SOCIAL SECURITY PLAN

for the employees of

L'INDUSTRIE DE LA SERRURERIE ET LA MENUISERIE MÉTALLIQUE DE LA RÉGION DE MONTRÉAL

All Active Employees

SOCIAL SECURITY PLAN

for

Employees

of

L'INDUSTRIE DE LA SERRURERIE ET LA MENUISERIE MÉTALLIQUE DE LA RÉGION DE MONTRÉAL

Contract No : 552 – C

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.

GROUP INSURANCE

Social Security Plan
for Employees of

L'INDUSTRIE DE LA SERRURERIE ET LA MENUISERIE MÉTALLIQUE DE LA RÉGION DE MONTRÉAL

Drawn up in accordance with decree 790
and amendments

FOR INFORMATION

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SUMMARY OF BENEFITS

The Summary of Benefits briefly describes your group insurance plan coverage, based on the category of employees you belong to. To obtain a complete description of the coverage, please consult the pages that outline the specific coverage.

YOUR PERSONAL COVERAGE

ALL ACTIVE EMPLOYEES

Participant's Life Insurance

Sum insured: $20,000

This benefit ceases on the date of your retirement.

Life Insurance for your Dependents

Sum insured

Spouse: $5,000

Each child aged

- less than 24 hours: None
- 24 hours and more: $2,500

This coverage ceases on the date of your retirement.

Short-Term Disability Insurance

60% of your weekly salary paid by the employer, not exceeding 40 hours per week.

Weekly maximum:
The amount payable is limited to the amount payable under the Employment Insurance Act, subject to a minimum benefit of $70.

Waiting period

Accident:	0 day
Hospitalization [(1)]:	0 day
Illness:	7 consecutive calendar days

[(1)] **Day surgery**: Waiting period for hospitalization also applies to a patient admitted for day surgery, regardless of the length of the stay. Surgery must be subsequent to an accident or illness, and must be medically required. However, the waiting period does not apply in the case of a patient registered in an outpatient clinic or the emergency ward.

Maximum benefit period:

42 weeks (If the participant receives payments from Employment Insurance, the Maximum Benefit Payment Period will be reduced accordingly by the number of weeks of payments from Employment Insurance).

The Short-Term Disability insurance benefit will not be payable for any period during which the participant is receiving Employment Insurance sickness benefits.

The benefits are not taxable and are payable on a calendar day basis.

This coverage terminates on the date of your retirement.

Long-Term Disability Insurance

60% of the basic monthly salary, the result being rounded to the next dollar.

Monthly maximum: $2,000, subject to applicable reductions.

However, the overall maximum must not exceed 85% of the net monthly salary determined at the onset of disability.

Elimination Period:	42 weeks Payment of benefits begins after the termination of the maximum benefit period provided under the Short-term Disability Income Insurance, if applicable.
Maximum Benefit Period:	To the participant's 65th birthday

Benefits are non taxable.

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

Prescription Drug Insurance
applicable to Quebec residents only
(eligible drugs as per the list of
the *Régie de l'assurance-maladie du Québec)*

Maximum contribution for the participant and spouse during the calendar year:

As stated under the Act respecting prescription drug insurance (R.S.Q., chapter A-29.01).

The participant's maximum contribution will include any amounts paid as a deductible and/or coinsurance for a dependent child.

Deductible:

As stated under the Supplemental Health Insurance benefit, subject to any maximum stated under the Act respecting prescription drug insurance.

Reimbursement by the insurer:

As stated under the Supplemental Health Insurance benefit. However, if the level of reimbursement is less than that provided by the Act respecting prescription drug insurance, the reimbursement level will be as per the minimum reimbursement level allowed.

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

Termination:

This benefit terminates on your 65th birthday or the date of your retirement, if earlier, subject to the Special Provision For Insured Persons Age 65 and Over included under this benefit.

Supplemental Health Insurance
for you and your dependents

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: $1,000,000 per 3 consecutive calendar years

ALL OTHER MEDICAL EXPENSES INCURRED IN CANADA	
Deductible:	None
Reimbursement:	70%
Maximum:	Unlimited

This coverage ends on the date of your retirement.

Supplemental Health Insurance
for you and your dependents

Medical Expenses

Eligible expenses	Maximum payable	
Fees for nursing care	$10,000	per calendar year.
External breast prostheses		2 per calendar year.
Surgical bras		2 per calendar year.
Capillary prostheses	$250	per lifetime.
Sclerosing injections	$20	per visit.
Hearing aids	$350	per period of 5 years.
Glucometer or reflectometer		1 device per period of 5 years.
Fees for an audiologist and a speech therapist	$700	per calendar year for both types of specialists combined One treatment per day.
Fees for a physiotherapist (including a physical rehabilitation therapist), a chiropractor, a podiatrist, a naturopath or a massotherapist	$700	per calendar year, per specialist. One treatment per day.
Fees for a psychologist and a psychotherapist	$700	per calendar year, combined. One treatment per day.
X-rays by a chiropractor	$50	per calendar year.
Convalescent home or clinic		Semi-private room. Maximum of 60 days per calendar year.
Surgical compression hose		2 pairs per calendar year.

Supplemental Health Insurance
for you and your dependents (cont'd)

Medical Expenses (cont'd)

Eligible expenses	Maximum payable
Diagnostic laboratory and x-ray procedure fees	$700 per calendar year.
Orthopedic shoes (including ortheses and alterations)	70% of the cost.
Drug addiction or alcoholism treatment centre	$80 per day. Maximum of $2,500 per calendar year.
Eye glasses or contact lenses:	
• under 18 years of age	$250 per period of 12 consecutive months;
• 18 years of age and over	$250 per period of 24 consecutive months. **These expenses are not subject to the deductible and are reimbursed at 100%.**
Eye examinations (18-64 years of age)	One examination per period of 24 consecutive months. **These expenses are not subject to the deductible and are reimbursed at 100%.**

Dental Care for you and your dependents

Deductible	
– Individual coverage:	$50
– Family coverage:	$50
Reimbursement	
• Preventive and Curative treatments:	80%
• Major treatments:	50%
Annual maximum amount for Preventive, Curative and Major treatments:	$1,000 per insured person, per calendar year

Expenses are reimbursed according to the Dental Surgeons Association's Fee Guide for the current year or, if applicable, the Dental Hygienists Association's Fee Guide for the current year, subject to any limits which are stated under the Dental Care Insurance benefit. If there is no fee guide for the reference year, the insurer will determine the level of dental expenses to be reimbursed according to the latest fee guide plus an inflationary adjustment.

This coverage ends on the date of your retirement.

ELIGIBILITY

Employees subject to the decree

These employees are eligible on the first day of the month that follows the month during which they have completed the number of contibutory work hours subject to decree no. 790 required in order to become insured, in accordance with the procedures adopted by the Joint Committee.

Each employee subject to the decree is not entitled to the benefits until his or her employer has made a report to the Joint Committee detailing all the hours worked by the employee and remitted the employer's own contributions as well as those deducted from the employee's salary to the Joint Committee. Should it be otherwise, the Joint Committee will study any claim upon its merit and will make its decisions based on justice and equity.

Employees not subject to the decree

The first day of the month following the date the Committee has received 12 weekly contributions.

REQUEST FOR INSURANCE

To request insurance, you must complete a participation request for you and your dependents, if applicable. The request form is available from your employer.

REQUIRED INFORMATION

All employees, subject to the decree or not, must obtain an information card from their employer or their union. The card must be completed and sent to the insurer.

You must inform the insurer of any changes, including marital status.

BENEFICIARY

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

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

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

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

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

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.

DEPENDENTS

The participant's spouse and the participant's children or the children of the participant's spouse residing in Canada. When insurance covers dependents, "spouse" and "child" are defined as follows:

a) Spouse

The person who is married to or is in a civil union with the participant, or the person designated by the participant, whom he declares publicly to

be his spouse and with whom he has been living on a permanent basis for at least one year, or less, if a child is born from their union.

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

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

b) Child

An unmarried child of the participant or 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 under 26 years of age and is attending a recognized educational institution on a full-time basis; or

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

CONTRIBUTIONS

Each employee subject to decree no. 790 is required to contribute the amount established by the decree and modified by regulation from time to time for each hour worked. Each employer is required to contribute the amount established by the decree and modified by regulation from time to time for each hour worked, for each employee subject to decree no. 790. The employees' contributions are deducted from their salaries by the employer and, along with the employer's contributions, are remitted to the Building Materials Joint Committee.

For permanent and regular employees not subject to the decree working for employers subject to and participating in the plan, the employers and employees will contribute each week an amount established and published by the Committee, based on the contributions for employees subject to the decree, multiplied by 40 hours per week, plus administration charges established by the Committee.

These contributions are used to pay the premiums due under the insurance contract in order to supply benefits payable under the plan and cover the administration costs.

ADMINISTRATION

The Building Materials Joint Committee collects the employer and employee contributions and is also required by law to collect sales taxes on contributions and remit it to the appropriate government organizations.

A social security sub-committee made up of an equal number of employers and employees has been named by the Building Materials Joint Committee to administer the plan.

CONTINUATION AND TERMINATION OF INSURANCE

Employees subject to the decree

Each employee will receive a credit of one hour for each hour worked from which contributions are made to the Social Security Plan.

At the end of the month, insurance hours are deducted from each employee's credits, based on the number of hours established and published by the Committee under the decree and modified as required in accordance with the costs of the Social Security Plan.

Each employee remains insured as long as he or she works the minimum number of hours required to remain insured, in accordance with the table published by the Committee. However, if during a month, an employee does not meet this minimum, his or her insurance will terminate at the end of such month, unless the employee has the minimum number of hours required to remain insured to his or her credit at the end of such month, in accordance with the table published by the Committee. In this case, the employee remains insured for the period indicated in this table, based on the number of hours of work to his or her credit.

An employee's credit is equal to the total of accumulated hours of contributory work less the hours required according to the table published by the Committee in order to keep the employee's insurance in force for each month during which the employee is covered under the plan.

Employees subject to the decree or not

a) Voluntary extension of insurance

When an employee's insurance terminates, the employee has the right to extend the insurance, except disability insurance, for the period of

6 months, including a maximum of 3 months coming from the hour bank, as long as:

i) the employee is insured under this contract when he or she requests the insurance extension;

ii) the monthly premium is paid to the insurer for each month of insurance.

b) Extension of insurance without premium payment

In addition, if the employee is receiving disability benefits in accordance with this contract, or disability benefits under the Workers' Compensation Act, the Employment Insurance Act or any provincial automobile insurance act, his or her insurance remains in force for as long as the employee receives these benefits, without exceeding 104 weeks. The payment of premiums is suspended during the period the employee is receiving either one of the above-mentioned benefits.

CLAIMS

When an employee or a dependent is entitled to present a claim in accordance with the plan, the employee must complete a claim form available from his or her employer, union or the Administrator at the address indicated on the front page of this document. The employee must also ask the attending physician to complete the appropriate section of the form. In the case of a disability claim, the employee must also obtain a certificate from his or her employer. The claimant should attach all receipts and bills to the claim form and certificate, if applicable, and send or deliver these documents to the insurer.

INDIVIDUAL CERTIFICATE

The policyholder issues individual certificates of participation to be delivered to each participant.

This certificate does not guaranty any contractual right and, in case of conflict, the contract provisions prevail.

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.

CLAIMS NOTICE AND TIME LIMITS

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

  The insurer must be notified of any claim for Supplemental Health or Dental Care insurance within 15 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, if the group policy terminates, a claim for Supplemental Health or Dental Care insurance must be submitted to the insurer within 90 days following the termination date of the policy.

- **Other Benefits:**

  Any other claim must be submitted on forms provided for that purpose by the insurer within the 31 days immediately following the date of the event which gives entitlement to benefits.

Satisfactory written proof must be provided to the insurer within 90 days immediately following the date benefits became payable. However, 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.

Any claim submitted after the 90 period and while the plan is in force limits the insurer's responsibility to the 90 period preceding the date that any written request was received.

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

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

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

The insurer retains the right to audit all claims at any stage, including after payment has been made, for fraud or misrepresentation. If the insurer

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

SUBROGATION

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

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

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

In the event that the participant or dependent fails to reimburse the insurer in accordance with the group policy, no future benefits will be paid by the insurer until such time as the insurer recovers (a) the total amount of benefits paid to the participant or dependent; and (b) an amount that reasonably reflects, as

determined by the insurer, the total amount or value of any future benefits payable to the participant or the dependent. The insurer's recovery in this regard shall not exceed the participant or dependent's gross damages or settlement recovered. The insurer shall also have the right to seek recovery directly from the participant or dependent in the event that any overpayment has resulted from the lack of reimbursement.

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

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

LIMITATION ON LEGAL ACTIONS

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

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

SUM INSURED

Upon your death, the sum insured indicated in the Summary of Benefits is paid to your beneficiary.

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.

EXTENSION OF LIFE INSURANCE WITHOUT PREMIUM PAYMENT

If you cease to work and are under 65 years of age, your life insurance is extended without premium payment up to the 31st day following the date you left.

WAIVER OF PREMIUMS

If you become disabled, you are eligible for a waiver of premiums under this benefit if you meet the following conditions:

a) you are under 65 years of age when the disability started;

b) you became disabled before terminating your employment and while insured under this contract;

c) you were disabled for at least 6 months when you presented your proof of disability; this proof must be deemed satisfactory by the insurer and must be given to the insurer within 9 months of the start of the disability. The insurer is not responsible for any expenses related to providing this proof.

DEPENDENTS' LIFE INSURANCE

SUM INSURED

The sum insured that you will receive upon the death of an insured dependent is indicated in the Summary of Benefits.

WAIVER OF PREMIUMS

As long as you are eligible to have your premiums waived under your life insurance coverage, you are also exempt from the payment of premiums for this coverage, under the same conditions.

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 Dependents' Life Insurance benefit provided by the policyholder for at least 5 years,

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

A spouse whose life insurance 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.

SHORT-TERM DISABILITY INSURANCE

PURPOSE OF THE COVERAGE

If, as a result of illness or accidental injury, you are unable to perform all the functions of your regular employment, the weekly benefit indicated in the Summary of Benefits will be paid to you after the waiting period has expired, provided that you do not receive any remuneration arising directly or indirectly from any employment and that you require regular and satisfactory care given by a physician.

Also, if you are undergoing treatment for alcoholism or drug addiction, the benefits will be paid for the length of the stay, in accordance with the clauses provided for an absence due to illness and from the first week of absence if you complete the recommended treatment.

PARTICULARS

Beginning of Benefits

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

Amount of Benefits

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

Termination of the Benefit

Weekly disability benefits cease at the earliest of the following dates:

a) the date on which the maximum benefit period specified in the Summary of Benefits is completed;

b) the date on which you cease to be disabled;

c) the date on which you attain the age of termination indicated in the Summary of Benefits;

d) the date on which you take your retirement;

e) upon your death;

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

g) the date on which you fail to provide proof required by the insurer;

h) the date on which you begin paid employment.

SUCCESSIVE PERIODS OF DISABILITY

If you have returned to active work and become disabled again within a 15-day period and if such disability results from the same cause or related causes as the previous disability, the disability is considered to be a continuation of the previous disability, providing you are not entitled to monthly disability benefits.

However, if you have returned to active work and become disabled while 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 REDUCTIONS

a) No weekly benefits will be payable for any accidental injury or illness for which benefits are payable or would have been payable had a satisfactory application been made under any workers' compensation act or similar law.

b) Weekly benefits will be reduced by any benefit payable under the Crime Victims Compensation Act, the Québec Automobile Insurance Act or any other similar legislation or public plan, and by 85% of any benefit payable by the Régie des rentes du Québec or by the Canada Pension Plan, without taking into account any subsequent adjustments made by such public plans.

c) No weekly benefit is payable:

   i) during any period during which the Participant is receiving Employment Insurance sickness benefits;

   ii) during any leave taken in accordance with provincial or federal legislation or during any leave taken in agreement with the employer;

iii) during any extension of such a leave, if you were entitled to and requested such extension.

However, if your insurance is kept in force during such a leave, the elimination period of the disability income benefit begins on the date you would have returned to work should you have been actively at work.

d) The insurance does not cover any disability resulting from one of the following causes:

i) any injury or illness resulting from civil unrest, insurrection or war, whether war be declared or not, or participation in a riot;

ii) self-inflicted injury unless medical evidence establishes that the injury was directly related to a mental health illness;

iii) cessation of work to receive care which is not medically required or which is given for cosmetic purposes, unless such care is for an illness or an accidental injury;

iv) injury or illness resulting from committing, attempting to commit, or provoking an assault or criminal offence.

e) If the disability occurs during a temporary lay-off, strike, lock-out or annual holiday paid by your employer and while this coverage was in effect, the waiting period begins on the date you would normally have returned to work.

LONG-TERM DISABILITY INSURANCE

PURPOSE OF THE COVERAGE

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

SPECIAL DEFINITION

Disability

A state of complete and continuous incapacity, resulting from illness or accidental injury, which wholly prevents the participant from performing:

a) Each and every task of his regular employment during the elimination period and during the 24 months immediately following this period, regardless of the availability of such occupation; and

b) Afterwards, any remunerated function or work for which he is reasonably qualified by training, education or experience, regardless of the availability of such occupation.

Disability will only be recognized if the participant receives no remuneration arising either directly or indirectly from any employment, except under a rehabilitation program approved by the insurer.

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 in accordance with 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 any disability benefits which are payable to you or

which would have been payable to you had a satisfactory application been made 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.

Moreover, the amount of monthly disability income benefits payable by the insurer is adjusted so that the sum of all income, compensation, indemnity and benefits which you would or could receive, due to your disability, from: (a) the policyholder, (b) any government body, and (c) under any group insurance or pension plan to which the policyholder contributes, may at no time exceed the OVERALL MAXIMUM, as defined in the Summary of Benefits.

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

However, if benefits payable under the present benefit are taxable, they will be calculated as follows:

1° the indemnity payable by the insurer,

2° less the federal and provincial taxes applicable, according to the participant's personal exemption,

3° less the indemnity payable by the government plan.

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

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

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

c) The date on which you reach the age of 65;

d) 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;

e) The date of your death;

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

g) The date on which you fail to provide any evidence of disability required by the insurer;

h) 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;

i) The date on which you engage in a remunerative occupation, unless it is rehabilitation employment;

j) The date on which you are incarcerated after committing a criminal offence for which you were found guilty.

SUCCESSIVE PERIODS OF DISABILITY

If you have returned to active work again and become disabled while the coverage is in force, within 6 consecutive months of the first disability 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. During the elimination period, successive periods of disability from a single cause separated by 15 days or less will be considered as the same period.

However, if you have returned to active work again and 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 resulting from one of the following causes:

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

   ii) Self-inflicted injury unless medical evidence establishes that the injury was directly related to a mental health illness;

   iii) 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;

   iv) Injury or illness resulting from committing, attempting to commit, or provoking an assault or criminal offence.

b) A monthly indemnity is not payable for any illness or accidental injury:

i) During any leave taken in accordance with provincial or federal legislation or during any leave taken by agreement with the employer;

ii) During any extension of such a leave, if you were entitled to and requested such extension.

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

c) If disability results from drug addiction or alcoholism, the monthly disability benefits will be payable provided that you follow a closed treatment program approved by the insurer.

d) If you are out of Canada and the United States for a period of more than 90 consecutive days, 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.

e) 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 the 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 your 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.

REHABILITATION PROGRAM

If you were disabled for at least the elimination period and, on the prescription and under the supervision of your physician, register for a rehabilitation program approved by the insurer, you are eligible to receive the indemnity payable under this benefit for a maximum period of 24 months 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 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.

PRESCRIPTION DRUG INSURANCE

Applicable to Quebec Residents Only

The insurer undertakes to reimburse the expense of prescription drugs which are listed under the Basic Prescription Drug Insurance Plan of Quebec, for each insured person who is a resident of Quebec and who is registered with the *Régie de l'assurance-maladie du Quebec* (hereafter referred to as the "Board"), regardless of the insured person's state of health.

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

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

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

DEFINITIONS

As used in this benefit:

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

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

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

Maximum contribution: The maximum contribution is the total amount paid by the insured person beyond which the cost of the covered expenses which

are eligible as per the list under the Basic Prescription Drug Insurance Plan of Quebec is covered 100% by the insurer.

SPECIAL PROVISION FOR INSURED PERSONS AGE 65 AND OVER

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

For the purpose of the group policy, insured persons age 65 and over will be presumed to be covered with the Board for the Basic Prescription Drug Insurance Plan of Quebec. In addition, dependents of a participant who is 65 years of age or over will be presumed to be covered with the Board for the Basic Prescription Drug Plan of Quebec, regardless of age.

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

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

COVERED EXPENSES

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

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

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

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

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

Dispensing Quantity Limitations

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

EXCLUSION

None, except if provided by the Act respecting prescription drug insurance or one of its regulations.

CO-ORDINATION OF BENEFITS

Will be as provided for under the Co-ordination of Benefits provision of the Supplemental Health Insurance benefit.

SUPPLEMENTAL HEALTH INSURANCE

PURPOSE OF THE COVERAGE

If, as a result of sickness, accidental injury or pregnancy, you or one of your insured dependents incur expenses for care and services described hereafter, the insurer will reimburse the covered expenses, subject to the terms and conditions specified hereinafter.

SPECIAL DEFINITIONS

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

Hospital: Hospital means an institution providing care of short duration

a) legally acknowledged as such;

b) intended for the care of bedridden patients; and

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

Units set aside for convalescent or chronic care purposes in hospitals are excluded.

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.

Original or generic drug: If mention is made of these two types of drugs, the *original* drug refers to the drug that was first developed and launched in the marketplace. The *generic* drug refers to any reproduction of the original drug.

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

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, and orthopedic appliances, excluding stethoscopes and sphygmomanometers.

HOSPITALIZATION IN THE PROVINCE OF RESIDENCE

The insurer reimburses that part of hospital expenses incurred in the province of residence which exceeds the amount reimbursed by government plans, up to the daily maximum specified in the Summary of Benefits, and without any limit as to the number of days of hospitalization.

EMERGENCY MEDICAL 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 for the services and supplies listed herein will be covered, up to the maximum amount reimbursed by the insurer, per insured, per 3 consecutive calendar-year period, as specified in the Summary of Benefits for expenses incurred outside the province of residence, when they are incurred as a result of a medical emergency which occurs during an insured person's absence from his province of residence provided:

a) the medical emergency occurs during the first 90 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;

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

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

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

a) Services of a physician;

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

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

d) Diagnostic, medical imaging and laboratory services;

e) Paramedical services provided during a hospital confinement;

f) Hospital out-patient services and supplies;

g) Drugs;

h) Medical appliances and supplies provided out of hospital;

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

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

Limitations For Emergency Medical Expenses Incurred Outside The Province Of Residence

If the insured person should become hospitalized outside 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 endan-

gering 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.

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

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) Expenses incurred for emergency ambulance transportation, including by airplane or train, to the nearest hospital able to provide the necessary treatment and the return transportation by ambulance when necessary.

   ii) Services rendered at the insured's home by a registered who is no relation to the insured and who does not normally reside with the latter, up to the maximum indicated in the Summary of Benefits.

iii) Clinic or hospital fees as an outpatient.

iv) Medication prescribed by a healthcare provider who is legally licensed to prescribe drugs and sold by a licensed pharmacist.

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

Dispensing Limitations

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

As part of its pre-authorization process, the insurer may request that a drug be purchased from a preferred pharmacy network that has been approved by the insurer. If the insured person should choose to use another pharmacy, the amount reimbursed to the insured person will be based on the amount which would have been charged by the insurer's approved pharmacy network. The insurer will not be responsible for any amounts in excess of the amounts that would have been reimbursed had the insured person used the approved pharmacy network.

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

v) Blood or plasma transfusions.

vi) Purchase of artificial limbs and eyes, if the loss occurred while insured, hernial belts, casts, slings and crutches.

vii) The cost of oxygen and its administration.

viii) Rental of a wheelchair (excluding an electric wheelchair except for quadriplegics), an iron lung and any other therapeutic equipment (excluding batteries).

ix) Dental care by a dentist not given at a hospital, and required as a result of an accidental injury to whole, healthy, natural teeth that occurred while insured, in accordance with the normal suggested

fee for a general practitioner. Only care received within 6 months of the accident is admissible. Other dental fees are excluded.

x) Purchase of external mammary prostheses, up to the maximum indicated in the Summary of Benefits.

xi) Purchase of surgical bras required following a mastectomy, up to the maximum indicated in the Summary of Benefits.

xii) Purchase of capillary prostheses required following chemotherapy, up to the maximum indicated in the Summary of Benefits.

xiii) Sclerosing injection fees, up to the maximum indicated in the Summary of Benefits.

xiv) 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 or an audiologist.

Covered expenses are limited to the maximum specified in the Summary of Benefits.

xv) Purchase of a glucometer or a reflectometer for insulin-dependent diabetics, up to the maximum indicated in the Summary of Benefits.

xvi) Paramedical care given by one of the paramedical practitioners listed in the Summary of Benefits, with the exception of such care given outside of the province of residence.

The eligible expenses, per insured, are limited to one professional visit per day, up to the maximum indicated in the Summary of Benefits.

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

A chiropractor's X-ray fees, up to the maximum indicated in the Summary of Benefits.

xvii) Expenses for a stay in a recognized clinic or convalescent home (including the costs of a room, meals and nursing care), up to the maximum indicated in the Summary of Benefits.

xviii) Purchase of surgical support hose, up to the maximum indicated in the Summary of Benefits.

xix) Laboratory and X-ray examinations, and X-ray treatments with radium or radioactive isotopes, up to the maximum indicated in the Summary of Benefits.

xx) The cost of orthopedic shoes, up to the maximum indicated in the Summary of Benefits, and the cost of modifying a regular shoe or the cost of purchasing, repairing, modifying or adjusting an insert or device added to a regular shoe.

xxi) Costs for a stay in a recognized treatment centre for alcoholism or drug addiction, up to the maximum indicated in the Summary of Benefits, without limit as to the number of days.

xxii) Orthopedic appliances with rigid support; back supports; shoulder harnesses; had halters and cervical collars;

b) Eye glasses (frame and corrective lenses) or contact lenses are reimburseable when prescribed by an ophthalmologist or optometrist, up to the maximum per insured indicated in the Summary of Benefits.

c) Expenses for eye examinations carried out by an ophthalmologist or optometrist for insureds 18 to 64 years of age, up to the maximum indicated in the Summary of Benefits.

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

EXTENSION OF COVERAGE WHEN INSURANCE IS TERMINATED

If within 90 days following the termination of a participant's insurance, such participant must incur fees for hospitalization or, within 12 months following the termination of his or her insurance, the participant must incur fees for medical expenses which would have entitled him or her to receive benefits if the insurance had been in force, the insurer will reimburse the admissible expenses if:

a) these expenses result from an accidental injury or illness which occurred before the termination of insurance and for which medical expenses were incurred before such termination,

and

b) the insured was totally disabled following the accidental injury or illness from the date of termination of the insurance to the date the expenses were incurred.

No benefits will be payable for expenses incurred after the termination of the contract or the present coverage.

EXCLUSIONS

This coverage does not include:

a) Expenses which are or would normally be payable or reimburseable under a private or public insurance plan, if a claim had been submitted;

b) 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) Any injury or illness resulting from civil unrest, insurrection or war, whether war be declared or not, or participation in a riot;

d) Any treatment or appliance, related directly or indirectly to full mouth reconstruction, to correct vertical dimension and temporomandibular joint dysfunction;

e) Fees following surgery or treatment which is not medically required, and which is given for cosmetic purposes (except admissible expenses in accordance with this coverage) or for any reason other than curative, or which exceeds ordinary surgery or treatment given in accordance with current therapeutic practice, and treatment which is given in relation to an operation or treatment of an experimental nature;

f) Any portion of the charge for services in excess of the reasonable and customary care for an illness of the same nature and severity in the locality where the service is provided;

g) 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;

h) Rest cures or travel for health reasons;

i) The prescription, the initial purchase, adjustment or replacement of hearing aids;

j) All care or treatment related to fertility or infertility;

k) The 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, etc.;

l) 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 any other expenses incurred for care or treatment that is not recognized as normal, customary and common practice;

m) The purchase of food or nutritional supplements and expenses incurred in the treatment of obesity, whether or not these are prescribed for a medical reason;

n) Expenses incurred for the administration of serums, vaccines and injectable medications;

o) Fees for replacement of lost, stolen or broken glasses, or for sunglasses or tinted glasses, or safety glasses or spare frames;

p) Expenses incurred for growth hormone care or treatments;

q) Contraceptives (other than oral), except if mention is made that such expenses are covered in your plan;

r) Expenses incurred for problems related to erectile dysfunction;

s) Any drugs which are excluded from coverage by the insurer under the Dispensing Limitations provision of this benefit;

t) Expenses incurred 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.

REIMBURSEMENT

The insurer reimburses a certain percentage of the eligible expenses incurred during a calendar year, after the deductible has been satisfied for that year. The reimbursement percentages are indicated 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 this policy is cancelled due to termination of

a) his employment; or

b) his group membership,

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

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

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

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

SUPPLEMENTAL HEALTH INSURANCE – EMERGENCY OUT OF PROVINCE ASSISTANCE

This coverage provides the insured person, who is already covered under a government health insurance plan, with medical assistance in case of emergency for any accidental injury or illness which occurs during the first 90 days of the insured person's absence from his province of residence, while on vacation or business trips, or if the absence is due to his attendance at an accredited educational institution on a full-time basis, the emergency occurs during the school year for which he is enrolled at the institution, subject to the conditions that follow.

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

SPECIAL DEFINITIONS

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 which prevents the insured person from continuing his trip.

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

Member of the Immediate Family: 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 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 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, accidental injury or illness which justifies intervention by the Medical Assistance Service.

MEDICAL ASSISTANCE

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

i) 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 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 accidental injury 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 accidental injury or illness, if required by the medical emergency.

- Organize 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 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 SUPPLEMENTAL HEALTH INSURANCE which is part of the present plan for emergency hospitalization and medical or surgical care outside of his province of residence.

  If need be, the Medical Assistance Service will advance up to $10,000 in legal Canadian tender, after reaching an agreement with the insurer, for the participant and his 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 90 days following his return to his province of residence. 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 dependents submit under the present plan.

v) Return of Deceased

- Should the insured person die due to an illness or accidental injury, the Medical Assistance Service will take care of all the arrangements and pay up to $3,000 per insured person for the postmortem expenses, the coffin and transportation of the deceased to the place of burial in his province of residence. 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 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. 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 Member of the Immediate Family

- The Medical Assistance Service will organize the return of a member of the immediate family who has lost the use of his 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 member of the immediate family to his usual place of residence. 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 Member of the Immediate Family

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

ix) Living Expenses for Accommodation and Meals

- When return is postponed due to an hospitalization period of an insured person for more than 24 hours or because of death, the living expenses incurred by the insured person, by a member of the immediate family accompanying the insured person or visiting the insured person according to the circumstances provided in the previous paragraph (*Visit from a Member of the Immediate Family*) are reimbursed, after approval from the insurer, subject to a daily maximum of $150 per insured person, and to a global reimbursement of $1,500 for all insured persons.

  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 $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 $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 home, office or elsewhere, or holds messages for the insured person or the members of his immediate family for 15 days.

iii) Legal Assistance

- Should an insured person require legal assistance, the Medical Assistance Service assists him 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 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 SUPPLEMENTAL HEALTH INSURANCE of the present plan.

vi) Lost Baggage or Documents

- If the insured person loses or has his baggage stolen, the Medical Assistance Service will help him 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, directly or indirectly, from a self-inflicted injury unless medical evidence establishes that the injury was directly related to a mental health illness;

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;

h) Care or services if the insured person's medical condition was not stable before the absence from his province of residence began and the medical emergency results directly or indirectly from that medical condition. The insurer determines, at its sole discretion, what stable means. In this assessment, the insurer may take into consideration the following:

   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 that absence.

PROVISIONS

Notice of Claim

As soon as the insured person is aware of an incident, he 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 accidental injury.

Prescription

Claims must be made within 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 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.

DENTAL CARE

PURPOSE OF THE COVERAGE

Upon receipt of satisfactory proof that you have incurred eligible expenses for yourself or one of your dependents, when the present coverage for such participant or dependent is in force, the insurer will pay, to such participant, the eligible expenses in accordance with this coverage.

The insurer may pay the benefits, with your written consent, to any person or institution and is not responsible for the application of the benefit thus paid.

For the purposes of this coverage, expenses are considered incurred on the date the treatment is given.

ELIGIBLE EXPENSES

Only those items included below which are specified in the Summary of Benefits will be considered "eligible expenses" provided they were rendered in the province of residence of the participant, by a general practitioner, a specialist on the recommendation of a general practitioner or by a dental hygienist.

PREVENTIVE AND CURATIVE TREATMENT

a) Diagnosis, prevention, restoration and minor surgery
   - i) One routine examination per year;
   - ii) Complete X-rays, once every 3 years (normal or panoramic);
   - iii) Intraoral X-rays, 2 times per year;
   - iv) Prophylaxis, including scaling of teeth, 2 times per year;
   - v) Topical application of fluoride, 2 times per year;
   - vi) Extractions, including an alveolectomy during a tooth extraction;
   - vii) Surgical extraction of impacted teeth;

viii) Surgical excision of tumours, cysts, neoplasms, as well as incising and draining an abscess;

ix) Amalgam, silicate, acrylic resin or composite fillings;

x) X-ray diagnoses and laboratory analyses necessary for dental surgery;

xi) General anesthetic necessary for dental surgery;

xii) Cost of medication and its administration when supplied and injected at the dentist's office;

xiii) Installation of space maintainers following the loss of primary teeth, and installation of corrective retainers (except orthodontics);

xiv) Consultations at the dentist's request.

b) Endodontic and periodontic services

i) Any endodontic treatment, including root canal treatment;

ii) Any periodontic treatment.

MAJOR TREATMENT

a) Surface or in-depth inlays;

b) Crowns and gold or ceramic on metal inlays when other materials are not compatible;

c) Initial provision of fixed bridges or partial or complete dentures (no limit to the number of missing teeth);

d) Replacement of a fixed bridge or existing partial or complete denture only if:

i) the replacement is made necessary following the extraction of natural teeth while covered under this coverage;

ii) the existing fixed or removable denture is at least 4 years old and can no longer be used;

iii) the existing fixed or removable denture is temporary and is replaced by a permanent denture in the 12 months following the placement of the temporary denture.

e) Services of a licensed denturologist, when necessary;

f) Other necessary oral surgery not covered under preventive and curative treatment;

g) Refilling, rebasing or repair of a fixed bridge or an existing partial or complete denture.

EXCLUSIONS AND LIMITATIONS

a) No benefit shall be payable for:

i) Expenses incurred for cosmetic purposes, including the personalization of dental prostheses;

ii) Expenses incurred when the insured was not covered. In the case of prosthetic apparatus, the expenses are only reimbursed if the casts were taken while the participant was insured under the plan or if the installation or delivery of the prosthesis was made within 3 months following the termination of the insurance;

iii) Replacement of retainers or dentures which are lost or stolen;

iv) Orthodontic expenses;

v) Expenses that the beneficiary is not required to pay;

vi) Expenses incurred for a treatment that is supplied or paid for by another employer for past or current services;

vii) Expenses reimbursable by any government plan;

viii) Care that is not necessary for the treatment of the current problem, or that is not recommended by the attending dental surgeon, or that exceeds the expenses contained in the current fee guide at the time of treatment;

ix) Charges for missed appointments;

x) Expenses incurred for completing claim forms;

xi) Expenses for diet recommendations, dental plaque control programs and pit and fissure sealants;

xii) Expenses incurred for new procedures or treatments that are not currently used (oral implantology);

xiii) Care required following an injury or illness caused by an act of war, whether war be declared or not;

xiv) Care for which the employee can be reimbursed in accordance with any workers' compensation act;

xv) Dental care required to correct damage caused to natural teeth following an accident;

xvi) Experimental care and treatment;

xvii) Care following active participation in a criminal act;

xviii) Expenses for services and supplies resulting, directly or indirectly, from a self-inflicted injury unless medical evidence establishes that the injury was directly related to a mental health illness.

b) The amount of the benefits will be reduced by any benefit payable under the Crime Victims Compensation Act, the provincial health insurance plan, the Quebec Automobile Insurance Act or any other similar legislation or public plan to this effect.

c) If more than one type of procedure would be suitable for the treatment of a dental condition, the insurer will pay the least expensive treatment under this coverage that will produce a professionally adequate result.

d) Whenever an insured's proposed dental treatment plan exceeds $300, such program must first be submitted to the insurer so that the insurer may determine, prior to the commencement of treatment, the amount reimburseable in accordance with this coverage.

e) Replacement of existing removable dentures shall only be payable once every 4 years following the date of the original installation or a replacement of such dentures for which expenses were payable under this benefit.

f) For those who became insured after the eligibility date, reimbursement is limited to $50 per person during the first 12 months of insurance, to a maximum amount of $150 per family.

Extension of Benefit

If an insured person receives, within 30 days following immediately the end of his insurance, the dental treatments indicated hereafter, the insurer must pay the benefit which the said person would have been entitled if the insurance was kept in force, provided the plan was in force at the date the treatment is rendered:

a) Complete and partial prostheses provided the first impression was taken before the end of the insurance;

b) Fixed prostheses, gold restorations, onlays, inlays and crowns provided the tooth was prepared before the end of insurance;

c) Endodontic treatments provided the tooth has been opened for the root canal treatment before the end of insurance.

CO-ORDINATION OF BENEFITS

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

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

ii) any government sponsored plan, and

iii) any non-insured employee benefit plan.

CONVERSION PRIVILEGE

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

a) his employment; or

b) his group membership,

will be able to convert his dental care insurance coverage to an individual insurance contract without having to submit evidence of insurability to the insurer, provided he is also converting his supplemental health insurance. Failure to convert his supplemental health insurance will prevent the participant from converting his dental care insurance.

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

The participant must make application and pay all required premium for the individual insurance contract within 60 days of the termination date of his insurance under the policy. Failure to submit the application and premium

within such 60 days will prevent the participant from obtaining the insurance under the individual insurance contract.

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

COPY OF CONTRACT AND ENROLMENT MATERIAL

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

SUBMITTING CLAIMS

Health and Dental Claims

The participant must submit a completed claim form with the original receipts (if applicable) to the following address:

For participants residing in Quebec

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

For participants residing outside Quebec

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

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

SUBMITTING CLAIMS

Disability Claims

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

For participants residing in Quebec

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

For participants residing outside Quebec

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

IMPORTANT NOTICE
For Persons Hospitalized Outside their Province of Residence

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

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

PROTECTING PERSONAL INFORMATION

Industrial Alliance 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

ANNEX – BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Policy No. 100008772 issued by Special Markets Solutions, a division of Industrial Alliance Insurance and Financial Services Inc.

You are covered for a principal sum amount of $20,000.00, if an injury is sustained as the result of any accident anywhere in the world - 24 hours per day - on or off the job.

ACCIDENTAL DEATH, DISMEMBERMENT AND SPECIFIC LOSS INDEMNITY

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

	% of Principal Sum
Life	100%
Both Hands, Both Feet or Entire Sight of Both Eyes	100%
One Hand and One Foot or One Hand and Entire Sight of One Eye	100%
One Foot and Entire Sight of One Eye or Speech and Hearing in Both Ears	100%
One Arm or One Leg	75%
One Hand or One Foot	66.6%
The Entire Sight of One Eye	66.6%
Speech or Hearing in Both Ears	66.6%
Four Fingers of One Hand (including the Thumb)	40%
Four Fingers of One Hand (excluding the Thumb)	35%
The Thumb and Index Finger of One Hand or Hearing in One Ear	33.3%
All Toes on One Foot	33.3%
The Thumb and all Fingers of One Hand (excluding the Index Finger)	20%
All Toes including the Big Toe	20%
The Thumb or Three Fingers of One Hand (excluding the Thumb and Index Finger)	15%
The Index Finger of One Hand	10%
Four Toes of One Foot (excluding the Big Toe)	10%
Two Fingers of One Hand (excluding the Thumb and Index Finger)	8%
The Middle Finger of One Hand	8%

ANNEX – BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

	% of Principal Sum
Two Toes of One Foot	5%
One Finger (excluding the Thumb, Index and Middle Finger) or One Toe of One Foot	3%
Quadriplegia (total paralysis of all four limbs)	200%
Paraplegia (total paralysis of the lower limbs)	200%
Hemiplegia (total paralysis of one side of the body)	200%

CONTINUATION OF COVERAGE

Coverage can be continued while the insured is on an approved leave of absence, maternity/parental leave, lay-off or disability. This continuation is subject to continued payment of premiums and is granted for a maximum of 12 months (or to age 65 if on disability leave) or on the date the insured returns to work, whichever is earlier.

CONVERSION OPTION

Upon termination of active employment with the Policyholder, an insured may convert his/her insurance to an individual accident insurance plan, with no evidence of insurability, for an amount of principal sum equal to or lower than the amount of principal sum in force at the time of termination. Application for conversion must be made within 31 days. Premiums become payable annually in advance.

CRITICAL ILLNESS BENEFIT

If an insured is diagnosed by a specialist with a Covered Condition while his Critical Illness Benefit is in force and survives for 30 days following the date of diagnosis or such longer period, the Company will pay such insured an amount of $1,000.00, subject to the terms and conditions of the policy. The date of diagnosis must be later than the issue date of the insured's coverage under the policy. If the insured dies before the Critical Illness Benefit is paid, the Critical Illness Benefit will be paid to the estate of such insured. Payment of the Critical Illness Benefit is limited to only the first Covered Condition to occur.

In case of cancer recurrences or metastases, no benefit will be payable if that cancer was originally diagnosed prior to the issue date of the insured's coverage, regardless of the date of the recurrence or metastases.

In addition to general policy Exclusions and Limitations, the Critical Illness Benefit will not be paid if a Covered Condition results directly or indirectly from any one or more of the following:

(a) any illness, disease, mental, nervous or psychiatric condition or disorder for which any one of medical advice, treatment, service, prescribed medication, diagnosis or consultation, including consultation to investigate and/or diagnose (where diagnosis has not yet been made) was received by the insured or would have been received by a prudent individual within the 24 months immediately preceding the issue date of an Insured's coverage. This exclusion applies for the first 24 months following the issue date of the insured's coverage under the policy.

(b) taking poison or inhaling gas, whether voluntarily or involuntarily, not connected with the employment of the insured;

(c) taking any drug other than as prescribed by a licensed physician;

In addition, the Critical Illness Benefit will not be paid if the insured suffers Stroke as a result, directly or indirectly, from amateur or professional boxing, bungee jumping, B.A.S.E. jumping, cliff diving, mountain climbing, motor vehicle race or speed competition on land and/or water, parachuting or underwater activities, including scuba diving and snuba diving.

An insured will not be entitled to a Critical Illness Benefit if, within the first 90 days following the issue date of the insured's coverage under the policy, such insured has a diagnosis of cancer (covered or excluded under the policy) or any signs, symptoms or investigations that lead to a diagnosis of cancer (covered or excluded under the policy), regardless of when the diagnosis is actually made.

"Covered Condition" means Cancer (Life-Threatening), Coronary Artery Bypass Surgery, Heart Attack, or Stroke.

ANNEX – BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

DAY CARE BENEFIT ($5,000)

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

EDUCATION BENEFIT ($10,000)

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

FAMILY TRANSPORTATION BENEFIT ($15,000)

If injury results in confinement as an inpatient in a hospital, and such injury results in a loss being payable under the Accidental Death, Dismemberment and Specific Loss Indemnity, and the hospital is located at least 150 km from the insured's residence, the Company will pay the expenses actually incurred by a member of the immediate family for hotel accommodation and transportation by the most direct route to the confined insured. If transportation occurs in a vehicle or device other than one operated under a license for the conveyance of passengers for hire, then reimbursement of transportation expenses will be limited to a maximum of $0.35 per kilometre travelled.

HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT ($15,000)

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

ANNEX – BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

IDENTIFICATION BENEFIT ($10,000)

If injury results in loss of life, and requires body identification, the Company will pay the expenses actually incurred by a member of the immediate family for lodging, board and transportation by the most direct route, provided the body is located not less than 150 kilometres from the member of the immediate family's residence and the identification of the body is required by the police or a similar law enforcement agency having authority over such matters. If transportation occurs in a vehicle or device other than one operated under the license for the conveyance of passengers for hire, then reimbursement of transportation expenses will be limited to a maximum of $0.35 per kilometre travelled.

REHABILITATION BENEFIT ($15,000)

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

REPATRIATION BENEFIT ($15,000)

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

SEAT BELT BENEFIT

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

ANNEX – BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

SPOUSAL RETRAINING BENEFIT ($15,000)

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

WAIVER OF PREMIUM

In the event of total disability, provided such disability has continued for an uninterrupted period of 6 consecutive months preventing an insured from engaging in any and every occupation and waiver of premium has been approved and accepted by the group long term disability carrier, then premium under this plan will be waived until the earlier of: death, recovery, retirement or the date the policy is cancelled.

LIMITED AIR TRAVEL COVERAGE

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

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

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

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

ANNEX – BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

TERMINATION OF INSURANCE OF AN INSURED

Coverage will terminate immediately on the earliest of: (a) the policy termination date; (b) the premium due date if the Policyholder fails to pay the insured's premium, except as a result of an inadvertent error; (c) the premium due date coinciding with or immediately following the date an insured retires; (d) the premium due date next following the date an insured is ineligible for coverage, except as provided under the part titled "Continuation of Coverage".

WHEN DOES THIS INSURANCE NOT APPLY?

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

BENEFICIARY

Indemnity payable in the event of the loss of life of an insured is payable in accordance with the beneficiary designation in effect under the Policyholder's current Basic Group Life Insurance policy. Unless otherwise indicated and if there is no such designation, the indemnity is payable to the estate of the insured. All other indemnities are payable to the insured, with the exception of indemnities payable under the following parts:

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

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

ANNEX – BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

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

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

NOTES