICIPATION IN THIS BENEFIT IS MANDATORY.**

## Medical Expenses

Part-time Teachers: you may, as regards your dependents, choose to have coverage for all eligible expenses of the present benefit, or only for the medication part of this benefit, subject to the deductible and reimbursement percentage specified in the present Summary of Benefits.

| Covered Expenses | Maximums Per Insured Person |
|---|---|
| Fees for nursing care | $500 per day, maximum $10,000 per calendar year. |
| Fees for remote areas (travelling expenses) | $50 per day, $500 per calendar year.<br>**These expenses are reimbursed in full (100%).** |
| Therapeutic appliances | $10,000 lifetime. |
| Breast prostheses | $300 per 24 months. |
| Medical elastic stockings | 3 pairs per calendar year. |
| Room and board in a rehabilitation institution or a convalescent home | Semi-private room rate, without limit as to the number of days.<br>**These expenses have no deductible and are reimbursed in full (100%).** |
| Cost of laboratory analyses, electro-cardiograms, electroencephalograms, nuchal scans, prenatal screening tests, radiation treatments, gastrointestinal diagnostic programs and x-rays, performed in a commercial esta-blishment or a private clinic | **These expenses are reimbursed at 50% of the first $500 of expenses incurred in a calendar year and at 75% of the following $1,500.** |
| Wigs and hairpieces | $500 per calendar year. |
| Sclerosing injections | $20 per visit. |
| Paramedical fees for a physiotherapist and a physical rehabilitation therapist | $35 per visit.<br>One (1) treatment per day.<br>**These expenses are reimbursed in full (100%).** |

**Medical Expenses** (cont'd)

| Covered Expenses | Maximums Per Insured Person |
|---|---|
| Paramedical fees for a speech therapist, an audiologist and an occupational therapist | Unlimited.<br>One (1) treatment per day. |
| Paramedical fees for a chiropractor, an osteopath, a podiatrist (chiropodist), a dietician and an acupuncturist | $30 per visit, $30 per x-ray. Combined maximum of $500 for all these professionals.<br>One (1) treatment per day.<br>**These expenses are reimbursed in full (100%).** |
| Paramedical fees for a psychologist, a psychiatrist and a psychoanalyst, and fees for a social worker and an orientation counsellor | Combined maximum of $1,000 per calendar year for all these professionals.<br>**These expenses are reimbursed at 50%.** |
| Glucometer or reflectometer | One (1) device lifetime. |
| Closed treatment program for alcoholism or drug addiction (participant only) | $175 per day, 35 days per treatment program.<br>One (1) treatment program lifetime.<br>**These expenses are reimbursed in full (100%).** |
| Vision care | Eyeglasses (frame and lenses) or contact lenses up to a maximum of $100 or in excess of this amount for contact lenses, if medically necessary and purchased following surgery and if purchase is made within 12 months of the operation.<br>Only one of these maximums is applicable per period of 24 consecutive months.<br>**Vision care expenses are subject to the deductible and are reimbursed in full (100%).** |

## DEFINITIONS

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

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

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

**Actively at Work**: The status of a participant who is performing his or her usual duties on a continuous basis. Wherever there is mention of a number of full-time work days, public holidays are considered full-time work days.

**Board**: A school board recognized by QPAT.

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

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

a) Spouse

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

b) Dependent Child

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

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

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

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

**Disability**: A state of incapacity resulting from an illness, including surgery directly related to family planning, an accident or pregnancy complication, which requires medical care and which, during the first forty-eight (48) months of disability, completely prevents the participant from performing the usual duties of his or her job and any other similar job involving similar compensation that is offered to him or her by the employer and, after the first forty-eight (48) months of disability, completely prevents the participant from performing any gainful occupation for which he or she is reasonably qualified by his or her education, training and experience, without regard for the availability of this type of job.

**Disability Period**: Any continuous period of disability or series of successive disability periods separated by less than:

- twenty-two (22) days of active, full-time work or availability for full-time work,

or

- eight (8) days of active, full-time work if the disability period that precedes the participant's return to work is equal to or less than three (3) calendar months, not including the period between the end of the work year and the beginning of the next work year and the annual vacation period for teachers in the adult education and vocational education sectors,

unless the participant can present satisfactory proof that a subsequent disability period is attributable to an illness or accident completely unrelated to the cause of the previous disability.

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

**Elimination Period**: The continuous period indicated in the Summary of Benefits during which a participant must be absent from work due to disability before he or she can begin to receive disability income benefit payments under a disability income benefit.

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

**Employer**: A school board recognized by QPAT.

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

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

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

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

**Participant**: Any employee insured under this plan.

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

**Salary**: The remuneration to which a teacher is entitled by reason of his or her experience level and category, according to the salary scale provided in the collective agreement, as stated by the employer.

**Salary (Net)**: The participant's annual salary that he or she would have received during the last week of the elimination period of the long-term disability income benefit under this plan had he or she not been disabled, less the following deductions:

a) the employee's annual Employment Insurance premium;

b) the employee's annual Québec or Canada Pension Plan contribution;

c) income tax deducted according to the tax tables established under the Canadian Income Tax Act and the income tax act of the participant's province of residence.

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

## PARTICULARS

### PLAN AMENDMENT

The benefits herein provided are complementary to the benefits provided by government plans. Any modification brought to one of these plans after the effective date of the present plan will in no way modify the benefits herein provided, unless an agreement is signed by the authorized officers of the insurer and the policyholder.

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

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

## INCONTESTABILITY

Whenever evidence of insurability is required to approve insurance for a participant or a dependent, or to approve one of the benefits, the statements made in such proof are, except in cases of error in age or fraud, accepted as true and incontestable after the said participant's or dependent's insurance or benefit has been in force for two (2) years, and provided the participant or dependent is still living at that time.

If the insurance is cancelled and then reinstated, the two-year period starts as of the date the insurance has been reinstated.

## RENUNCIATION

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

## INDIVIDUAL CERTIFICATES

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

## LAWFUL CURRENCY

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

BENEFICIARY

Any participant may name a beneficiary or change a named beneficiary, subject to the provisions of the law, by written declaration signed by the participant and delivered to the insurer's head office.

The insurer declines any responsibility with respect to the sufficiency or validity of such nomination or change of beneficiary.

The rights of a beneficiary who dies before the participant revert to the participant.

If no beneficiary has been named, the death benefit is paid to the participant's rightful claimants.

## INSURANCE

ELIGIBILITY

a) The following persons are eligible for the Participant's Life Insurance, the Participant's Additional Life Insurance, the Dependents' Life Insurance, the Health Insurance and the Long-Term Disability Income Insurance:

   i) any full-time teacher;

   ii) any part-time teacher.

b) An employee's eligibility begins:

   i) on the effective date of this plan, if he or she is working for a board on that date;

   ii) in all other cases, on the date stipulated in the Summary of Benefits, if applicable.

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

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

PARTICIPATION IN HEALTH INSURANCE

Participation in this insurance is mandatory for all employees who fulfil the requirements with regard to eligibility described in the ELIGIBILITY provision above.

However, with prior written notice from his or her employer, an employee may refuse or cease participation in the said benefit as of the end of the premium period stipulated in the notice, provided he or she can provide satisfactory proof that he or she is insured under group insurance coverage with similar benefits.

An employee who refused or ceased participation in Health Insurance in accordance with the provisions of the preceding paragraph, may participate in this insurance under the following conditions:

a) He or she must establish to the insurer's satisfaction that:

    i) he or she was formerly insured under the said benefit, or under a health insurance component of some other plan containing similar benefits;

    ii) he or she is no longer able to continue participation in the said benefit or plan;

    iii) his or her application is presented within a period of sixty (60) days following termination of his or her insurance. If he or she applies more than sixty (60) days following the termination of his or her insurance, the insurance provided under the Health Insurance benefit will not take effect until the first day of the month following the end of a sixty (60) day period beginning on the date the application is received by the insurer.

b) For employees who, prior to their application, were not insured under the Health Insurance benefit, the insurer cannot be held responsible for the payment of benefits that may be payable by the previous insurer under an extended coverage or conversion provision.

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

In the case of Part-time Teachers, if this form is completed more than sixty (60) days following the date on which his or her dependents become eligible, the employee or retiree must, at his or her expense, provide satisfactory evidence of insurability for his or her dependents. Dependents will be eligible for coverage under the drug coverage of the present contract on the date of the application, and all additional benefits on the date the evidence of insurability is accepted by the insurer.

Any Full-time teacher may insure his or her dependent children, or his or her spouse and dependent children under the Health Insurance benefit.

Any Part-time teacher may insure his or her dependent children, or his or her spouse and dependent children, under the drug section of the present contract.

PARTICIPATION IN LIFE INSURANCE

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

Any eligible employee who wishes to participate in this benefit must complete an application, and submit evidence of insurability deemed satisfactory by the insurer for any amount in excess of the non-evidence maximum.

Any employee may insure his or her dependent children, or his or her spouse and dependent children, under the Dependents' Life Insurance benefit.

PARTICIPATION IN LONG-TERM DISABILITY INCOME INSURANCE

Participation in this benefit assumes participation in Health Insurance unless an exemption is granted under the provisions described in the PARTICIPATION IN HEALTH INSURANCE section.

Participation in Long-Term Disability Income Insurance is mandatory for full-time teachers, and optional for part-time teachers.

However, a full-time teacher may be exempted from participating if he or she submits a request to his or her employer, and establishes to the insurer's satisfaction that he or she fulfils at least one of the following conditions:

a) He or she is a member of the *Teachers' Pension Plan (TPP)*;

b) He or she is a member of the *Régime de retraite des fonctionnaires (RRF)*, the *Régime de retraite de certains enseignants (RRCE)*, or the *Régime de retraite des enseignants et des organismes public (RREGOP)*, and is at least fifty-three (53) years of age;

c) He or she is a member of a professional association and is insured under a similar group insurance benefit (proof that the said participant's insurance is in force, along with a copy of the policy, must be attached to the participation exemption request);

d) He or she requests or has requested a retirement departure without the option of returning, if the said retirement departure must be taken within two (2) years from the date of the request for exemption from participation in this coverage (a copy of the departure agreement must be attached to the participation exemption request).

Any eligible employee who wishes to participate in this benefit must complete an application to this effect and send it to the insurer via his or her employer.

No evidence of insurability is required for employees who become eligible after the effective date of this plan, and who have completed and sent an application to the

insurer within sixty (60) days from the date on which they became eligible under this benefit.

## EFFECTIVE DATE OF INSURANCE UNDER THE HEALTH INSURANCE BENEFIT

a) The employee's insurance, regardless of his or her insurability status, takes effect on the effective date of this plan, if he or she fulfils the requirements with regard to eligibility at that time, otherwise it takes effect on the day he or she fulfils these requirements.

In accordance with the stipulations of the PARTICIPATION IN HEALTH INSURANCE provision, the insurance of an employee who refused or ceased participation in the plan, under the stipulations of the said provision, take effect on the first day of the month during which the insurer receives the application.

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

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

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

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

In the case of Part-time Teachers, if the application for dependents' coverage is received after the sixty (60) days following their eligibility date, evidence of insurability will be required.

Dependents will be eligible for coverage under the drug section of the present plan on the date of the application, and all additional benefits on the date the evidence of insurability is accepted by the insurer.

## EFFECTIVE DATE OF INSURANCE UNDER THE LIFE INSURANCE BENEFIT

a) Current employees who were insured under the former life insurance benefit in force immediately prior to the effective date of this plan:

The insurance for such employees begins on the effective date of the contract, provided they were then actively at work, otherwise, on the date of their return to work.

b) Employees who become eligible after the effective date of this contract:

The insurance for such employees begins on the date they become eligible, provided they complete an application and send it to the insurer within sixty

(60) days of this date, and provided they were then actively at work, otherwise, on the date of their return to work.

If the application is completed and received by the insurer after this sixty (60) day period, the employee must provide, at his or her expense, satisfactory evidence of insurability. He or she is enrolled in the insurance on the first day of the month following receipt by the employer of the insurer's approval of the application if the said evidence was accepted within a period of thirty (30) days following receipt of the last evidence to be provided by the employee, provided he or she was then actively at work, otherwise, on the date of his or her return to work.

If the evidence of insurability is not accepted by the insurer within the said thirty (30) day period, the insurance will take effect on the date that corresponds to the first day of the month following a period of thirty (30) days following receipt of the last evidence to be provided by the employee, provided he or she was then actively at work, otherwise, on the date of his or her return to work, provided that the evidence of insurability is, in the end, accepted by the insurer.

c) The dependents' insurance takes effect on the latest of the following dates:

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

   ii) the date that corresponds to the first day of the month following the employer's receipt of the insurer's acceptance of the evidence of insurability with respect to the employee's dependents;

   iii) the date on which he or she becomes a dependent of the employee.

## EFFECTIVE DATE OF INSURANCE UNDER THE LONG-TERM DISABILITY INCOME INSURANCE BENEFIT

a) Current employees who were insured under the former long-term disability income insurance benefit in force immediately prior to the effective date of this plan:

   The insurance for such employees begins on the effective date of the plan, provided they were then actively at work, or actively at work on the last day they should normally have been at work, otherwise, on the date of their return to work.

b) Employees who become eligible after the effective date of the present plan:

   The insurance for such employees begins on the date on which they become eligible, provided they complete an application and send it to the insurer within sixty (60) days of this date, and provided they were then actively at work, otherwise, on the date of their return to work.

If the application is completed and received by the insurer after this sixty (60) day period, the employee must provide, at his or her expense, satisfactory evidence of insurability. He or she is enrolled in the insurance on the first day of the month following the employer's receipt of the insurer's approval of the application if the said evidence was accepted within a period of thirty (30) days following receipt of the last evidence to be provided by the employee, provided he or she was then actively at work, otherwise, on the date of his or her return to work.

If the evidence of insurability is not accepted by the insurer within the said thirty (30) day period, the insurance will take effect as of the date that corresponds to the first day of the month following a period of thirty (30) days following receipt of the last evidence to be provided by the employee, provided he or she was then actively at work, otherwise, on the date of his or her return to work, provided that the evidence of insurability is, in the end, accepted by the insurer.

## TERMINATION OF INSURANCE

### Health Insurance

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

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

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

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

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

### Other Benefits

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

    i) The termination date of this contract;

    ii) The date on which he or she ceases to participate in the Health Insurance benefit, unless he or she is exempted as provided in the PARTICIPATION IN HEALTH INSURANCE provision of the present plan;

    iii) The termination date of the benefit in question;

iv) Upon the death of the participant;

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

b) For the Life Insurance benefit, on the earlier of the following dates:

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

ii) On the participant's retirement date if he or she failed to submit a request to keep the insurance in force within the prescribed period.

c) For the Long-Term Disability Income Insurance benefit, the date on which the participant turns sixty-three (63), if he or she is not totally disabled.

d) Dependents: The insurance for all dependents terminates at midnight on the earliest of the following dates:

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

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

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

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

INTERRUPTION OF A PARTICIPANT'S INSURANCE

a) In the case of a temporary absence without pay as stipulated in the agreement, participation is suspended (with the exception of the Health Insurance benefit of the present plan, provided premiums continue to be paid) for the duration of the absence, and resumes automatically upon active return to work with pay. However, the participant may maintain his or her participation in all benefits in force by paying, via his or her employer, the total premium stipulated under the present plan in accordance with the situation that prevailed prior to the beginning of this temporary absence without pay.

b) In the case of a temporary absence with pay, participation remains in force for all benefits.

c) In the case where a participant is dismissed and the dismissal is contested by way of a grievance or arbitration under the labour law, the participant may maintain in force the insurance provided under the benefits in which he or she was participating in accordance with the situation prior to the date of

the contested dismissal, by paying, via the employer, the total premium stipulated in the plan, until judgment is made.

d) Participants who do not take advantage of the provisions under this clause enabling them to maintain the insurance in force from the beginning of their temporary absence without pay, cannot do so later during this absence.

e) If the insurance remains in force, a disability beginning during a temporary interruption in work is considered to have begun on the date on which the participant should normally return to work.

## BENEFITS

CLAIMS NOTICE

**Health Insurance:**

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

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

**Participant's Life Insurance, Participant's Additional Life Insurance, Dependents' Life Insurance, Long-Term Disability Income Insurance:**

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

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

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

Notwithstanding any provisions to the contrary, upon cancellation of the plan, any income disability claim must be submitted to the insurer within six (6) months of the onset of such disability. Any other claim must be submitted within ninety (90) days following cancellation of the plan.

## RIGHT OF RECOVERY

If the insured person can claim to a third party indemnities for loss entitling him or her to benefits payable under the present contract, the insurer is entitled to recover from any person, including the insured person, any insurer or any other organization, the benefit payments that the insured person would have received or been entitled to receive, subject however to the maximum amount of indemnities payable under the benefits of the present contract.

The insurer may ask the participant to sign the *Reimbursement Promise* and complete the *Supplementary Questionnaire*. If the participant fails to deliver to the insurer either of these documents, duly completed, within thirty (30) days of the request, the benefits payable under the present contract will only be paid to him or her when he or she has satisfied the stipulated requirements.

## MEDICAL EXAMINATION

The insurer has the right to require, as often as deemed necessary and at its own expense, a medical examination of any person for whom a claim is submitted and to obtain the report of any physician or any dentist having examined such person.

Failure on the part of an insured person to submit to such examination results in the loss of any right to benefits.

## BENEFIT PAYMENT

The insurer will pay the benefits according to the terms of the contract, within thirty (30) days following the receipt of the required satisfactory proof of claim. However, in the case of disability claims, the thirty (30) days commence from the expiry of the elimination period if such date is subsequent to submitting satisfactory proof of claim. Payments are made according to the terms and conditions of the contract with retroactive adjustments.

Disability income benefits payable to a participant incapable of managing his or her assets and giving receipt are paid to the guardian or curator. However, after a six (6) month period following the date the participant was declared unfit by a physician, the insurer will continue to pay the benefits provided the institution of a protective supervision is undertaken.

Upon your death, if the present benefit was chosen, the insurer undertakes to pay to the beneficiary the sum insured as indicated in the Summary of Benefits, based on the class to which you belong, and subject to the terms and conditions hereinafter specified.

## CONVERSION PRIVILEGE

If you have not attained age sixty-five (65) and your group coverage is cancelled due to termination of employment or of group membership, and not because of cancellation of this plan (subject, however, to any legal provision to this effect), you can, within thirty-one (31) days of such cancellation, convert all or part of your life insurance coverage into an individual life insurance contract of a type usually issued by the insurer, without having to provide evidence of insurability. You may choose one of the following types of insurance:

- permanent;
- term to age sixty-five (65);
- one-year (1) term convertible into permanent or term to age sixty-five (65) at the end of one (1) year.

In all cases, the face amount of the individual policy is the least of the following amounts, whether you be insured by more than one life insurance benefit, optional life insurance benefit or by more than one group insurance policy issued by the insurer:

a) The amount selected at the time of conversion;

b) The amount for which you were insured immediately prior to the termination of your insurance;

c) The difference between the amount for which you were insured immediately prior to the termination of your insurance, and the amount for which you are eligible under a new group life insurance contract;

d) Two hundred thousand dollars ($200,000).

When termination of eligibility for insurance is due to cancellation or modification of the group policy, only those participants insured for a continuous period of five (5) years may exercise this conversion privilege.

Such individual insurance policy shall not contain a disability clause, nor an accidental death and dismemberment clause, and the premium shall be based on

the insurer's rates in effect which apply to the plan and to the amount of such policy, according to your age and to the class of risk to which you belong.

The said 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 (1) term policy within thirty-one (31) days following the date of the termination of your insurance, and will take effect only at the expiration of that period.

Should you die during the period of thirty-one (31) days following the termination of your insurance, the insurer shall pay an amount equal to the convertible amount of insurance prior to the termination of your insurance.

WAIVER OF PREMIUMS

a) If you are under sixty-five (65) years of age and become disabled, you are eligible for waiver of premiums under this benefit, if you became disabled according to the definition of *Disability* of the present contract and fulfill the following conditions:

   i) You are less than sixty-five (65) years of age at the onset of disability;

   ii) You became disabled according to the definition of Disability in the GENERAL PROVISIONS, before the termination of employment and while insured under the present benefit;

   iii) You have been disabled for at least six (6) continuous months. Proof of disability must be satisfactory to the insurer and must be submitted within nine (9) months from the onset of disability, at no expense to the insurer.

   The amount of insurance for which waiver of premiums is granted will not be greater than that which was in force on your life at the onset of disability; this amount will be subject to reduction and termination as indicated in the Summary of Benefits, if applicable, as if you were actively at work.

b) Waiver of premiums begins on the day following a continuous period of six (6) months of disability.

c) If premiums are waived under this article, you must provide the insurer with proof of disability, as often as the insurer may reasonably require. Such proof is to be provided at no expense to the insurer.

d) The waiver of premiums terminates on the earliest of the following dates:

   i) The date on which you cease to be disabled;

   ii) The date on which you fail to submit to an examination by the physician designated by the insurer;

iii) The date on which you retire or reach the normal retirement age under the employer's pension plan, but never beyond the normal retirement age indicated in the Summary of Benefits of the present plan;

iv) The date on which you reach age sixty-five (65);

v) The date on which you fail to provide any proof of disability required by the insurer.

# PARTICIPANT'S ADDITIONAL LIFE INSURANCE

You may obtain an amount of additional life insurance if you so request and furnish evidence of insurability satisfactory to the insurer.

If you wish to submit an application for participation in the present benefit, you should have the maximum amount of insurance with evidence of insurability from the PARTICIPANT'S LIFE INSURANCE BENEFIT of the present plan.

The sum insured under this benefit is indicated in the Schedule of Benefits, according to the class to which you belong and the amount of coverage chosen.

The insurer undertakes to pay to the beneficiary the sum insured at the time of death, subject to the terms and conditions hereinafter specified.

## EXCLUSION

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

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

a) the additional life insurance is reinstated;

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

## WAIVER OF PREMIUMS

If premiums are waived under the article *Waiver of Premiums* of your life insurance benefit, you are also entitled to waiver of premiums for the present benefit, under the same conditions.

## SPECIAL PROVISIONS

Any other provisions of the PARTICIPANT'S LIFE INSURANCE benefit forms an integral part of the present benefit.

# DEPENDENT'S LIFE INSURANCE

Upon the death of an insured dependent, if the present benefit was chosen, the insurer undertakes to pay to the participant the benefits specified herein, subject to the terms and conditions hereinafter specified.

The sum insured under this benefit, based on the class to which you belong, is shown in the Summary of Benefits.

## WAIVER OF PREMIUMS

If premiums are waived under the article *Waiver of Premiums* of your life insurance benefit, you are also entitled to waiver of premiums for the present benefit, under the same conditions.

Moreover, if you are not covered under the LIFE INSURANCE BENEFIT, you are entitled to waiver of premiums for the present benefit, subject however to all other provisions described under *Waiver of Premiums* of the LIFE INSURANCE BENEFIT.

If you become disabled due to illness or accidental injury and if the present benefit was chosen, the insurer undertakes to pay you the monthly indemnity specified herein for each month or part of a month (one-thirtieth (1/30) of the monthly indemnity for each day) during which the disability lasts, subject to the terms and conditions hereinafter specified.

PARTICULARS

**Beginning of Benefits**

Payment of monthly indemnity begins following expiry of the elimination period specified in the Summary of Benefits.

**Amount of Benefits**

The amount of monthly indemnity payable under this benefit is determined according to a formula set forth in the Summary of Benefits and may not exceed the monthly maximum amount therein specified.

**Reduction of Benefits**

The monthly indemnity payable under this benefit will be reduced, after the application of the monthly maximum indicated in the Summary of Benefits, by:

a) any remuneration received from the employer;

b) the net initial monthly amount of any disability benefit payable in relation to the disability in question by the employer's pension plan.

Moreover, when the aforementioned disability benefits and the gross initial monthly amount of any disability benefits that are payable or which would have been payable had you made a satisfactory application under:

a) the Québec or Canada Pension Plan, excluding benefits payable on behalf of dependent children;

b) a workers' compensation act;

c) a provincial automobile insurance law;

d) a provincial crime victims compensation act;

e) any other provincial labour legislation of your province of residence

exceed the OVERALL MAXIMUM, as defined in the Summary of Benefits, the amount of the disability benefit payable by the insurer is then adjusted so as to not exceed the maximum.

Future cost of living adjustments made to amounts received from any of the above-mentioned sources will not bring about further reductions.

**Termination of Benefits**

The monthly indemnity ceases on the earliest of the following dates:

a) The date on which you cease to be disabled;

b) The date on which you reach the age of sixty-five (65);

c) The date on which you retire or reach the normal retirement age under the employer's pension plan, but never beyond the normal retirement age indicated in the Summary of Benefits of the present plan;

d) The date of your death;

e) The date on which you fail to submit to an examination by the physician designated by the insurer within thirty-one (31) days of written request by the latter;

f) The date on which you fail to provide any evidence of disability required by the insurer within thirty-one (31) days of written request by the latter;

g) The date on which you refuse to participate in a rehabilitation program or to engage in rehabilitation employment which the insurer and its consulting physicians deem reasonably appropriate.

SUCCESSIVE PERIODS OF DISABILITY

If you return to active work and again become disabled while the coverage is in force, within the period equivalent to a disability period as described in the GENERAL PROVISIONS, and if such disability results from the same cause as the previous disability or from related causes, this is considered to be a continuation of the previous disability.

However, if you return to active work and again become disabled while the coverage is in force, due to an illness or accidental injury totally unrelated to the previous cause of disability, the disability is considered to be a new disability and a new elimination period will apply.

## EXCLUSIONS AND LIMITATIONS

a) The benefit specified herein does not cover any disability:

i) during which you are not under the regular and continuous care of a physician or a specialist, except in the case of a stationary state recognized by a physician or a specialist, to the insurer's satisfaction;

ii) resulting from committing or attempting to commit a criminal act, active participation in a riot or insurrection, or intentionally self-inflicted injuries, whether you were conscious or not of your actions;

iii) resulting from esthetic treatments;

iv) resulting from alcoholism or drug addiction, unless you are receiving medical treatment or care in view of rehabilitation, to the insurer's satisfaction;

v) resulting directly or indirectly from a war (whether war be declared or not), or a civil war;

vi) during which you are entitled to indemnities or benefits, related or not to your disability, under the Employment Insurance Act;

vii) during which you were performing a gainful occupation, unless it is rehabilitation employment;

viii) resulting from a flight or attempted flight on board an airplane or other aircraft if you are part of the crew or perform any function relating to the flight, or participate in the flight as a parachutist;

b) If you are out of Canada and the United States for a period of ninety (90) consecutive days or more, you will no longer be entitled to the indemnity under the present benefit and such entitlement will be restored only upon your return, subject to all other provisions of the present benefit.

c) The insurance provided herewith does not cover any disability resulting from an illness or accidental injury which occurs during a strike, lock-out or temporary layoff, if your benefit is not kept in force during the strike, lock-out or temporary layoff.

However, if your benefit is kept in force, the elimination period of the disability income benefit begins on the date you would have returned to work.

## WAIVER OF PREMIUMS

If premiums are waived under the article *Waiver of Premiums* of your life insurance benefit, you are also entitled to waiver of premiums for the present benefit, under the same conditions.

Moreover, if you are not covered under the LIFE INSURANCE BENEFIT, you are entitled to waiver of premiums for the present benefit, subject however to all other provisions described under *Waiver of Premiums* of the LIFE INSURANCE BENEFIT.

## REHABILITATION PROGRAM

If, on the prescription and under the supervision of your physician, you register for a rehabilitation program approved by the insurer, you are eligible to receive the indemnity payable under this benefit, in addition to receiving the remuneration payable under this rehabilitation program.

However, the sum of the remuneration payable under the rehabilitation program and the monthly indemnity under this benefit must not exceed the monthly salary you were being paid at the onset of disability. If this sum exceeds one hundred per cent (100%) of the net monthly salary determined at the onset of disability, the income payable under this benefit will be reduced so as not to exceed this salary.

## INDEXATION

The initial amount of the indemnity provided herein is adjusted on the first day of January of each year to the cost of living index determined on October 31 of the previous year, in accordance with the terms and conditions with respect to cost of living adjustments used by the Québec Pension Plan, without, however, exceeding the MAXIMUM ANNUAL INDEXATION RATE in the Summary of Benefits. The first adjustment is made on the first day of January following the start of the indemnity payments.

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

**Québec residents:**

Moreover, the insurer undertakes to reimburse coverage provided under the BASIC PRESCRIPTION DRUG INSURANCE PLAN of Québec, for participants aged less than sixty-five (65), as well as their dependents, regardless of their age or of the risk associated with their health.

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

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

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

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

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

SPECIAL DEFINITIONS

**Hospital**: Hospital means an institution

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

b) intended for the care of bedridden patients; and

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

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

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

a) legally acknowledged as such; and

b) intended for the care of bedridden patients.

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

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

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

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

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

## HOSPITALIZATION IN CANADA

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

## EMERGENCY EXPENSES OUTSIDE THE PROVINCE OF RESIDENCE

The insurer reimburses hospitalization, medical and surgical expenses outside the province of residence of the insured person, in case of emergency, for that part of eligible expenses that exceeds the amount paid by a provincial health insurance plan whose coverage is compulsory for all insured persons.

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

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

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

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

## MEDICAL EXPENSES IN CANADA

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

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

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

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

   ii) Licensed ambulance service by air, road or train for emergency transportation to the nearest hospital equipped to provide the required treatment, or for transportation therefrom, when the physical condition of the insured person precludes the use of any other means of transportation;

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

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

   v) Drugs or medicine which can be obtained with a written prescription only, and which have a valid DIN (*Drug Identification Number*). Certain drugs and medication "over the counter", which are not accessible to the public and are directly controlled by the pharmacist

(cardiotropic drugs, bronchial dilators, insulin and diabetes tests), are also covered under the same terms and conditions.

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

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

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

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

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

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

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

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

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

xiii) Cost of laboratory analyses, electrocardiograms, electroencepha-lograms, nuchal scans, prenatal screening tests, radiation treat-ments, gastrointestinal diagnostic treatments and x-rays, performed in a commercial establishment or a private clinic, up to the maximum indicated in the Summary of Benefits;

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

- xv) Purchase or rental of crutches, as previously approved by the insurer, and purchase of hernial belts, corsets, splints and casts;
- xvi) Purchase of wigs and hairpieces following chemotherapy, up to the maximum indicated in the Summary of Benefits;
- xvii) Fees for sclerosing injections that are medically necessary, up to the maximum indicated in the Summary of Benefits.
- xviii) Purchase of a blood glucose monitor for insured persons with diabetes who have an insulin-dependent medical condition;
- xix) The daily cost of room and board in a recognized clinic, located in Canada or the United States, specializing in rehabilitation for alcoholism and other drug addiction where the patient actually receives curative treatment, up to the maximums indicated in the Summary of Benefits. The clinic must be run by a physician and under the constant supervision of a registered nurse. This benefit applies only to the participant;
- xx) Purchase of blood and blood plasma.

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

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

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

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

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

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

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

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

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

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

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

EXCLUSIONS AND REDUCTIONS

a) This benefit does not cover:

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

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

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

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

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

  vi) Eye examination;

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

  viii) Purchase of food or nutritional supplements;

ix) The following products or drugs are not covered:

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

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

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

xii) Care or treatments related to fertility or infertility;

xiii) Expenses incurred for problems related to erectile dysfunction.

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

CALCULATION OF REIMBURSEMENT

**Deductible**

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

**Carry-over Provision**

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

**Reimbursement**

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

**Maximum Benefit Per Insured Person**

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

**Coordination of Benefits**

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

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

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

c) any non-insured employee benefit plan.

CONVERSION PRIVILEGE

If you have not attained age sixty-five (65), you may, without having to provide evidence of insurability, obtain health insurance coverage under a separate plan in accordance with the rates and conditions determined by the insurer and then in effect for this type of coverage, provided that written request is sent to the insurer's head office, or to a designated regional office, within thirty-one (31) days of termination of your eligibility under this coverage.

WAIVER OF PREMIUMS

If premiums are waived under the article *Waiver of Premiums* of your life insurance benefit, you are also entitled to waiver of premiums for the present benefit, under the same conditions.

Moreover, if you are not covered under the LIFE INSURANCE BENEFIT, you are entitled to waiver of premiums for the present benefit, subject however to all other provisions described under *Waiver of Premiums* of the LIFE INSURANCE BENEFIT.

Waiver of premiums of the present benefit terminates automatically on the date of termination of the present benefit.

# MEDICAL ASSISTANCE OUTSIDE CANADA

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

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

Dependents of a part-time teacher insured for the medication part of the HEALTH INSURANCE benefit of the present plan are not insured under the present benefit.

## SPECIAL DEFINITIONS

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

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

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

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

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

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

b) provides care to bedridden patients;

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

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

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

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

MEDICAL ASSISTANCE

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

i) Twenty-four (24) Hour Access

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

ii) Medical Care

The Medical Assistance Service will:

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

iii) Medical Transportation

The Medical Assistance Service will:

- Arrange for transportation or transfer of the insured person by any appropriate means recommended by the attending physician, which the Medical Assistance Service agrees to, to a hospital near the scene of the accident or illness, if required by the medical emergency.
- Organize the return of the insured person to his or her residence or to a hospital near his or her residence after initial medical care has been provided, by an appropriate means of transportation, provided that the return is medically necessary and permissible. The Medical Assistance Service arranges for the insured person's return using the most appropriate means of transportation: air ambulance, helicopter, commercial airline, train or ambulance.
- The expenses incurred for transporting or transferring the insured person as described in the two previous paragraphs will be paid by the insurer.

iv) Payment of Medical Expenses and Cash Advance

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

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

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

v) Return of Deceased

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

vi) Return of Dependent Children

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

vii) Return of a Family Member

- The Medical Assistance Service will organize the return of a family member who has lost the use of his or her airplane ticket due to the insured person's hospitalization or death. The Medical Assistance Service will make the arrangements to provide economy transportation for a family member to his or her usual place of residence in Canada. If the return tickets

are still valid, only the additional cost for return transportation will be paid, after deducting the value of the tickets.

viii) Visit from a Family Member

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

ix) Meals and Accommodation

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

x) Vehicle Return

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

xi) Cash Advances

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

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

i) Telephone Interpretation Service

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

ii) Messages

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

iii) Legal Assistance

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

iv) Travel Information

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

v) Emergency Medication

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

vi) Lost Baggage or Documents

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

EXCLUSIONS

This benefit does not cover:

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

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

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

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

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

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

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

PROVISIONS

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

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

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

LIABILITY

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

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

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

# PROTECTING PERSONAL INFORMATION

Industrial Alliance 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. Industrial Alliance recognizes and respects a person's right to privacy concerning his or her personal information.

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

Access to the file will be limited to Industrial Alliance 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 Industrial Alliance 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 Industrial Alliance has medical information about the participant which was not obtained directly from the participant, Industrial Alliance 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 Industrial Alliance Group, 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