Your group insurance plan

COMITÉ PARITAIRE DES BOUEURS DE LA RÉGION DE MONTRÉAL

Policy No. Q1069

Hourly Employees

Desjardins
Insurance
Life • Health • Retirement

BENEFIT SCHEDULE

GENERAL GUIDELINES

Participation:	Mandatory

Eligibility Requirements

Number of hours worked per week:	A minimum of 20 hours per week
Eligibility Period:	After 500 hours of service for the Employer.

BASIC PARTICIPANT LIFE INSURANCE BENEFIT

Amount of Insurance:	* $25,000
Non-Evidence Maximum of Insurability:	$25,000
*** Reduction of Amount:**	On the 65th birthday of the Participant, the amount applicable to the Participant will be reduced by 50%.

Benefit Termination

Age Limit:	Age 71 of the Participant, or retirement whichever occurs first.

DEPENDENT LIFE INSURANCE BENEFIT

Amount of Insurance:	Spouse: $5,000 Each Child: $2,500
Commencement of Newborn Children Insurance:	24 hours after birth
Reduction of Amount:	On the 65th birthday of the Participant, the amount applicable to the Spouse will be reduced by 50%.

Benefit Termination

Age Limit:	Age 71 of the Participant, or retirement whichever occurs first.

PARTICIPANT OPTIONAL LIFE INSURANCE BENEFIT

Amount of Insurance: Any multiple of $10,000 with a minimum of $20,000 and a maximum of $300,000.

Benefit Termination

Age Limit: Age 65 of the Participant, or retirement whichever occurs first.

SPOUSE OPTIONAL LIFE INSURANCE BENEFIT

Amount of Insurance: Any multiple of $10,000 with a minimum of $20,000 and a maximum of $150,000.

Benefit Termination

Age Limit: Age 65 of the Participant, or retirement whichever occurs first.

PARTICIPANT WEEKLY INDEMNITY BENEFIT

Percentage and Maximum of Benefit:	60% of weekly Earnings, rounded to the next $1, if not already a multiple, up to an amount equal to the maximum benefit payable under the Employment Insurance Act.
Carve Out with Employment Insurance Act:	Standard wrap around plan: the Maximum Benefit Period includes the number of weeks during which Employment Insurance benefits are paid.
Elimination Period:	7 days in case of Accident 7 days in case of Illness Nil if Hospitalized.
Payment Basis:	7 days (calendar)
Maximum Benefit Period:	52 weeks
Taxability of Benefits:	Taxable

Benefit Termination

Age Limit:	Age 70 of the Participant, or retirement whichever occurs first.

EXTENDED HEALTH CARE BENEFIT

Deductible Amount

Drug Co-pay:	$5 per prescription
Hospitalization Expenses:	Nil
Travel Insurance:	Nil
Other Expenses:	$50 per single coverage, or $100 per family coverage each Calendar Year.

Percentage of Reimbursement

Drugs:	70%
Short-term Hospitalization Expenses:	100%
Long-term Hospitalization Expenses:	70%
Travel Insurance:	100%
Referral Treatment:	80%
Other Expenses:	70%

Limits for Eligible Expenses

Short-Term Hospitalization Expenses:	The cost of a semi-private room for each day of Hospitalization with no limit as to the number of days.

Long-term Hospitalization Expenses in a Convalescent / Rehabilitation Centre:	The cost of a semi-private room for each day of Hospitalization, up to a combined maximum of 180 days per Calendar Year.
Travel Insurance:	Lifetime maximum payable amount of $5,000,000 per Insured Person.
Nursing Care:	Eligible amount of $300 per day, up to a payable amount of $10,000 per Insured Person each Calendar Year.
Paramedical Services:	
• Acupuncturist • massage therapist, orthotherapist or kinesiologist • naturopath • physiotherapist or physical rehabilitation therapist • speech therapist	Eligible amount of $300 for all specialists per Insured Person each Calendar Year.
• Chiropractor • osteopath • podiatrist	Eligible amount of $300 for all specialists per Insured Person each Calendar Year.
• Psychologist, social worker, psychoanalyst or psychiatrist	Eligible amount of $300 for all specialists per Insured Person each Calendar Year.

Benefit Termination

Age Limit:	The date of retirement.

DEFINITIONS

Wherever used in the policy:

Accident means any event due to sudden and unforeseeable external causes that inflicts bodily injuries that are certified by a Physician, directly and independently of any other cause. It does not mean any form of disease, or degenerative process, an inguinal, femoral, umbilical or incisional hernia, or any infection other than an infection of a visible, external cut or wound accidentally sustained.

Actively At Work means, on any day, the performance by the Employee of all the usual and customary duties of his job with the Employer for the scheduled number of hours for that day.

Age means the age of the Insured Person on his last birthday when stated or calculated, or on the day when an event referred to under the policy occurs.

Child means a person who:

1) is under 21 years of Age, and over whom the Participant or the Spouse of the Participant exercises parental authority or exercised parental authority until he reached the Age of majority; or

2) has no spouse, is 25 years old or under and is, or is deemed to be, a full-time student at an accredited educational institution, and over whom the Participant or the Spouse of the Participant would exercise parental authority if he were a minor; or

3) has reached the Age of majority, has no spouse, and is suffering from a "functional impairment" that must have existed when the status of the person fit the definition of either 1) or 2) above. In addition, in order to be considered a "person suffering from a functional impairment," this person must be living with the Participant or the Spouse of the Participant who would exercise parental authority over him as if he were a minor.

   It is understood that a functional impairment will be defined as stipulated under the regulations of any provincial legislation, when covered under such regulations.

Continuing Medical Care means the treatment a Participant receives. It must be accepted by the medical profession as an effective, appropriate and essential treatment in the diagnosis or care of the specific Illness or injury. It must be reasonable, considered as standard practice and provided or prescribed by a Physician or, when the Insurer deems necessary, by a specialist in the appropriate field. Such care is not limited to examination and tests, and must be provided at the frequency required for the specific Illness or injury.

Dependent means a Spouse or Child who is domiciled in Canada. However, if a Dependent is domiciled outside Canada, such Dependent may be deemed to be domiciled in Canada provided such individual is covered under a provincial medical plan and prior written approval is obtained from the Insurer.

Earnings means the regular rate of pay of an Employee paid by the Employer, including overtime pay paid on a regular basis. This does not include bonuses, non-regular overtime pay, professional fees, accommodation and meal allowances, amounts paid by the Employer as fringe benefits, isolation allowances and any lump sum.

For the Participant Weekly Indemnity Insurance benefit that is registered for premium reduction under the Employment Insurance Act, if applicable, bonuses, overtime pay or any other form of pay included in regular compensation and declared to the Insurer is part of Earnings.

For an Employee whose pay is derived in whole or in part from commissions or dividends, Earnings means the average regular rate of pay of an Employee paid by the Employer including commissions and dividends as shown on the income taxation slips of the Employee for the previous two calendar years. If employed less than two years but more than one, Earnings will be averaged over the length of time employed. If employed less than one year, Earnings will be the regular rate of pay of the Employee as reported by the Employer.

Employee means a person who is domiciled in Canada and who is employed by the Employer on a permanent full-time basis for not less than the number of hours specified in the Benefit Schedule. However, if an Employee is domiciled outside Canada, such Employee may be deemed to be domiciled in Canada provided prior written approval is obtained from the Insurer.

Employer means any companies listed on the application of the Policyholder for the policy or specified in the Benefit Schedule.

Family-Related Leave means any leave of absence from work taken by a Participant in accordance with such provincial or federal legislation, or an agreement between the Participant and the Employer.

Hospital means any hospital that is designated as such by law and is intended for the care and treatment of sick and injured individuals, and which has organized facilities for diagnosis and major surgeries as well as 24 hour nursing service. The term does not include a nursing home, home for the aged or chronically ill, rest home, Convalescent Hospital, or a place for the care and treatment of alcoholism or drug abuse.

Illness means any health deterioration or bodily disorder certified by a Physician. For the purposes of the policy, organ donations and related complications are also considered illnesses.

Immediate Family means a person who is the Spouse, son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law of the Participant.

Insured Person means the Participant or one of his insured Dependents, as the case may be.

Insurer means Desjardins Financial Security Life Assurance Company.

Maternity Leave means any leave of absence from work due to pregnancy in accordance with any labour standards legislation that is applicable in the Insured Person's province of residence. Maternity Leave consists of a voluntary portion and a "health related portion". The "health related portion" of the Maternity Leave commences on the date of the delivery and lasts for at least 6 weeks (8 weeks for a Caesarean delivery). The person is considered to be on Maternity Leave during the entire period for which she is receiving maternity benefits under any provincial or federal legislation. If she is absent from work due to a Total Disability that commenced before or during pregnancy, she is considered to be on Maternity Leave in accordance with any provincial or federal legislation.

Parental Leave means any leave of absence from work taken by a Participant to take care of his newborn or adopted child, in accordance with such provincial or federal labour standards legislation, or an agreement between the Participant and the Employer.

Participant means an Employee who is insured under the policy.

Physician means a legally qualified medical practitioner lawfully entitled to practice medicine in the place where he provides the medical services.

Policyholder means the company or group indicated on the application and specified on the cover page of the policy.

Spouse means an eligible person who is domiciled in Canada and who at the time of the event giving rise to a claim:

1) is legally married to or living in a civil union with the Participant; or

2) has been living with the Participant in a conjugal relationship for at least 12 months and has not been separated from the Participant for 90 days or more as a result of a breakdown in the relationship; or

3) is living in a conjugal relationship with the Participant who is the natural parent of the Spouse's Child and has not been separated from the Participant for 90 days or more as a result of a breakdown in the relationship.

However, if two individuals fit the definition of Spouse, the Insurer will recognize only one Spouse for all benefits under the same plan in the following order:

1) the eligible Spouse whom the Participant last designated as such in writing to the Insurer, subject to approval of any evidence of insurability required under the policy; or

2) the Spouse to whom the Participant is legally married or with whom the Participant is living in a civil union.

At any one time, only one person may be insured as a Spouse of the Participant.

ELIGIBILITY

EMPLOYEE ELIGIBILITY

An Employee is eligible for insurance:

1) on the EFFECTIVE DATE, if he meets the Eligibility Requirements specified in the Benefit Schedule; or

2) after the EFFECTIVE DATE, on the date on which he meets the Eligibility Requirements specified in the Benefit Schedule.

A Participant, whose insurance under the policy terminated due to termination of employment and who is re-hired by the Employer within 6 months immediately following the termination of his insurance, will be eligible for the reinstatement of his insurance on the date he resumes employment, provided application for reinstatement is made within 31 days of eligibility.

DEPENDENT ELIGIBILITY

A Participant with a Dependent on the date he becomes eligible for insurance under the policy will be eligible for Dependent insurance on such date.

A Participant without Dependents who is insured under the policy will be eligible for Dependent insurance on the date he acquires a Dependent.

INSURANCE APPLICATION

An eligible Participant must complete an application or an application for exemption for himself and for his Dependents, if any, within 60 days of the date on which he becomes eligible.

INDIVIDUALS AGE 65 AND OVER

Individuals Age 65 and over are automatically covered under the Quebec drug insurance plan for drugs and other products included on this plan's list. Individuals who would like to continue their coverage for drugs under the Extended Health Care Benefit of the policy after they turn 65 must apply in writing beforehand to the Insurer, who will determine the required insurance premium, if applicable. However, Dependents cannot continue their coverage if the Participant does not remain insured.

A request for the continuation of insurance or for the Participant and/or his Dependents to opt out, where applicable, must be made in writing to the Insurer within 60 days of the date on which the individual becomes eligible for the Quebec drug insurance plan.

EVIDENCE OF INSURABILITY

Evidence of insurability means any declaration relating to an individual's physical health or to other factual information that could have a bearing on the acceptance of the risk. Only declarations that are provided on the forms approved by the Insurer will be accepted.

COMMENCEMENT OF INSURANCE

COMMENCEMENT OF PARTICIPANT INSURANCE

The insurance of any Employee will become effective on the latest of the following dates, provided that Employee is Actively At Work on such date:

1) the Effective Date of the policy,

2) the date on which he first becomes eligible, provided his written application, completed using the form required by the Insurer, is received by the Insurer within 180 days of his date of eligibility,

3) the date on which the insurability of the Employee is approved by the Insurer, if the application of the Employee for insurance is received by the Insurer more than 180 days after the date of his eligibility, except for the Extended Health Care Benefit, the date on which his written application, completed using the form required by the Insurer, is signed by him.

If an Employee is not Actively At Work on the date his insurance would have otherwise commenced, such insurance will commence on the first day he is subsequently Actively At Work.

If the Employee is not Actively At Work on the date his insurance would have otherwise commenced, due solely to a paid leave or a statutory holiday, then he will be considered Actively At Work on such date.

If a Participant requests an amount of insurance that exceeds the maximum amount the Insurer will provide without evidence of insurability, as specified in the Benefit Schedule, this excess amount will become effective on the latest of the dates specified in the preceding provision or on the date on which the insurability of the Participant is approved, if later.

With respect to the Dental Care Benefit, if included in the policy, if the Employee applies more than 60 days after the date of his eligibility, evidence that the insurability of an Employee is satisfactory will not be required; however, his dental coverage will be limited as set forth in the RESTRICTIONS, EXCLUSIONS AND LIMITATIONS section of the Dental Care Benefit.

COMMENCEMENT OF DEPENDENT INSURANCE

The insurance for the Dependent of a Participant will become effective on the latest of the following dates:

1) the date on which the insurance of a Participant first becomes effective under the policy,

2) the date on which a Participant insured under the policy first becomes eligible for Dependent insurance, provided written application is made within 60 days of the date of such eligibility,

3) the date on which the insurability of the Dependent is approved by the Insurer, if evidence of insurability is requested of a Participant because his application for insurance is received more than 60 days after the date he became eligible, except for the Extended Health Care Benefit, the date on which his written application, completed using the form required by the Insurer, is signed by him,

4) the date on which the insurability of the Dependent is approved by the Insurer, if the application of the Participant for Dependent insurance is made more than 60 days after the Participant first became eligible for such insurance, except for the Extended Health Care Benefit, the date on which the written application, completed using the form required by the Insurer, is signed by the Participant.

The insurance for any individual becoming an eligible Dependent of a Participant insured with Dependent insurance will become effective on the date on which such individual becomes a Dependent as defined in the policy.

If a Dependent (other than a newborn Child) is confined to a Hospital on the date his insurance would have otherwise become effective, his insurance will commence on the day immediately following his discharge from the Hospital. This does not apply to the Extended Health Care Benefit.

TERMINATION OF INSURANCE

TERMINATION OF PARTICIPANT INSURANCE

Except as specifically provided to the contrary elsewhere in the policy, the insurance of the Participant will terminate on the earliest of the following dates:

1) the date the Participant no longer qualifies as an Employee, as defined in the policy,

2) the date the Participant ceases to belong to a class of Participants eligible for insurance,

3) the date the Participant reaches the applicable Age Limit specified in the Benefit Schedule,

4) the end of the period for which required premiums were paid on behalf of the Participant,

5) the date the Participant retires,

6) the date the Participant ceases to be Actively At Work,

7) the date of termination of the policy.

TERMINATION OF DEPENDENT INSURANCE

Except as specifically provided to the contrary elsewhere in the policy, the Dependent insurance of a Participant will terminate on the earliest of the following dates:

1) the date the insurance of the Participant terminates,

2) the date the Participant no longer has any Dependents,

3) the end of the period for which required premiums for Dependent insurance were paid on behalf of the Participant,

4) the date Dependent insurance under the policy is terminated.

The insurance of any Dependent of a Participant will terminate on the date the Dependent no longer qualifies as a Dependent, as defined in the policy.

CONTINUATION OF INSURANCE

If a Participant ceases to be Actively At Work, the insurance may be continued as specified in the policy.

CLAIMS

NOTICE AND PROOF OF CLAIM

Notice and proof of any claim must be received by the Insurer within the time limit, if any, specified for each Benefit. However, if the policy terminates, no payment will be made unless the notice and proof of a claim is submitted to the Insurer within 120 days of the date of termination of the policy.

Failure to submit notice or proof of claim within the prescribed time limit does not invalidate the claim, provided that the notice and proof of the claim are sent as soon as reasonably possible. However, no payment will be made if the notice and proof of claim are sent more than 12 months after the expenses were incurred.

Every action or proceeding against the Insurer for the recovery of insurance money payable under this policy is absolutely barred unless commenced within the time set out in the insurance act or other legislation of the province of residence of the Participant.

BENEFICIARY

For life insurance only and subject to legal provisions, a Participant may designate or revoke, at any time, one or several beneficiaries of the insurance on written notice to the Head Office of the Insurer. The rights of a beneficiary who dies before the Participant revert to the latter.

The Insurer assumes no responsibility with respect to the validity of any beneficiary designation or revocation.

The death benefit payable when a Dependent dies is paid to the Participant, if alive. If the Participant is deceased, the death benefit is paid as follows:

1) in the event of the Spouse's death:

   to the Spouse's legal heirs;

2) in the event of the death of the Participant's Dependent Child:

   a) to the Spouse, if alive, or

   b) if the Spouse is deceased, to the legal heirs of the Dependent Child.

CLAIMS

Claims under the policy must be submitted to the Insurer on the appropriate form.

Any living benefits will be paid to the Participant unless otherwise indicated in the policy.

Within 90 days of a death, the beneficiary or the Participant must submit to the Insurer proof of death, including a death certificate, proof of the Age, and Earnings of the Participant or the insured Dependent, as well as any other information deemed useful by the Insurer.

If the designated beneficiary is the estate or personal representative of the deceased, or is a minor, or dies before the Participant, or is not competent to give valid release, the Insurer reserves the right to pay, at its option and at its discretion, a part of the proceeds of the Participant Life Insurance Benefit in an amount not exceeding $5,000 to any person the Insurer deems equitably entitled to such amount to cover the Participant's burial expenses. Such payment will fully discharge the Insurer, and the other insurers, provided this payment is made in good faith.

MEDICAL EXAMINATIONS

From time to time, the Insurer will be entitled to have a claimant examined by a Physician or Physicians of its choice.

CO-ORDINATION OF BENEFITS

If an individual, who is insured for a Benefit that is subject to the CO-ORDINATION OF BENEFITS provision, is also insured under another Plan that provides similar benefits, the amount of benefits payable during any calendar year will be co-ordinated.

Coordination of benefits under the policy will be done in accordance with the guidelines of the Canadian Life and Health Insurance Association so that the total payments under all Plans will not exceed the individual's total incurred eligible expenses.

As used in this provision, "Plan" means the policy and any plan providing benefits or services under

1) other group insurance programs;

2) any other arrangement of coverage for individuals in a group, whether on an insured or uninsured basis;

3) government programs or any insurance required by statute.

The term "Plan" will be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion which does not.

BASIC PARTICIPANT LIFE INSURANCE BENEFIT

EVIDENCE OF INSURABILITY

Evidence of insurability satisfactory to the Insurer will be required of a Participant applying for any amount of Basic Participant Life Insurance in excess of the amount specified in the Benefit Schedule as the Non-Evidence Maximum of Insurability under the Basic Participant Life Insurance Benefit.

PAYMENT OF BENEFIT

Upon receipt of Proof of Claim satisfactory to the Insurer that a Participant died while insured under this Benefit, the Insurer will pay the amount of Life Insurance applicable to such Participant in accordance with the Benefit Schedule and other applicable policy provisions.

BENEFIT TERMINATION

This Benefit terminates on the date the Participant attains the Age Limit specified in the Benefit Schedule or on the earliest of the dates indicated in the TERMINATION OF PARTICIPANT INSURANCE provision.

CONVERSION PRIVILEGE

If the Life Insurance of a Participant aged 65 or younger terminates or is reduced for any reason other than due to policy termination, the Participant will be entitled to convert any amount of insurance, up to the terminated amount, to an individual policy without evidence of insurability.

In addition, the amount of insurance that may be converted will be further limited to the lesser of

1) the maximum amount applicable in the province of residence of the Participant; or

2) the difference between the amount of Life Insurance in force on the date of termination of insurance and the amount of insurance for which the Participant is eligible under another group life insurance at the time of exercising his conversion right.

If the Life Insurance of a Participant aged 65 or younger terminates because of the termination of the policy and provided that the Participant was insured under this Benefit for five consecutive years immediately prior to such policy termination, the Participant will be entitled to convert to an individual policy any amount of insurance, up to the higher of $10,000 or 25% of the Participant's amount of insurance, without evidence of insurability. However, such amount of insurance will be reduced by any group life insurance for which the Participant becomes eligible during the 31 days following the termination of the policy.

The individual policy selected in accordance with the above will be subject to the following conditions:

1) The Participant must submit written application for conversion to the Insurer and must pay the first premium within 31 days of the termination of his insurance under this Benefit;

2) The individual policy may be insurance for a non-convertible Term to Age 65, insurance for a non-renewable 1-Year Convertible Term or any regular permanent plan issued by the Insurer at the date of conversion, excluding special permanent plans as may be designated by the Insurer from time to time. The individual policy will not include any special benefit provisions for which an extra premium is charged and will not be a plan under which the amount of insurance may or will increase in the future; at least one permanent plan will be available for conversion at all times. A Dividend Option under which dividends are used to obtain additional insurance may be elected at the time of conversion, if permitted by the Insurer;

3) In the event the individual policy selected is insurance for a non-renewable 1-Year Convertible Term, the Participant may elect to pay a single premium or quarterly premiums. The policy can be converted to one of the plans described above, but cannot be converted to insurance for another 1-Year Convertible Term;

4) The individual policy issued will conform to the conditions, terms, and amounts of individual insurance plans regularly used by the Insurer at the date of conversion;

5) The individual policy premium will be based on the rate used by the Insurer on the effective date of that policy and that is applicable to the plan and the amount of the policy issued, the Age of the Participant at nearest birthday and the class of risk to which he belongs;

6) If the amount of Life Insurance that may be converted is less than the minimum amount for which the Insurer will then normally issue the selected plan, the individual policy must be for the full amount that the Participant may convert;

7) The individual policy will not take effect prior to the end of the 31 day period immediately following the date of termination of insurance of the Participant under this Benefit.

The amount of Life Insurance for which a Participant who is insured under this Benefit is eligible in accordance with the Benefit Schedule will be reduced by the amount of any individual Life Insurance in force on the life of the Participant that was issued previously in accordance with the CONVERSION PRIVILEGE of the policy or the corresponding provision of any other group policy issued by the Insurer.

EXTENSION OF BENEFIT AFTER TERMINATION

If a Participant dies within 31 days of termination of insurance under this Benefit, the amount of Life Insurance he was eligible to convert will be payable.

NOTICE AND PROOF OF CLAIM

Before settling any death claim, the Insurer will require satisfactory written proof of the occurrence, cause and circumstances of the death, the eligibility of the deceased at the time of death, the date of birth of the deceased, and the right of the claimant to receive the proceeds.

Any death claim notice must be submitted to the Insurer within 30 days of the death and the written proof of claim must be submitted within 90 days of the death.

Subject to applicable legislation, the Insurer may request an autopsy in order to assess its liability in connection with a claim.

The benefit payable on the death of a Participant will be paid to the beneficiary designated by the Participant within 30 days of receipt of satisfactory proof of claim to the Insurer.

DEPENDENT LIFE INSURANCE BENEFIT

PAYMENT OF BENEFIT

Upon receipt of Proof of Claim satisfactory to the Insurer that a Dependent died while insured under this Benefit, the Insurer will pay the amount of Dependent Life Insurance applicable to such individual in accordance with the Benefit Schedule and other applicable policy provisions.

COMMENCEMENT OF NEWBORN CHILDREN INSURANCE

Insurance for a newborn Child of a Participant with insured Dependents will commence in accordance with the terms specified in the Benefit Schedule and the policy provisions, including those that pertain to the COMMENCEMENT OF DEPENDENT INSURANCE.

BENEFIT TERMINATION

This Benefit terminates on the date the Participant attains the Age Limit specified in the Benefit Schedule or on the earliest of the dates indicated in the TERMINATION OF DEPENDENT INSURANCE provision.

DEPENDENT CONVERSION PRIVILEGE

If the Dependent Life Insurance of a Dependent aged 65 or younger, insured for a minimum amount of $5,000, terminates, the Participant, or the insured Dependent in the event of the death of such Participant, may convert the Dependent Life Insurance to an individual policy, without evidence of insurability, subject to the following conditions:

1) The written application for conversion must be submitted to the Insurer and the first premium paid within 31 days of the date of termination of the insurance of the Dependent under this Benefit;

2) The individual policy may be any regular permanent plan issued by the Insurer at the date of conversion, excluding special permanent plans as may be designated by the Insurer from time to time. The individual policy will not include any special benefit provisions for which an extra premium is charged and will not be a plan under which the amount of insurance may or will increase in the future; at least one permanent plan will be available for conversion at all times;

3) The individual policy issued will conform to the conditions, terms and amounts of individual insurance plans regularly used by the Insurer at the date of conversion;

4) The individual policy premium will be based on the rate used by the Insurer on the effective date of that policy and that is applicable to the plan and the amount of the policy issued, the Dependent's Age at nearest birthday and the class of risk to which the Dependent belongs;

5) If the amount of Dependent Life Insurance that may be converted is less than the minimum amount for which the Insurer will normally issue the selected plan, the individual policy must be for the full amount that the Dependent may convert;

6) The individual policy will not take effect prior to the end of the 31 day period immediately following the date of termination of insurance on the Dependent under this Benefit.

EXTENSION OF BENEFIT AFTER TERMINATION

If a Dependent dies within 31 days of the termination of his insurance under this Benefit, the amount of Dependent Life Insurance payable will be the amount that the Participant or the Dependent, in the event of the death of such Participant, was eligible to convert.

DEPENDENT BENEFIT EXTENSION AFTER PARTICIPANT'S DEATH

In the event of the death of the Participant and subject to policy provisions, insurance under this Benefit will continue for insured Dependents, without premium payment, until the earliest of the following dates:

1) 24 months following the death of the Participant;

2) the date on which the Dependent ceases to be eligible as a Dependent for a reason other than the death of the Participant;

3) the date on which Dependent insurance would have terminated if the Participant had not died; or

4) the date on which this Benefit or policy terminates.

NOTICE AND PROOF OF CLAIM

Before settling any death claim, the Insurer will require satisfactory written proof of the occurrence, cause and circumstances of the death, the eligibility of the deceased at the time of death, the date of birth of the deceased, and the right of the claimant to receive the proceeds.

Subject to applicable legislation, the Insurer may request an autopsy in order to assess its liability in connection with a claim.

PARTICIPANT OPTIONAL LIFE INSURANCE BENEFIT

ELIGIBILITY AND EVIDENCE OF INSURABILITY

As a prior eligibility requirement for this Benefit, evidence of insurability satisfactory to the Insurer will be required of a Participant applying for any amount of Participant Optional Life Insurance.

PAYMENT OF BENEFIT

Upon receipt of Proof of Claim satisfactory to the Insurer that a Participant died while insured under this Benefit, the Insurer will pay the amount of Optional Life Insurance applicable to such Participant in accordance with the Benefit Schedule and other applicable policy provisions.

SUICIDE EXCLUSION

No Optional Life Insurance Benefit is payable in respect of a Participant who commits suicide or dies as a result of a suicide attempt, while sane or insane, within two years of the effective date or reinstatement date of his insurance, or the effective date of any subsequent increase to the initial amount of insurance. The insurance or the increase, as the case may be, is then null and void and the Insurer’s liability is limited to refunding the premiums paid.

BENEFIT TERMINATION

This Benefit terminates on the date the Participant attains the Age Limit specified in the Benefit Schedule or on the earliest of the dates indicated in the TERMINATION OF PARTICIPANT INSURANCE provision.

CONVERSION PRIVILEGE

If the Optional Life Insurance of a Participant aged 65 or younger terminates under any of the conditions specified under the CONVERSION PRIVILEGE of the Basic Participant Life Insurance Benefit and not solely the Participant's request, the Participant will be entitled to convert that insurance to an individual policy, without evidence of insurability.

The terms, conditions and restrictions applicable under the CONVERSION PRIVILEGE of the Basic Participant Life Insurance Benefit will apply to any individual policy available under this Benefit except that the maximum amount that may be converted under this Benefit will be the maximum specified under the CONVERSION PRIVILEGE of the Basic Participant Life Insurance Benefit, minus the amount of any Basic Participant Life Insurance that may be converted.

EXTENSION OF BENEFIT AFTER TERMINATION

If a Participant dies within 31 days of termination of insurance under this Benefit, the amount of Optional Life Insurance he was eligible to convert will be payable.

NOTICE AND PROOF OF CLAIM

Before settling any death claim, the Insurer will require written satisfactory proof of the occurrence, cause and circumstances of the death, the eligibility of the deceased at the time of death, the date of birth of the deceased, and the right of the claimant to receive the proceeds.

Subject to applicable legislation, the Insurer may request an autopsy in order to assess its liability in connection with a claim.

SPOUSE OPTIONAL LIFE INSURANCE BENEFIT

ELIGIBILITY AND EVIDENCE OF INSURABILITY

As a prior eligibility requirement for this Benefit, evidence of insurability satisfactory to the Insurer will be required of a Spouse applying for any amount of Spouse Optional Life Insurance.

PAYMENT OF BENEFIT

Upon receipt of Proof of Claim satisfactory to the Insurer that a Dependent Spouse died while insured under this Benefit, the Insurer will pay the amount of Optional Life Insurance applicable to such Spouse in accordance with the Benefit Schedule and other applicable policy provisions.

SUICIDE EXCLUSION

No Spouse Optional Life Insurance Benefit is payable in respect of a Spouse who commits suicide or dies as a result of a suicide attempt, while sane or insane, within two years of the effective date or reinstatement date of his insurance, or the effective date of any subsequent increase to the initial amount of insurance. The insurance or the increase, as the case may be, is then null and void and the Insurer's liability is limited to refunding the premiums paid.

BENEFIT TERMINATION

This Benefit terminates on the date the Participant attains the Age Limit specified in the Benefit Schedule or on the earliest of the dates indicated in the TERMINATION OF DEPENDENT INSURANCE provision.

CONVERSION PRIVILEGE

If the Optional Life Insurance of a Spouse age 65 or younger terminates for any reason other than at the Participant's request, the Participant, or the Spouse in the event of the death of such Participant, may convert this insurance to an individual policy, without evidence of insurability.

The amount of life insurance that may be converted for the Spouse must be at least the amount applicable in the province of residence of the Participant, without exceeding the amount of Spouse Optional Life Insurance in force for the Spouse on the conversion date.

The terms, conditions and restrictions applicable under the CONVERSION PRIVILEGE of the Dependent Life Insurance Benefit will apply to any individual policy available under this Benefit.

EXTENSION OF BENEFIT AFTER TERMINATION

If a Spouse dies within 31 days of termination of his insurance under this Benefit, the amount of Spouse Optional Life Insurance payable will be the amount that the Participant or the Spouse, in the event of the death of such Participant, was eligible to convert.

NOTICE AND PROOF OF CLAIM

Before settling any death claim, the Insurer will require written satisfactory proof of the occurrence, cause and circumstances of the death, the eligibility of the deceased at the time of death, the date of birth of the deceased, and the right of the claimant to receive the proceeds.

Subject to applicable legislation, the Insurer may request an autopsy in order to assess its liability in connection with a claim.

PARTICIPANT WEEKLY INDEMNITY BENEFIT

DEFINITIONS

As used in this Benefit

Elimination Period means the period, as specified in the Benefit Schedule, of continuous Total Disability that must be completed before Weekly Indemnity Benefits commence under this Benefit.

If a Participant can and does continue his coverage under this Benefit throughout any absence or leave (other than a Maternity, Parental or Family-Related absence or leave) as described in the policy, and such Participant becomes Totally Disabled during such leave, the Elimination Period will be deemed to commence on the date the Participant is scheduled to return to active work.

Hospitalization means:

1) to be admitted to a Hospital as an in-patient for more than 18 consecutive hours; or

2) any Hospital stay during which the Participant undergoes surgery performed by a Physician and which required local or general anaesthesia, excluding any minor surgery that can be performed in the office of a Physician.

Maximum Benefit Period means the maximum number of weeks during which benefits are payable. This period is specified in the Benefit Schedule. If this benefit, in accordance with the Benefit Schedule, is carved out with the Employment Insurance Act (EI) as a standard wrap around plan, the Maximum Benefit Period includes the number of weeks during which EI benefits are paid by Human Resources Development Canada.

Net Weekly Earnings means the weekly Earnings in effect immediately prior to commencement of Total Disability less all income taxes and contributions to the Canada/Quebec Pension Plan and Employment Insurance payable thereon.

Total Disability or Totally Disabled means the inability of the Participant as a result of an Illness or Accident to perform all the usual duties of his main occupation and which requires Continuing Medical Care.

A Participant who needs a driver's licence issued by the government to perform the duties of his regular occupation is not considered disabled simply because his licence has been revoked or has not been renewed.

PAYMENT OF BENEFIT

Upon receipt of Proof of Claim satisfactory to the Insurer that

1) a Participant became Totally Disabled while insured under this Benefit and remained Totally Disabled during the Elimination Period, and

2) the Participant is under Continuing Medical Care of a Physician, as defined under the DEFINITIONS provision of the policy,

the Insurer will pay Weekly Indemnity Benefits for as long as the Participant is Totally Disabled, in accordance with applicable policy provisions, up to the Maximum Benefit Period.

To qualify for Weekly Indemnity Benefits, any Accident causing the Total Disability, as defined in the DEFINITIONS above, must be confirmed by a Physician and sustained not more than 30 days prior to the onset of such disability.

The "health related portion" of the Maternity Leave taken by a Participant is considered to be a period of Total Disability for the purposes of benefit payment under this Benefit, whether the Participant's insurance was continued during the leave or not. The maternity benefits payable under any public or private plan are deducted from the benefits payable to the Participant for this period, in accordance with the provisions of this contract.

For a Total Disability that begins during the voluntary leave portion of a Maternity Leave, or during a Parental or Family-Related Leave, benefits are payable from the later of the following dates, provided the current benefit remained in force and provided the Participant is still Totally Disabled and insured under this Benefit:

1) the end of Elimination Period;

2) the scheduled date of return to work.

The amount of Weekly Indemnity Benefit payable under this Benefit will be the amount specified in the Benefit Schedule based on the Earnings in effect immediately prior to commencement of Total Disability.

The Weekly Indemnity payments may be taxable in accordance with the Benefit Schedule.

Weekly Indemnity Benefits are payable weekly in arrears, commencing on the later of

1) the completion of the Elimination Period; and

2) the first day the Participant consults a Physician.

The Elimination Period is expressed in calendar days.

Any payments for a period of less than one week will be at the daily rate of 1/7th of the Weekly Indemnity Benefit.

DISABILITY MANAGEMENT

The Insurer may at any time require a Totally Disabled Participant to participate in a disability management program or to take up rehabilitative employment that is considered appropriate by the Insurer.

The Insurer will actively co-ordinate all disability management program services listed below and will also facilitate and ensure case follow-up:

1) co-ordination of access to health care services;

2) support program for returning to work;

3) negotiations for a gradual return to work;

4) rehabilitation program, which may include evaluation, treatment, training, placement and job search services.

If a Totally Disabled Participant, while receiving Weekly Indemnity Benefits, takes part in a disability management program or takes up rehabilitative employment under the supervision of his Physician and with the approval of the Insurer:

1) the Participant will still be considered Totally Disabled while taking part in this program, subject to the Maximum Benefit Period specified in the Benefit Schedule;

2) if, while taking part in this program, a Participant becomes Totally Disabled again, the terms and conditions of this Benefit will re-apply to the Participant as if he had been Totally Disabled during the rehabilitation period;

3) the Maximum Benefit Period during any period of Total Disability will continue to apply even if the Participant is taking part in an approved disability management program or rehabilitative employment;

4) if, while taking part in this program, the Participant earns any income, the Weekly Indemnity Benefits payable by the Insurer to the Participant will be reduced by the amount produced by the following formula:

$$(A \div B) \times C$$

A = Income earned from any rehabilitative activity

B = Weekly Earnings of the Participant immediately prior to commencement of Total Disability

C = Weekly Indemnity Benefits otherwise payable under this Benefit

5) while the Participant is taking part in a disability management program, the Insurer will reduce his Weekly Indemnity Benefits so that his total income from all sources, if any, does not exceed 100% his Net Earnings immediately prior to commencement of Total Disability if this Benefit is non-taxable, or 100% of his gross Earnings immediately prior to commencement of Total Disability if this Benefit is taxable.

The Participant's total income from all sources includes any of the following listed below that he has received or is eligible to receive:

a) any weekly benefits payable under this Benefit;

b) any weekly Earnings or payment from the Employer;

c) any disability benefits payable under the Canada Pension Plan or the Quebec Pension Plan, but excluding benefits payable on behalf of his Dependents and any increase in benefits after benefit payments commence due solely to the cost-of-living;

d) any disability benefits payable under the Workers' Compensation Act or similar legislation or any other government plan, excluding benefits payable under the Employment Insurance Act;

e) any benefits payable from a retirement or pension plan provided by the Policyholder, excluding any increase in benefits after benefit payments commence due solely to the cost-of-living;

f) any indemnity payable for loss of time under any government plan requiring or providing automobile insurance benefits on a no-fault basis, provided that these plans have been approved as an acceptable limitation and still permit this Benefit to be registered for premium reduction under the Employment Insurance Act, as amended from time to time.

A Participant who refuses to take part in a disability management program, does not participate in such program in good faith, or does not take up rehabilitative employment considered appropriate by the Insurer will no longer be eligible for Weekly Indemnity Benefits under the policy.

RECURRENT TOTAL DISABILITY

Successive periods of Total Disability occurring after the Weekly Indemnity Benefits became payable are considered to be the same period of Total Disability unless they are separated by at least:

1) 31 consecutive days of active full-time employment, if Total Disability is due to the same cause or related causes; or

2) 1 day of active full-time employment, if Total Disability is due to an entirely unrelated cause.

Whenever successive periods of Total Disability are considered to be the same period of Total Disability, the Elimination Period will not be applied a second time and the same amount as for the initial Total Disability minus any payments already made will be payable for the remainder of the Maximum Benefit Period.

REDUCTION OF WEEKLY INDEMNITY BENEFITS, LIMITATIONS AND EXCLUSIONS

1) Reduction of Weekly Indemnity Benefits

Weekly Indemnity Benefits payable under this Benefit will be reduced by

a) any benefits the Participant is eligible to receive under any Workers' Compensation Act or similar legislation;

b) if the Maximum Benefit Period exceeds 17 weeks, any disability benefits the Participant is eligible to receive under the Canada Pension Plan or the Quebec Pension Plan excluding

i) benefits payable on behalf of his Dependents; and

ii) any increase in benefits due solely to the cost-of-living, after benefit payments commence;

c) any income replacement indemnity payable to a Participant under

i) the Automobile Insurance Act of the Province of Quebec;

ii) the Ontario Motorist Protection Plan; or

iii) any other government no-fault automobile insurance plan

provided that these plans have been approved as an acceptable limitation and still permit this Benefit to be registered for premium reduction under the Employment Insurance Act, as amended from time to time;

d) any income replacement benefits paid to the Participant under any other federal or provincial legislation; and

e) any benefit paid to the Participant under any employee benefit plan established by the Policyholder,

f) any severance or wrongful dismissal payments.

The Insurer may, at its discretion, estimate the amount of a government plan award pending notice of the actual award.

The Insurer may also reduce the Weekly Indemnity payments even if the Participant, who is required to make the necessary application, fails or refuses to exercise his rights under the above-mentioned legislation or plans.

If the Participant receives a lump-sum payment from any of the sources indicated above, the Insurer will reduce the Weekly Indemnity payments by this amount, calculated on a weekly basis.

2) Limitations

No benefits are payable for a Total Disability period

a) during the voluntary leave portion of the Maternity Leave as described under the DEFINITIONS section, for a Total Disability occurring during this period;

b) during a Parental or Family-Related Leave, for a Total Disability occurring during this period;

c) during any work stoppage due to a strike, lock-out, Leave of Absence or lay-off, for a Total Disability occurring during this period;

d) during the imprisonment of the Participant due to conviction of an offence;

e) if the Participant remains outside Canada for longer than 3 months for any reason whatsoever, unless the Insurer gives prior written consent to continue paying benefits during this period;

f) for which benefits are effectively paid by Human Resources Development Canada, if this benefit, in accordance with the Benefit Schedule, is carved out with the Employment Insurance Act, as a standard wrap around plan. Maternity benefits paid by Human Resources Development Canada during the "health related portion" of the Maternity leave described under the DEFINITIONS section, will not be included in the above.

3) Exclusions

No benefits are payable for a Total Disability resulting directly or indirectly from any one of the following causes:

a) war, whether the war be declared or not, or service in the armed forces of any country, or participation in a riot, insurrection or civil commotion;

b) committing, or attempting to commit a criminal offence;

c) cosmetic surgery or treatment, unless such surgery or treatment is required as a result of an Accident that occurred while the Participant was insured under this Benefit;

d) alcohol or drug abuse unless, for such abuse, the Participant is actively taking part in a therapeutic program supervised by a Physician on an on-going basis, is receiving Continuing Medical Care or treatment for rehabilitation and is staying in an established treatment centre qualified to provide the necessary treatment or care;

e) driving a motorized vehicle while impaired by drugs, or with an alcohol level that exceeds the limit set under the Criminal Code of Canada.

TERMINATION OF BENEFITS

Weekly Indemnity Benefits payable under this Benefit will cease on the earliest of

1) the date the Participant ceases to be Totally Disabled;

2) the date the Participant engages in any gainful occupation other than an approved gainful occupation for the purpose of rehabilitation;

3) the date the Participant fails to furnish satisfactory proof of continued Total Disability to the Insurer;

4) the date payments have been paid up to the Maximum Benefit Period for any period of Total Disability;

5) the date the Participant refuses to participate in a disability management program or to take up rehabilitative employment considered appropriate by the Insurer; and

6) the date the Participant attains the Age Limit under this Benefit. However, if a Participant is Totally Disabled prior to this Age Limit and on attaining it he is still so disabled and has not yet received 15 weeks of benefit payments for that disability, notwithstanding the Age Limit of this Benefit, coverage will be extended to the earliest of

   a) the date such Participant has received 15 weeks of benefits;

   b) the date such Participant ceases to be Totally Disabled; or

   c) the date such Participant retires.

EXTENSION OF BENEFIT AFTER TERMINATION

If a Participant is Totally Disabled on the date his insurance terminates, the Insurer will continue insurance for that Total Disability as if the insurance under this Benefit for that Participant were still in force, provided such Total Disability continues uninterrupted, subject to all other provisions of the policy.

NOTICE AND PROOF OF CLAIM

Written proof of a claim must be submitted to the Insurer within 60 days of the date Total Disability commenced.

Subsequent written proof satisfactory to the Insurer of continued Total Disability must be submitted to the Insurer at its request.

EXTENDED HEALTH CARE BENEFIT

DEFINITIONS

As used in this Benefit

Calendar Year means the period extending from January 1st to December 31st inclusive.

Convalescent/Rehabilitation Centre means any facility or institution in Canada which is licensed as a convalescent hospital by the licensing body having jurisdiction for the care and treatment of sick and injured persons who require supervision of either a Physician or a registered nurse. This institution must provide nursing care 24 hours a day by a registered nurse and maintain a daily record of each patient under the care of a Physician. However, it does not include a nursing home, home for the aged, or the chronically ill, home for the mentally ill, rest home, or an institution for the care and treatment of alcoholism or drug addiction.

Day Surgery means any surgery performed by a Physician that requires local or general anaesthesia, with the exception of any minor surgery performed in the office of the Physician.

Dentist means a person who is licensed to practise dentistry by the appropriate authority of the jurisdiction where the services are provided.

Dispensing fee means the part of the price of each prescription sold by a drugstore which corresponds to the amount covering the cost of the pharmacist's services.

Drugs available on prescription means drugs prescribed by a Physician or a dental surgeon. This will also include certain drugs requiring a prescription when prescribed by other health practitioners where permitted to do so by provincial law.

Hospitalization means

1) to be admitted to a Hospital as an In-patient for more than 18 consecutive hours; or

2) any Hospital stay in order to receive Day Surgery.

In-patient means a person admitted to and assigned a bed in a Hospital In-patient area on the order of a Physician.

Mark-up means the part of the price of each prescription sold by a drugstore which corresponds to the profit made on the drug.

Medical Emergency means any acute and unexpected condition, Illness or injury requiring immediate medical treatment.

Medical Recommendation means the order to provide medication or care given by a Physician, dental surgeon or a podiatrist duly authorized to do so in the normal performance of his profession.

Orthesis means any orthopaedic appliance constructed of rigid material, such as metal or plastic, used to maintain a part of the body in the correct position. Elastic supports are not included in this category.

Patient assistance program means the program offered by some drug manufacturers to provide Insured Persons with information, education and financial assistance if they are prescribed certain drugs.

Exclusion: If an Insured Person refuses to enrol in such a program, this person might not be eligible for reimbursement of the drug expenses.

Patient support program means the program providing support to help Insured Persons manage their health and medication.

Exclusion: If an Insured Person refuses to enrol in such a program, this person might not be eligible for reimbursement of the drug expenses.

Period Of Hospitalization means any continuous period of Hospitalization in a Canadian Hospital or successive periods of Hospitalization resulting from the same Illness or Accident and separated by less than 60 consecutive days during which the Insured Person was not hospitalized. If, during a given period, Hospitalization results from an Illness or Accident entirely unrelated to the Illness or Accident that resulted in the previous Hospitalization, this Hospitalization will be treated as a new Period Of Hospitalization.

Prosthesis means an appliance used to replace all, or part, of a limb or organ.

Sound Tooth means a natural tooth that is not afflicted with any pathology either itself or in the adjacent structures. In addition, a tooth that has been treated or repaired and restored to normal function will be considered sound.

Stable refers to the health condition of an Insured Person who, within 30 days prior to the trip departure date, is not affected by any medical condition, or is affected by a medical condition that:

1) does not require a change or for which no change was recommended in the treatment or dosage of prescribed drugs; and

2) does not demonstrate any symptoms that would indicate a deterioration of the medical condition in the course of the trip.

Total Disability or Totally Disabled means a state of incapacity, resulting from an Illness or Accident, which wholly prevents the Participant from working in any occupation for which he is suited by education, training and experience.

Vehicle means a car, a motor home or a van with a maximum load of 1,000 kilograms.

PAYMENT OF BENEFIT

Upon receipt of Proof of Claim satisfactory to the Insurer that a Participant, or one of his Dependents, while insured under this Benefit, incurred Eligible Expenses, the Insurer will reimburse the portion of expenses in excess of the Deductible, where applicable, subject to the applicable Percentage of Reimbursement and the limits specified in the Benefit Schedule, and in accordance with the other applicable provisions of this Benefit and the policy.

To be eligible, the expenses must have been incurred as a result of Illness, pregnancy or an Accident, and cover care:

1) which is medically necessary to treat the Insured Person;

2) which is generally provided for an Illness or injury of similar type or seriousness; and

3) which, unless otherwise indicated, was on the prior recommendation of the attending Physician.

In addition, the Eligible Expenses will be limited to the reasonable and customary charges generally paid in the area where the services are provided, except for the portion regarding the drug insurance benefit corresponding to the Quebec drug insurance plan.

Eligible Expenses will be considered to have been incurred on the date the service or supply was provided.

The maximum eligible drug expenses that a Participant can incur for himself and for all of his insured Dependents, which remains his responsibility, is determined by the Régie de l'assurance maladie du Québec with respect to the Deductible, Drug Co-pay if any and the portion of eligible drug expenses that is not paid by the Insurer given the Percentage of Reimbursement under this Benefit. For drug expenses subsequently incurred during the same Calendar Year, the Percentage of Reimbursement is modified to 100%.

Preferred providers network

The Insurer may select suppliers for the distribution of drugs and supplies and may restrict payment for Eligible Expenses incurred at another supplier.

DEDUCTIBLE

The Deductible is the amount of Eligible Expenses that the Participant must pay in any Calendar Year before reimbursement will be made under this Benefit. The Deductible is specified in the Benefit Schedule.

CO-PAY

The Co-pay is the portion of Eligible Expenses that the Participant must pay for each drug for which expenses were incurred before reimbursement will be made under this Benefit. The Co-pay is specified in the Benefit Schedule.

PERCENTAGE OF REIMBURSEMENT

The Percentage of Reimbursement specified in the Benefit Schedule is the percentage of Eligible Expenses in excess of the Deductible that will be reimbursed by the Insurer, in accordance with the provisions of this Benefit.

DRUG EXPENSE LIMITS

The maximum amount specified in the BENEFIT SCHEDULE is applicable to all drug expenses incurred by each Insured Person, per Calendar Year.

ELIGIBLE EXPENSES IN CANADA – EXTENDED HEALTH CARE

Eligible Expenses include charges for the following and must be incurred:

1) in the Participant's province of residence; and

2) outside the Participant's province of residence, but in Canada, for any reason other than a Medical Emergency.

HOSPITALIZATION EXPENSES

Hospital: Hospital charges for active treatment for each day of Hospitalization, with no limit as to the number of days, up to the maximum specified in the Benefit Schedule.

Convalescent/Rehabilitation Centre: semi-private accommodation and meals in a licensed Convalescent or Rehabilitation Centre, provided that the Insured Person was admitted within 14 days of discharge from a Hospital to which he was confined as an In-patient and that this stay was primarily required for rehabilitation and not custodial care, up to the maximum specified in the Benefit Schedule.

DRUGS

1) Drugs that are necessary for treatment in respect of an Illness or injury and that are available only on prescription from a Physician or a dental surgeon (code "PR", "C" or "N" in the Compendium of Pharmaceuticals and Specialties) and dispensed by a pharmacist, or by a Physician, if there is no pharmacist.

   Also eligible are drugs available on prescription that are necessary for the treatment of certain pathological conditions, excluding homeopathic preparations, and for which the therapeutic indication suggested by the manufacturer in the Compendium of Pharmaceuticals and Specialties is directly linked to the treatment of the following pathological conditions:

   cardiac problems;

   pulmonary problems;

   diabetes;

   arthritis;

   Parkinson’s disease;

epilepsy;

cystic fibrosis;

glaucoma.

Drugs and other products that the Quebec drug insurance plan would cover for the Participant and his Dependents, if they were not covered under a group insurance plan, are also eligible. These expenses are not limited to reasonable and customary charges in the area in which services are rendered.

2) For an Insured Person aged 65 or over and covered under the Quebec drug insurance plan, the drugs described in paragraph 1) that are necessary for treatment in respect of an Illness or injury, that are not covered under the Quebec drug insurance plan, and that are available only on prescription and dispensed by a pharmacist, or by a Physician, if there is no pharmacist.

   Eligible drug expenses that are used to cover the Deductible and Co-insurance under the Quebec drug insurance plan are also eligible, subject to the Deductible and Percentage of Reimbursement under this Benefit.

3) Injectable drugs, serums and vaccines prescribed by a Physician for preventing or treating an Illness. Preventive vaccines are limited to a payable amount of $200 per Calendar Year per Insured Person.

4) Reagent strips and syringes for the treatment of diabetes.

5) Anaesthetic administered during surgery that is not performed in a Hospital, up to a payable amount of $20 per operation.

PRIOR AUTHORIZATION DRUGS

Prior authorization by the Insurer is required for certain drugs listed on the Insurer's website. A prior authorization form completed by the Physician must be submitted to the Insurer in order to determine whether the prescribed drug meets the prior authorization criteria established by the Insurer. The criteria are based, in particular, on clinical practice guidelines and recommendations issued by health technology assessment agencies and they include verification that:

1) the drug is prescribed for a therapeutic indication approved by Health Canada, and

2) the drug's effectiveness is satisfactory compared to its associated cost.

Proof of the effectiveness of the approved drug, including medical results, may be requested during the course of treatment to determine if the drug is having the desired effect so that it may remain eligible for reimbursement.

The Insurer reserves the right to reimburse an equivalent or biosimilar drug when a less expensive equivalent or biosimilar drug is available on the market.

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PATIENT SUPPORT PROGRAM AND PATIENT ASSISTANCE PROGRAM

The Insurer may require Insured Persons to enrol in such programs.

HEALTH PROFESSIONALS

Nursing Care: Services of a registered nurse, a licensed practical nurse or a registered nursing assistant are eligible, up to the payable amount specified in the Benefit Schedule per Insured Person, provided the patient is not confined in a Hospital and the services are medically necessary, are not rendered solely for custodial care, supervision or companionship and psychotherapy, and come within the competence of such nurse. In addition, the nurse must not be related to the Participant or to any of his Dependents by birth or marriage, and must not ordinarily reside in his or his Dependent's home.

Paramedical Services: Services of the practitioner disciplines specified in the Benefit Schedule and up to the maximum amount specified, provided that the practitioner is operating within his recognized field. He must be a member in good standing of his professional association that must be recognized by the Insurer. Unless otherwise indicated in the Benefit Schedule, these services do not require prior Medical Recommendation.

Imaging techniques ordered by a chiropractor, a podiatrist or an osteopath are covered, up to a payable amount of $100 per Insured Person each Calendar Year for each of these specialists.

AMBULANCE

In the event of a Medical Emergency, or if the Insured Person must be transferred to another Hospital, transportation by a licensed ground ambulance

1) from the place of the Accident or Illness to the nearest Hospital where adequate medical treatment is available;

2) between Hospitals; and

3) from the Hospital to the place of residence of the Insured Person, when his condition warrants it.

Medical Emergency transportation by a licensed air ambulance to the nearest Hospital where adequate treatment is available, or to another Hospital when certified as medically necessary by the attending Physician.

MOBILITY AIDS

Conventional wheelchair: Rental or purchase, at the discretion of the Insurer.

Walkers or crutches: Purchase or rental, at the discretion of the Insurer.

ORTHOPAEDIC SUPPLIES

Spinal brace: Purchase, but not repair.

Brace for a limb, truss and plaster: Purchase, but not the repair or replacement.

Conventional hospital bed: Purchase or rental, at the discretion of the Insurer.

Orthopaedic shoes: Purchase of one pair each Calendar Year, up to a payable amount of $400 per Insured Person each Calendar Year. Orthopaedic shoes are defined as custom-molded shoes specifically designed for an individual to correct a foot defect, as well as open-toed shoes, in-flare or out-flare shoes, straight-laced shoes and shoes required for Denis Browne braces; these appliances are eligible provided they are manufactured and billed by laboratories licensed under the Public Health Protection Act. The cost of modifications or adjustments to stock item footwear is also eligible; off-the-shelf shoes that are regular stock are excluded. In-depth shoes are covered, up to a payable amount of $100 per Insured Person each Calendar Year.

ORTHESIS AND PROSTHESIS

Expenses incurred for a Prosthesis or an Orthesis are eligible, provided these appliances are manufactured (and billed in the case of podiatric ortheses and arch supports) by laboratories licensed under the Public Health Protection Act.

Podiatric Orthesis or arch support: Purchase, up to a combined eligible amount of $495 per Insured Person each Calendar Year.

Artificial limb: Purchase; the cost for the repair is also eligible; replacement is included when required due to physiological change.

Artificial eye: Purchase, including reimbursement for one polishing or one re-making of the artificial eye each Calendar Year, per Insured Person.

External breast Prosthesis: Purchase of an external breast Prosthesis when required because of total or radical mastectomy that has been performed while the Insured Person is covered under this Benefit or a comparable benefit in force immediately before the effective date of this Benefit, up to a maximum of 2 prosthesis per Insured Person for any period of 12 consecutive months.

Surgical brassieres: Purchase of an external breast Prosthesis when required because of total or radical mastectomy that has been performed while the Insured Person is covered under this Benefit or a comparable benefit in force immediately before the effective date of this Benefit, up to a maximum of 2 brassieres per Insured Person for any period of 12 consecutive months.

Hearing aids: Purchase on the written prescription of a licensed otolaryngologist, up to an eligible amount of $600 per Insured Person for any period of 48 consecutive months.

Wigs: Purchase of wigs required as a result of chemotherapy, up to a lifetime payable amount of $300 per Insured Person.

THERAPEUTIC EQUIPMENT

Glucometer or reflectant meter: Purchase, or rental, upon medical recommendation, up to an eligible amount of $300 for any period of 36 consecutive months.

Oxygen, and equipment required for its administration: Purchase or rental, at the discretion of the Insurer.

Apnea monitor: Purchase or rental, at the discretion of the Insurer.

Drainage pump and chest percussion accessories: Purchase.

TENS nerve stimulators: Purchase or rental, at the discretion of the Insurer, up to an eligible amount of $1,000 per Insured Person for any period of 60 consecutive months.

Insulin pumps: Purchase, up to a payable amount of $7,500 per Insured Person for any period of 60 consecutive months.

Other therapeutic equipment: Purchase or rental, at the discretion of the Insurer, provided such equipment is medically required and is intended to cure or treat the affliction, up to a lifetime payable amount of $10,000 per Insured Person. This category of equipment includes, for example, non-union bone stimulators, aerosol therapy equipment and intermittent positive pressure breathing machines.

MEDICAL SUPPLIES

Colostomy, ileostomy or uretherostomy supplies: Purchase.

Elastic support stockings: Purchase of medium or firm (over 20 mm/Hg) support stockings dispensed in a pharmacy or a medical facility, up to a maximum of 3 pairs each Calendar Year, per Insured Person.

Intra-uterine devices: Purchase, up to a payable amount of $100 per Insured Person each Calendar Year.

Supplies for paraplegics: Purchase, provided such supplies are required for the treatment and the care of a paraplegic Insured Person.

Catheter: Purchase.

Medical supplies for gavage: Purchase.

Medical supplies necessary following a tracheotomy: Purchase.

Opaque glass necessary during radiotherapy or psoriasis treatments: Purchase.

Compressive garments for the treatment of burns: Purchase.

Medicated dressings: Purchase.

DIAGNOSTIC SERVICES

Imaging techniques (including X-ray or MRI examinations), diagnostic laboratory tests and radiotherapy or radium therapy, up to a payable amount of $2,000 per Insured Person each Calendar Year. Such procedures do not include services received in a Hospital. Ultrasound are covered, up to a payable amount of $300 per Insured Person each Calendar Year.

DENTAL TREATMENT DUE TO AN ACCIDENT

The services of a dentist required to repair and replace healthy teeth as a result of an accidental blow to the mouth received while the Insured Person is covered under this Benefit or a comparable benefit in force immediately before the effective date of this Benefit, but not as a result of voluntarily or involuntarily putting food or any other object in his mouth. Dental services must be rendered within 12 months of the accident; otherwise, a treatment plan deemed satisfactory by the Insurer will be required before that deadline. No benefit is payable for services provided more than 2 years after the date of the accident.

COSMETIC SURGERY DUE TO AN ACCIDENT

The services for cosmetic surgery rendered as a result of an accident that happened while the insured is covered under this Benefit as long as services terminate within 180 days of the accident and are rendered while the insured is covered under this Benefit, up to a payable amount of $5,000 per Insured Person per accident.

OTHER TREATMENTS

Detoxification: Room and board charges in a licensed centre or a licensed private clinic specialized in the treatment of alcoholism and drug addiction, provided that the condition of the Insured Person requires treatment under the supervision and control of a Physician and that treatment has been approved by the Insurer, up to a maximum of Eligible Expenses of $80 per day and a lifetime payable amount of $2,500 per Insured Person.

HEALTH ASSISTANCE

Health Assistance is a confidential telephone service that is available 24 hours a day enabling the Insured Person to speak with experienced health care professionals and to obtain information immediately.

This telephone service provides the Insured Person with information on the following topics:

- health
- nutrition
- physical fitness
- availability of local resources
- immunization
- lifestyle
- child care

Health Assistance should be considered as a complement to medical consultations and emergency medical services (911 or other); it is not intended to replace the regular health care provider of the Insured Person, nor the emergency medical services of a municipality.

This information service may be of use in improving the quality of life of the Participant and of his Dependents.

The Insured Person may contact HEALTH ASSISTANCE at any time.

Calls from	**Dial**
Anywhere in Canada	1 877 875-2632

ELIGIBLE EXPENSES - REFERRAL TREATMENT

Eligible Expenses incurred outside the province of residence of the Insured Person as a result of a referral include those provided for in the TRAVEL INSURANCE section below, subject to the following provisions:

1) This service or treatment must not be available in Canada or in the normal province of residence of the Insured Person;

2) The Insured Person must provide the Insurer with a letter of referral from a Physician in his normal province of residence, indicating that he is being referred to another Physician;

3) The Insurer must give prior written approval;

4) The provincial health and/or hospital insurance plans must pay a portion of the Eligible Expenses.

The maximum amount payable by the Insurer under this provision is limited to the percentage specified in the Benefit Schedule and the following Eligible Expenses:

1) Expenses incurred outside the province of residence, but in Canada - no maximum limitation;

2) Expenses incurred outside Canada - up to a payable amount of $50,000 per Insured Person each Calendar Year.

ELIGIBLE EXPENSES - TRAVEL INSURANCE

If an Insured Person incurs Medical Emergency expenses during the first 180 days of a stay outside his province of residence, the Insurer will reimburse the Eligible Expenses in accordance with the Benefit Schedule and the following conditions:

1) the Insured Person must be covered under government health and hospital insurance plans;

2) expenses must be eligible under the Extended Health Care Benefit; and

3) expenses must be related to a Stable health condition prior to the trip departure date.

The Participant must contact the Insurer if the duration of the stay outside the province of residence is, or may be, longer than 180 days. Otherwise the Insured Person may not be covered under the Travel Insurance benefit.

1) Eligible Health Care Expenses

   a) Hospital services and room and board charges in a semi-private room until the Insured Person is discharged from the Hospital;

   b) Services of a Physician, a surgeon and an anaesthetist;

   c) All other Eligible Expenses that are covered under this Benefit in the normal province of residence of the Insured Person, excluding Hospital and Convalescent Care Eligible Expenses, if insured.

2) Eligible Transportation Expenses

   a) Expenses incurred for the repatriation of the Insured Person to his place of residence by a suitable means of public transportation to receive appropriate care as soon as his state of health allows it, provided the means of transportation originally arranged for the return trip cannot be used; repatriation must be approved and arranged by "Voyage Assistance". Furthermore, if "Voyage Assistance" recommends repatriation and the Insured Person declines, his insurance under the Travel Insurance provision will terminate.

   b) Expenses incurred for the repatriation (at the same time as the repatriation provided for above) of any Immediate Family member insured under this Benefit, if he cannot return to the point of departure by the means of transportation originally arranged for the return trip; repatriation must be approved and arranged by "Voyage Assistance".

   c) Round-trip economy transportation for a qualified medical attendant who is not a family member, a friend, or a travelling companion, provided the presence of this attendant is ordered by the attending Physician and approved by "Voyage Assistance".

   d) Round-trip economy air, bus or train transportation by the most direct route for one Immediate Family member to the Hospital where the Insured Person must be confined for at least 7 days (expenses will be reimbursed only if the Insured Person remains in Hospital for at least 7 days). This visit is eligible for reimbursement provided that the Insured Person is not accompanied by an Immediate Family member age 18 or over. The cost of meals and accommodation for the Immediate Family member up to $500 are also covered. The visit must be considered beneficial to the patient by the attending Physician, and prior approval must be obtained from "Voyage Assistance".

e) Cost of returning the personal or rented Vehicle of the Insured Person if the Insured Person suffers from a disability as a result of a Medical Emergency, certified by a Physician, that prevents him from operating this Vehicle and none of the Immediate Family members accompanying him are able to return it. A commercial agency may be hired to return the Vehicle, but the return must be arranged and approved by "Voyage Assistance". The amount reimbursed is limited to $1,000 per Participant.

f) If the Insured Person should die, round-trip economy air, bus or train transportation by the most direct route for one Immediate Family member of the deceased to identify the body before repatriation (the trip must be pre-approved and arranged by "Voyage Assistance"). These expenses are not reimbursed if the Insured Person was accompanied by an Immediate Family member age 18 or over.

g) If the Insured Person should die, the costs of preparation and the return of the body or ashes to the place of residence by the most direct route (plane, bus or train), up to $5,000; the cost of the burial coffin is not covered. The return must be pre-approved and arranged by "Voyage Assistance".

3) Eligible Daily Allowance

The cost of meals and accommodations for an Insured Person who must delay his return because of an Illness or bodily injury suffered by the Insured Person himself, an accompanying member of his Immediate Family or a travelling companion, as well as additional child care expenses for Children not accompanying the Insured Person. Eligible Expenses are limited to $200 per day per Participant for a maximum of 10 days and the Illness or injury must be certified by a Physician.

4) Eligible Long-distance Telephone Charges

Long-distance telephone charges to reach a member of the Immediate Family if the Insured Person is hospitalized, provided that the transportation allowance, provided under section d) above, to visit that person is not used and that the Insured Person is not accompanied by an Immediate Family member age 18 or over - up to $50 per day, and up to an overall maximum of $200 per Period Of Hospitalization.

5) Medical Decisions

Decisions by a Physician or other health care professional employed by, under contract to, or designated by "Voyage Assistance", regarding the medical need for providing any of the covered services outlined above are medical decisions based on medical factors and, as such, will be conclusive in determining the need for these services.

6) Voyage Assistance service

"Voyage Assistance" will take the necessary steps to provide the following services to any Insured Person who requires them:

a) 24 hour toll-free telephone assistance;

b) referral to Physicians or health-care facilities;

c) assistance for Hospital admission;

d) cash advances to the Hospital when required by the facility;

e) repatriation of the Insured Person to his home city, as soon as his state of health permits it;

f) establishing and staying in contact with the Insurer;

g) handling arrangements in the event of death;

h) repatriation of the Children of the Insured Person, if the Insured Person cannot be moved;

i) delivery of medical assistance and drugs to an Insured Person who is too far from health care facilities to be transported there;

j) arrangements to bring a member of the Immediate Family to the bedside of the Insured Person if he must be confined to Hospital for at least 7 days, provided that such visit is ordered by the attending Physician;

k) assistance in replacing lost or stolen travel documents so that the Insured Person can continue his trip;

l) referral to lawyers if legal problems arise;

m) translation services for emergency calls;

n) transmission of urgent messages to close friends or family in case of emergency; or

o) information prior to departure concerning passports, visas and vaccinations required in the country of destination.

In the event of a **MEDICAL EMERGENCY**, the insured must contact the travel assistance firm immediately.

Calls from	**Dial**
Montreal area	(514) 875-9170
Canada and United States	1-800-465-6390 (toll-free)
Elsewhere (excluding North and South America)	overseas code + 800 29485399 (toll-free)
Collect call (Anywhere worldwide)	(514) 875-9170

RESTRICTIONS, EXCLUSIONS AND LIMITATIONS

1) No reimbursement will be made under this Benefit for the following:

   a) services or treatment that a government health plan prohibits from being paid in whole or in part, except to the extent that it permits reimbursement of the excess amount;

   b) services, treatment or supplies that a person receives without charge or that are reimbursed under a provincial or federal law. If a person is not covered under the laws in question, the Insurer will not reimburse the expenses that would normally be covered under the hospital or health insurance legislation in force in the Insured Person's province of residence;

   c) services, treatment or supplies which are experimental in nature;

   d) expenses incurred for surgically implanted prostheses, except for crystalline lenses if covered under the policy;

   e) services, treatment or supplies provided to the Participant by the Employer;

   f) wheelchairs adapted or designed for sports activities;

   g) electric beds;

   h) monitoring devices such as stethoscopes, sphygmomanometers and similar equipment, and domestic appliances such as air purifiers, humidifiers, air conditioners, whirlpools and other similar equipment;

   i) equipment such as "Obus form" type;

   j) training, exercise programs, physical fitness programs using equipment or floor exercises, floating baths, mud baths, therapeutic baths, relaxation exercises, gym exercises, stretching and strengthening exercises, postural evaluations and ear candling;

k) diapers for incontinence;

l) dental services, except those provided for in this Benefit;

m) dental services and supplies for the purposes of full mouth reconstructions, for vertical dimension correction or for any other temporomandibular joint dysfunction;

n) travel for health reasons or for medical examinations required for insurance, consultation or assessment purposes;

o) services, treatment or supplies not included in the list of Eligible Expenses;

p) Eligible Expenses which result directly or indirectly from the following:

   i) cosmetic treatment, except those provided for in this Benefit;

   ii) committing, or attempting to commit a criminal offence;

   iii) any cause for which payment is provided under any Workers' Compensation Act or similar legislation or under any other government plan;

   iv) war, whether the war be declared or not, or service in the armed forces of any country, or participation in a riot, insurrection or civil commotion;

   v) driving a motorized Vehicle while impaired by drugs, or with an alcohol level that exceeds the limit set under the Criminal Code of Canada; the Eligible Expenses incurred for detoxification treatment and the expenses incurred for the purchase of medication covered under the Quebec drug insurance plan are not subject to this exclusion;

q) services, treatment or supplies for fertility treatment;

r) eye examinations, including refraction, unless otherwise indicated in the Benefit Schedule;

s) glasses, contact lenses and fitting of glasses and contact lenses, unless otherwise indicated in the Benefit Schedule;

t) sunglasses or safety glasses.

Benefits may be limited or no reimbursement made for services or supplies available at a supplier of the preferred providers network but obtained from another supplier.

2) Exclusions applicable to drugs

No reimbursement will be made under this Benefit for the following:

a) products and drugs, including hormones and injections, used in the treatment of obesity;

b) contraceptives (prophylactics and contraceptive jellies and foams) except those provided for under this Benefit;

c) the following products, whether or not prescribed:

i) shampoos and other scalp care products, including hair growth products;

ii) beauty-care products;

iii) cosmetics;

iv) so-called "natural" products and homeopathic preparations;

v) sun-tan emulsions (sunscreens);

vi) soaps;

vii) over-the-counter laxatives;

viii) over-the-counter antacids;

ix) skin softeners;

x) disinfectants and ordinary dressings;

xi) mineral water;

xii) any infant milk formulas;

xiii) proteins and food supplements (i.e. products used to supplement or complement a diet);

d) sclerosing injections used in the treatment of varicosities, telangiectasia and minor dilation when this treatment is primarily for cosmetic and not therapeutic purposes;

e) products and drugs used in the treatment of sexual dysfunctions;

f) products or drugs used as smoking cessation aids that are not covered under the Quebec drug insurance plan and expenses in excess of the maximum provided for smoking cessation aids under the Quebec drug insurance plan related to products or drugs used as smoking cessation aids;

g) products used in fertility treatment, except those covered under the Quebec drug insurance plan;

h) expenses incurred for services, products or drugs that are used to treat specific conditions other than those for which they are approved by Health Canada;

i) expenses incurred for services, products or drugs that are taken in a higher dose, greater quantity or at a frequency that exceeds the Insurer's established criteria of good clinical practice.

Benefits may be limited or no reimbursement made for drugs or supplies available at a supplier of the preferred providers network but obtained from another supplier.

Under no circumstances can the exclusions under the policy make this plan less extensive than the Quebec drug insurance plan.

3) Exclusions applicable to drugs requiring prior authorization

The Insurer reserves the right to apply certain restrictions, exclusions and limitations namely to services, products or drugs that do not meet the Insurer's prior authorization criteria on the date the expenses were incurred.

4) Drug restrictions

a) the Insurer reserves the right to apply certain restrictions for the reimbursement of drugs for which a less expensive equivalent drug is available on the market;

b) drugs and medicines dispensed must not be in excess of a 90 day supply.

5) Additional Limitations Applicable to Drugs

For biologic drugs, the Insurer reserves the right to reimburse a less expensive biosimilar drug if available on the market.

6) Additional Exclusions Applicable to Drugs

No reimbursement is made for:

a) Drugs or products that are on the Insurer's list of excluded drugs or products. This list is available on the Insurer's website. In part, the list is based on the drug or product's effectiveness and cost, clinical practice guidelines and recommendations issued by health technology assessment agencies.

b) Drugs or products that are or should be administered in a hospital or hospital setting, as determined by the Insurer. This includes drugs or products that require special supervision during treatment due to the severity of the patient's condition, the complexity of the treatment or for safety reasons. In part, the Insurer uses information from Health Canada approved product monographs and recommendations issued by health technology assessment agencies to make its determination.

7) Exclusions and limitations applicable to Travel Insurance

If an Insured Person fails to contact "Voyage Assistance" immediately when he requires Medical Emergency services that require Hospitalization outside the country, the Insurer may reduce or deny reimbursement of a portion of the incurred Eligible Expenses. It is understood that the Insurer is not responsible for the availability or quality of such services.

Exclusions applicable to the Extended Health Care Benefit also apply to the Travel Insurance provision. Furthermore, the Insurer will not pay any of the benefits provided for under the Travel Insurance provision in the following circumstances:

a) if the Insured Person is not covered under government health and hospital insurance plans;

b) if the purpose of the trip is to receive medical or paramedical treatment or Hospital services, unless the Insured Person was referred to another Physician, in accordance with the provisions of the REFERRAL TREATMENT section of this Benefit;

c) for elective, non-emergency treatment or surgery, when this service could have been provided in the province of residence of the Insured Person without endangering his life or health, even if such service is provided as a result of a Medical Emergency;

d) if the Insured Person does not agree to repatriation as recommended by "Voyage Assistance";

e) for health care and Hospital expenses incurred for an Insured Person who cannot be repatriated in his province of residence and who refuses medical treatment prescribed by the Physician, and approved by "Voyage Assistance";

f) for any Medical Emergency incurred in a country or region for which the Canadian government issued, prior to the trip departure date, one of the following travel warnings:

   i) avoid non-essential travel; or

   ii) avoid all travel.

   The Insured Person who is in the country or region for which a travel warning is issued during his trip is not subject to this exclusion. However, he must make the necessary arrangements to leave the country or region as soon as possible;

g) if the Insured Person refuses to disclose to the Insurer necessary information regarding other insurance plans under which he also has travel insurance coverage, or if he refuses the use of such information by the Insurer;

h) if the expenses incurred are related to a health condition that was not Stable prior to the trip departure date.

Travel Insurance benefits are limited to the maximum specified in the Benefit Schedule.

CO-ORDINATION OF BENEFITS

This Benefit is subject to the CO-ORDINATION OF BENEFITS provision in the CLAIMS section of the policy, and to the provisions below.

Total benefits payable under this Benefit and, if applicable, the PARTICIPANT ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT and the DEPENDENT ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT if included under the policy cannot exceed the amount of Eligible Expenses incurred.

If expenses incurred by the Insured Person are eligible for payment under both this Benefit and, if applicable, the PARTICIPANT ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT and the DEPENDENT ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT if included under the policy, such expenses will be payable under the ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS prior to any payment under this Benefit. As such, the liability of the Insurer under this Benefit will be limited to the unpaid balance of these Eligible Expenses.

BENEFIT TERMINATION

This Benefit terminates on the date the Participant attains the Age Limit specified in the Benefit Schedule or on the earliest of the dates indicated in the TERMINATION OF PARTICIPANT INSURANCE provision.

DEPENDENT BENEFIT EXTENSION AFTER PARTICIPANT'S DEATH

In the event of the death of the Participant and subject to policy provisions, insurance under this Benefit will continue for insured Dependents, without premium payment, until the earliest of the following dates:

1) 24 months following the death of the Participant;

2) the date on which the Dependent ceases to be eligible as a Dependent for a reason other than the death of the Participant;

3) the date on which Dependent insurance would have terminated if the Participant had not died; or

4) the date on which this Benefit or policy terminates.

NOTICE AND PROOF OF CLAIM

All claims, other than drug claims, must be submitted to the Insurer along with any receipts every 120 day period, if the amount claimed justifies it, and within 12 months of the date the expense was incurred. In the event of an Accident for which the Participant must submit a claim, written notice must be sent to the Insurer within the 30 days immediately following the Accident.

Subsequent written proof satisfactory to the Insurer of continuing Total Disability must be submitted to the Insurer in accordance with any request made by the Insurer.

DRUG CLAIMS

When incurring drug expenses, the Insured Person must show his payment card to the pharmacist. With this method of payment, which is referred to as “direct”, the Insured Person only pays the pharmacist for the uninsured portion of the drug expenses incurred and, therefore, the Participant is not required to submit a claim to the Insurer.

YOU SHOULD KNOW

HEALTH INQUIRIES

There are 2 ways to reach us for any question about Eligible Expenses under the Extended Health Care Benefit:

By e-mail at: Groupservice@dfs.ca

By phone at: 1 800 263-1810

For a better experience, it is important to have the policy number and the certificate number ready when an agent is available to take the call.

GENERAL INQUIRIES

To obtain any other information, visit the "Contact us" section of Desjardins Financial Security's website at **www.desjardinslifeinsurance.com**.

BENEFICIARY

This provision removes or restricts the right of the Participant to designate persons to whom or for whose amounts are to be payable for some benefits:

Only the benefits that include a benefit payment in the event of the Participant's death are subject to the designation of beneficiary(ies), and the same designation applies to all these benefits.

ACCESS TO THE POLICY

Upon request to Desjardins Financial Security, the Participant may obtain a copy of his application, his insurability report and the policy.

HOW TO FILE A COMPLAINT

If a Participant is unhappy about something we've said or done, feels they've been wronged or wants us to take corrective action he can file a complaint with the Dispute Resolution Officer at Desjardins Financial Security. The role of the Officer is to evaluate the merit of the decisions and practices of the company when one of its customers believes he has not received the service to which he was entitled.

There are 3 ways to reach the Dispute Resolution Officer

In writing, at the following address:

Dispute Resolution Officer

Desjardins Financial Security

200, rue des Commandeurs

Lévis (Québec) G6V 6R2

By e-mail at: disputeofficer@dfs.ca

By phone at: 1 877 838-8185

For further information on the procedure to follow in case of complaint, or to obtain the complaint form, visit the “Contact us” section of Desjardins Financial Security’s website at **www.desjardinslifeinsurance.com**.

Our commitment to you

We will always be here to answer your questions. You can rely on our knowledgeable team to deliver outstanding service and process your claims efficiently. We are here to help you stay healthy and to give you advice and financial support when you need them most.

desjardinslifeinsurance.com

Proud supporter of

Canadian Cancer Society

itsmylife.cancer.ca

Proud supporter of

breakthroughfund.ca

Desjardins Insurance refers to Desjardins Financial Security Life Assurance Company.
200, rue des Commandeurs
Lévis (QC) G6V 6R2 / 1-866-647-5013

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