

Group Insurance Plan

OLYMEL ST-DAMASE ET SYNDICAT TUAC - LOCAL 1991-P

Group: 4160

Issued for class:

1 - REGULARS UNIONIZED EMPLOYEES

Issued:

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Negotiated through:

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This explanatory brochure constitutes a useful and important guide.

This document contains texts briefly describing group insurance benefits of your plan. However, these texts do not confer any contractual rights and do not alter in any manner benefits of the plan. In all instances, the provisions and stipulations of the policy issued to the contract owner shall prevail.

We urge you to read it carefully and to save it for future reference whenever required.

Filing of claim

You can submit your claims by Internet on our secured site or by mail.

You can access our *online services* on our secured site at www.uvinsurance.ca under the **My Universe Login - Group Insurance - Member** section.

To send your claims by mail, you must include your original receipts and a completed form available from your group insurance plan administrator or online at www.uvinsurance.ca under the **Group Insurance - Learn more - Forms** section.



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SUMMARY OF BENEFITS

CONTRACT NO.: 4160, CLASS 1 - REGULARS UNIONIZED EMPLOYEES

LIFE INSURANCE BENEFIT FOR THE MEMBER

Effective date: Nov 1, 2022

INSURABLE AMOUNT:

The insurable amount is a fixed amount of \$ 40 000.

Maximum amount without proof: \$ 40 000

Maximum amount with proofs: \$ 40 000

Reduction of 50 % at the member's 65th birthday, for a maximum amount of: \$ 20 000

Reduction of 100 % at the member's 70th birthday.

Reduction of 100 % at retirement.

WAIVER OF PREMIUMS:

Waiver of premiums in the event of disability of the member up to age 65, after a waiting period of 6 months.

SUMMARY OF BENEFITS

CONTRACT NO.: 4160, CLASS 1 - REGULARS UNIONIZED EMPLOYEES

LIFE INSURANCE BENEFIT FOR DEPENDANTS

Effective date: Nov 1, 2022

INSURABLE AMOUNT:

	SPOUSE	CHILD(REN)*	CHILD(REN)**	CHILD(REN)***
Family coverage:	\$ 10 000	\$ 10 000	\$ 10 000	\$ 10 000

* Per child aged 24 hours to 14 days

** Per child aged 15 days to 6 months

*** Per child over 6 months

TERMINATION:

The maximum age for a dependent child is 21 years, or 26 years if a full time student.

Termination of benefit at age 70 for the member.

Termination of benefit upon retirement of the member.

WAIVER OF PREMIUMS:

Waiver of premiums in the event of disability of the member up to age 65, after a waiting period of 6 months.

SUMMARY OF BENEFITS

CONTRACT NO.: 4160, CLASS 1 - REGULARS UNIONIZED EMPLOYEES

SHORT-TERM DISABILITY BENEFIT

Effective date: Nov 1, 2022

INSURABLE AMOUNT:

Weekly insurable amount: 66.670 % of the salary rounded to the next dollar.

Maximum insurable amount: Is equal to HRDC

Taxation of the insurable amount: Taxable

The maximum of disability income: 100 % of the gross salary

WAITING PERIOD:

For an accident: 0 day

For an illness: 5 business days

For hospitalisation: 0 day

BENEFIT:

The maximum duration of benefits: 26 weeks

Frequency of cheques: Every 7 days, payable on a 5-day week basis.

Termination of benefit at: Age 65 for the member

WAIVER OF PREMIUMS:

Waiver of premiums in the event of disability of the member up to age 65, after a waiting period of 6 months.

SUMMARY OF BENEFITS

CONTRACT NO.: 4160, CLASS 1 - REGULARS UNIONIZED EMPLOYEES

LONG-TERM DISABILITY INSURANCE BENEFIT

Effective date: Nov 1, 2022

INSURABLE AMOUNT:

Monthly insurable amount: 75.000 % of the salary rounded to the next dollar.

Maximum insurable amount without proof: \$ 2 000

Maximum insurable amount with proof: \$ 2 000

Taxation of the insurable amount: Taxable

Maximum percentage of disability income: 75 % of the gross salary

WAITING PERIOD:

For an accident: 182 days

For an illness: 189 days

For hospitalisation: 182 days

BENEFIT:

The maximum duration of benefits: Age 65 for the member

Frequency of cheques: 1 per month

The definition of own occupation is: The inability to accomplish own occupation for 3 years.

Termination of benefit at: Age 65 for the member

WAIVER OF PREMIUMS:

Waiver of premiums in the event of disability of the member up to age 65, after a waiting period of 6 months.

SUMMARY OF BENEFITS

CONTRACT NO.: 4160, CLASS 1 - REGULARS UNIONIZED EMPLOYEES

HEALTH INSURANCE BENEFIT

Effective date: Nov 1, 2022

TOTAL AMOUNT PAYABLE:

The total amount payable for health insurance has no limit.

DEDUCTIBLE:

Individual coverage: \$ 25*

Family coverage: \$ 25*

Combined deductible: Yes, with drug insurance

**The deductible is applicable by calendar year.*

ELIGIBLE FEES:

Description	Refund	-----Per Period-----			Maximum	Type	Deductible	Max Age	
		Frequency	No.	Visit					
HOSPITALISATION:									
HOSP. PROV. RESIDENCE [*]	100%	See contract			See contract	(E)	No	99	
HOSP. OUT PROV. RES. [*]	100%	See contract			See contract	(P)	No	99	
CONVALESCENCE HOME [*]	100%	Calendar Year	180		See contract	(E)	No	99	
SUBSTANCE ABUSE TR. [*]	90%	See contract			\$80	\$2 500	(E)	Yes	99
[*] Semi-private room									
PARAMEDICAL EXPENSES:									
AUDIOLOGIST	90%	Calendar Year	11	\$40		(E)	Yes	99	
CHIROPRACTOR	90%	Calendar Year	11	\$40		(E)	Yes	99	
X-RAY (CHIROPRACTOR)	90%	Calendar Year		\$25	\$100	(E)	Yes	99	
MASSOTHERAPIST [1]	90%	Calendar Year	11	\$40		(E)	Yes	99	
NATUROPATH	90%	Calendar Year	11	\$40		(E)	Yes	99	
NATUROTHERAPIST	90%	Calendar Year	11	\$40		(E)	Yes	99	
ORTHOPHONIST	90%	Calendar Year	11	\$40		(E)	Yes	99	
ORTHOTHERAPIST [1]	90%	Calendar Year	11	\$40		(E)	Yes	99	
OSTEOPATH	90%	Calendar Year	11	\$40		(E)	Yes	99	
PHYSIOTHERAPIST [2]	90%	Calendar Year	11	\$40		(E)	Yes	99	
PODIATRIST	90%	Calendar Year	11	\$40		(E)	Yes	99	
PSYCHOANALYST [3]	90%	Calendar Year	11	\$40		(E)	Yes	99	
PSYCHOLOGIST [3]	90%	Calendar Year	11	\$40		(E)	Yes	99	
READAPTATION THERAP. [2]	90%	Calendar Year	11	\$40		(E)	Yes	99	
SOCIAL WORKER [3]	90%	Calendar Year	11	\$40		(E)	Yes	99	

Maximum amounts are combined for overall fees for each whole group.

These groups are: [1], [2], [3] and [4]

Type (E) = maximum eligible amount, Type (P) = maximum payable amount

[R] = medical recommendation required for these paramedical expenses

SUMMARY OF BENEFITS

CONTRACT NO.: 4160, CLASS 1 - REGULARS UNIONIZED EMPLOYEES

HEALTH INSURANCE BENEFIT

ELIGIBLE FEES (CONTINUED):

DESCRIPTION	Refund	-----Per Period-----			Maximum	Type	Deductible	Max Age
		Frequency	No.	Visit				
OTHER FEES:								
COLOSTOMY AND AL.	90%	See contract			Unlimited	(E)	Yes	99
AMBULANCE	90%	See contract			Unlimited	(E)	Yes	99
LAB TEST/DIAGNOSIS	90%	Calendar Year			\$1 000	(E)	Yes	99
ANESTHETIC	90%	See contract			Unlimited	(E)	Yes	99
HEARING AID	90%	48 months			\$600	(E)	Yes	99
RESP. APPRAR./OXYGEN	90%	Lifetime			\$10 000	(E)	Yes	99
BANDAGE / SPLINT	90%	See contract			Unlimited	(E)	Yes	99
OTHER PROSTHESIS	90%	See contract			\$5 000	(E)	Yes	99
DYN. ORTHOSIS / CORS.	90%	See contract			Unlimited	(E)	Yes	99
ELASTIC STOCKINGS	90%	Calendar Year	3		Unlimited	(E)	Yes	99
ORTHOPEDIC SHOES#1 [4]	75%	12 months	2		\$300	(E)	Yes	16
ORTHOPEDIC SHOES#2 [4]	75%	12 months	1		\$300	(E)	Yes	99
DENTAL ACCIDENT	90%	See contract			\$5 000	(E)	Yes	99
FOOT ORTHOSIS	90%	12 months			\$495	(E)	Yes	99
EYE EXAM	90%	24 months			\$75	(E)	Yes	65
MEDICAL SUPPLIES	90%	See contract			Unlimited	(E)	Yes	99
GLUCOMETER	90%	36 months			\$300	(E)	Yes	99
NURSE	90%	12 months		\$300	\$10 000	(E)	Yes	99
REGISTERED NURSE	90%	12 months			\$200	(E)	Yes	99
SCLER. INJEC. DRUGS	90%	Calendar Year		\$20		(E)	Yes	99
RENTAL (CHAIR/BED)	90%	See contract			Unlimited	(E)	Yes	99
CAPILLARY PROSTHESIS	90%	Lifetime		1	\$300	(E)	Yes	99
MAMMARY PROSTHESIS	90%	24 months			\$1 000	(E)	Yes	99
X-RAY	90%	Calendar Year			\$1 000	(P)	Yes	99
MAG. RESONANCE (MRI)	100%	Calendar Year			\$1 000	(P)	Yes	99
CARE OUT PROV.	100%	See contract			See contract	(P)	No	99
I.U.D.	90%	Calendar Year		1		(E)	Yes	99
TENS	90%	60 months			\$1 000	(E)	Yes	99
TRANSFUSION	90%	See contract			Unlimited	(E)	Yes	99

Maximum amounts are combined for overall fees for each whole group.

These groups are: [1], [2], [3] and [4]

Type (E) = maximum eligible amount, Type (P) = maximum payable amount

SUMMARY OF BENEFITS

CONTRACT NO.: 4160, CLASS 1 - REGULARS UNIONIZED EMPLOYEES

HEALTH INSURANCE BENEFIT

TERMINATION:

The maximum age for a dependent child is 21 years, or 26 years if a full time student.
Travel assistance as per the contract terminates at age 99 for the member.

WAIVER OF PREMIUMS:

Waiver of premiums in the event of disability of the member up to age 65, after a waiting period of 6 months. The waiver of premium terminates on the earliest of the following dates: The date this benefit terminates or the date this policy terminates.

REMARK(S) FOR HEALTH INSURANCE BENEFIT:

THE MAXIMUM AMOUNT OF ELIGIBLE EXPENSES REFUNDED BY THE INSURER FOR OUTSIDE THE INSURED'S PROVINCE OF RESIDENCE IS LIMITED TO FIVE MILLION DOLLARS (\$5,000,000) DURING THE INSURED'S LIFETIME.

TRIP CANCELLATION IS INCLUDED, REFER TO THE CONTRACT TRAVEL ASSISTANCE SERVICE SECTION.

OTHER PARAMEDICAL EXPENSES INCLUDED :

- KINESITHERAPIST COMBINED WITH MASSOTHERAPIST AND ORTHOTHERAPIST.
- NATUROPATH COMBINED WITH NATUROTHERAPIST.
- CHIROPODIST COMBINED WITH PODIATRIST.
- PSYCHOEDUCATOR COMBINED WITH PSYCHOANALYST AND SOCIAL WORKER.

OTHER ELEGIBLE FEES :

- REPLACEMENT MASK COMBINED WITH RESP.APPRAR/OXYGEN.
- DEEP SHOES: MAXIMUM PAYABLE AMOUNT OF \$ 100.00 PER CALENDAR YEAR.
- INSULIN PUMP : MAXIMUM PAYABLE AMOUNT OF \$ 7 500.00 PER 60 MONTH-PERIOD.
- SUPPLIES FOR THE INSULIN PUMP : MAXIMUM PAYABLE AMOUNT OF \$ 10 000.00 PER 60 MONTH-PERIOD.
- RX CHIROPODIST, RX PODIATRIST, RX NATUROPATH AND RX OSTEOPATH COMBINED WITH X-RAY.
- LABORATORY ANALYSIS: MAXIMUM PAYABLE AMOUNT OF \$ 1000.00 PER CALENDAR YEAR.
- POST-MASTECTOMY BRASSIERES SOLD BY A SPECIALIZED LABORATORY: MAXIMUM LIFETIME PAYABLE AMOUNT OF \$ 200.00.
- CONTACT LENSES OR INTRAOCULAR LENSES FOLLOWING A CATARACT SURGERY: MAXIMUM LIFETIME PAYABLE AMOUNT OF \$ 1000.00.
- THERAPEUTIC DEVICES: MAXIMUM LIFETIME PAYABLE AMOUNT OF \$ 10 000.00.
- TOMODENSITOMETRY: MAXIMUM PAYABLE AMOUNT OF \$ 1000.00 PER CALENDAR YEAR.
- ELECTROCARDIOGRAM: MAXIMUM PAYABLE AMOUNT OF \$ 1000.00 PER CALENDAR YEAR.
- ECHOGRAPHY: MAXIMUM PAYABLE AMOUNT OF \$ 300.00 PER CALENDAR YEAR.
- EXPENSES OF SURGERY NECESSARY TO THE REPAIR OF AN ESTHETIC DAMAGE ASCRIBABLE WITH AN ACCIDENT WHICH HAS OCCURRED WHEREAS THIS INSURANCE IS IN FORCE, WITH CONDITION WHICH THE SERVICES WERE DONE IN THE 36 MONTHS OF THE

SUMMARY OF BENEFITS

CONTRACT NO.: 4160, CLASS 1 - REGULARS UNIONIZED EMPLOYEES

HEALTH INSURANCE BENEFIT

DATE OF ACCIDENT: MAXIMUM PAYABLE AMOUNT OF 5000.00\$ BY ACCIDENT.

- SCREENING TESTS DURING PREGNANCY ARE COVERED UNDER LABORATORY ANALYSIS.

SUMMARY OF BENEFITS

CONTRACT NO.: 4160, CLASS 1 - REGULARS UNIONIZED EMPLOYEES

DRUG INSURANCE BENEFIT

Effective date: Sept 1, 2021

DEDUCTIBLE:

Individual coverage: \$ 25*

Family coverage: \$ 25*

Combined deductible: Yes, with health insurance

**The deductible is applicable by calendar year.*

REIMBURSEMENT:

For drugs prescribed in the province of residence according to the RESTRICTIVE drugs list.

Eligible innovator drugs: 90 %**

Eligible generic drugs: 90 %**

Eligible brand drugs: 90 %**

Drug card: Direct payment

*** After satisfying the deductible*

EMPLOYEE'S CONTRIBUTION:

Each year, the maximum an insured contributes for drug fees with respect to the deductible and the percentage of reimbursement is equal to the most recent amount determined by the "Régie de l'assurance maladie du Québec". This maximum applies to the total amount of drug fees incurred by the insured and their insured dependants. The maximum contribution does not apply to the drug cost that the member has to pay outside Quebec and to members residing outside Quebec.

TERMINATION:

The maximum age for a dependent child is 21 years, or 26 years if a full time student.

WAIVER OF PREMIUMS:

Waiver of premiums in the event of disability of the member up to age 65, after a waiting period of 6 months. The waiver of premium terminates on the earliest of the following dates: The date this benefit terminates or the date this policy terminates.

GENERAL PROVISIONS

DEFINITIONS

In the present policy, unless one of the benefits, a modification, an amendment or the “Summary of Benefits” stipulates otherwise, we hereby define:

a) ACCIDENT

A corporal blow diagnosed by a physician, arising directly and independently of all other causes, from the sudden, violent and unforeseeable action of an external cause.

b) MEMBER

An eligible and insured employee under this contract.

c) 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.

d) INSURED

A member or one of his dependants.

e) SPOUSE

A person with whom the insured is living. The union must be a marriage duly recognised by Quebec legislation or the common-law state of a single, widowed or divorced person having resided permanently for more than one year with a person who is also single, widowed or divorced, who is publicly presented as a spouse. The stated delay is not applicable if a child is born of the union. The dissolution of a marriage by divorce as well as legal separation results in the loss of the marital status. The same loss of marital status results in the event of any de facto separation of more than three (3) months, in the case of a non-legally contracted union.

The spouse is the one designated by the insured. Only one person may be insured as a spouse at any given time.

f) ELIMINATION PERIOD

A continuous period beginning at the start of a total disability during which no disability benefit is payable under this benefit.

g) DRUGS

Controlled or limited usage drugs including medication or narcotics as defined in the Food and Drugs Act and Narcotic Control Act.

h) EMPLOYEE

A person residing in Canada who works for an employer or duly registered member of the policyowner.

i) EMPLOYER

The policyowner or a subsidiary associated or affiliated company whose name appears in the “Summary of Benefits”.

j) CHILD

Any single child of the insured or of his spouse, including any legally adopted child, residing in Canada and who meets one of the following conditions:

- is under twenty-one (21) years of age, or;
- is under twenty-six (26) years of age and duly registered as a full time student at a recognised teaching institution, or;
- is totally disabled and became totally disabled while one of the two (2) preceding conditions existed, and resides with the member.

With regards to life insurance for dependants, the infant must be at least twenty-four (24) hours of age.

k) IMMEDIATE FAMILY

The insured, his spouse, his children, his father, his mother, his grandparents, his brothers, his sisters and his grand-children at least 18 years of age.

l) DEDUCTIBLE

The deductible is the part of eligible expenses that must be paid by the insured in each calendar year before a benefit is payable. If applicable, the deductible amount is specified in the "Summary of Benefits".

If the present contract replaces another, the fees disbursed between January 1st and the effective date of the contract will be applied toward the deductible.

In the event where there is no previous insurer, for the first year of insurance, the deductible is proportional to the number of months between the effective date and the end of the calendar year, unless otherwise agreed differently between the insurer and the policyowner.

m) TOTAL DISABILITY

For the elimination period stipulated in the "Summary of Benefits" and the twenty-four (24) months that follow, the inability of a person, due to illness or an accidental injury, to perform all the duties of his regular occupation; subsequently, the inability to perform any remunerative occupation that could reasonably be performed when taking into consideration the education, training or experience of that person, regardless of the availability of employment in the region of the member's place of residence.

n) ILLNESS

A deterioration of health or disorder of the organism diagnosed by a physician specialised in the treatment of the illness. Pregnancy is not considered to be an illness; only major complications due to pregnancy are considered to be a deterioration of health.

o) PHYSICIAN

Any legally authorised person who practices medicine in his field of specialty. The physician must not be the insured, or a member of his immediate family.

p) REGULAR OCCUPATION

All the functions, as a whole, that a person performs relating to his occupation.

q) TOTAL DISABILITY PERIOD

A continuous period of total disability or successive periods of total disability resulting from the same cause or from related causes and separated by one or several recurrence periods shorter than the recurrence period allowed under the said benefit. A new period of total disability begins when the insured returns to work on a full-time basis at full salary for at least one day and the disability is the result of a cause completely independent of the first disability.

r) RECURRENCE

A period immediately following the date a person ceases to be totally disabled.

s) DEPENDANT

The member's spouse or child taken individually in accordance with the definitions of spouse or child in the present contract. It is noted that the following persons are not to be considered as the member's dependants:

- 1) a child who is not depending on the member for financial support or who has a full-time job;
- 2) a child with a spouse.

t) REIMBURSEMENT PERCENTAGE

The percentage of admissible fees that can be reimbursed after deducting the deductible, as specified in the "Summary of Benefits".

u) POLICYOWNER

A corporate body or physical person stipulated in the face page of this policy or in the "Summary of Benefits". The policyowner is the owner of the contract. The policyowner may or may not be the employer.

v) RETIREMENT

Date on which a member ceases to work for reason of retirement or early retirement.

w) PROFESSIONAL RISK

Any risk related to a job, occupation, trade or profession.

x) GROSS EARNED INCOME

The regular gross earned income excluding bonuses, payments for overtime, fees, allowances for lodging and meals, isolation payments and any lump sum occasional payments which are not part of the regular remuneration.

For the members whose income derives totally or partially from commissions or performance bonuses, salary means the average percentage of the employee's pay, paid by the employer, including commissions indicated on the employee's T4 and T4A income tax forms during the two (2) preceding years. In the event where the employee has not completed two years of continued service with the same employer, but at least one year, an income average will be established based on the full duration of service. However, if the employee has been employed for less than one year, salary means the average percentage of the employee's pay as is declared by the employer.

However, for the short-term disability benefit, income represents the insurable remuneration as established by the Canadian employment insurance legislation if the plan is duly registered with the Human Resources and Social Development Canada (HRDC).

y) NET INCOME

For a salaried employee, net income is earned income less provincial and federal income taxes, contributions to unemployment insurance, Quebec Pension Plan and Canada Pension Plan deducted from the salary.

EMPLOYEE ELIGIBILITY

An employee becomes eligible for insurance:

- a) on the effective date of the contract if he meets the eligibility provisions stipulated in the "Summary of Benefits", or;
- b) after the effective date, from the date he meets the eligibility provisions stipulated in the "Summary of Benefits".

Seasonal employees or part-time employees (i.e. those working less than nine (9) months per year) and partial part-time employees (i.e. those who work less than twenty (20) hours per week) are eligible only if designated in the "Summary of Benefits".

DEPENDANT ELIGIBILITY

An employee's dependants become eligible for insurance on the later of the following dates:

- a) the date when the employee becomes eligible, or;
- b) the date when they become dependants as per the definition of a dependant stipulated in the present contract.

APPLICATION FOR INSURANCE

To be insured under this contract, an eligible employee must submit a written request by completing an application form provided by the insurer.

To insure his dependants, an employee must list them on his application form. For subsequent coverage, the employee must advise the policyowner, who must then complete the required form and forward it to the insurer without further delay.

EFFECTIVE DATE OF INSURANCE FOR THE EMPLOYEE

An employee's insurance becomes effective:

- a) on his date of eligibility, if the insurer has received the request for insurance on or before this date, or;
- b) on the date the insurer receives the request for insurance, if this date is within the thirty (30) day period following his eligibility date, or;

- c) on the date the insurer accepts the evidence of insurability that the employee must provide at his expense and which is satisfactory to the insurer, if the form requesting the insurance is received more than thirty (30) days after the eligibility date.

Notwithstanding the foregoing, any insurance that is subject to evidence of insurability becomes effective only on the date of acceptance of such proof by the insurer.

If the day on which the insurance becomes effective is a working day and the employee is not at work on that day for reasons other than a scheduled vacation period, his insurance becomes effective the day he returns to work full-time and is able to accomplish all the duties of his regular occupation.

If the day on which the insurance becomes effective is not a working day, the insurance becomes effective:

- a) on that date, provided the employee was actually at work on the last previous working day, otherwise;
- b) the day he returns to work full-time and is able to accomplish all the duties of his regular occupation.

EFFECTIVE DATE OF INSURANCE FOR A DEPENDANT

The insurance for a dependant becomes effective:

- a) on the date of eligibility of a dependant if the insurer has received the written request on or before that date; or
- b) on the date the insurer receives the request for insurance, if this date is within the thirty (30) day period following the dependant eligibility date; or
- c) on the date the insurer accepts the evidence of insurability that the employee must provide at his expense and which is satisfactory to the insurer, if the form requesting the insurance is received more than thirty (30) days after the dependant's eligibility date.

Any new dependant child of the member whose other dependants are already insured becomes rightfully and immediately insured. The name and date of birth of the new child must however be communicated to the insurer by means of a written notice for the processing of future claims.

However, with the exception of any newborn, if a dependant is hospitalised on the effective date of his own life, such insurance becomes effective only on the day after leaving the hospital.

CLAIMS

a) FILING A CLAIM

Any claim for benefits under this contract must be filed with the insurer within thirty (30) days thereafter.

b) PROOF OF CLAIM

The insured must submit to the insurer the required proof according to the benefit in the ninety (90) days following the event. It is the insured's

responsibility to assume all expenses incurred for proof satisfactory to the insurer.

c) ADDITIONAL DELAY

Failure in filing a claim or submitting proof within the specified period will not invalidate a claim under the contract if proven that it was impossible for the insured to file the claim on time, and the claim was filed or the proof was submitted within twelve (12) months following the date of the event giving rise to the claim.

d) PAYMENT

The insurer must pay claims within thirty (30) days following the date of receipt of all required proof.

All amounts become payable to the member, if living. Otherwise, the amounts are payable to the designated beneficiary.

e) BENEFICIARY

Providing it is not contrary to law and where no irrevocable beneficiary designation has been made, an insured may, by giving a written notice to the insurer, designate or revoke any beneficiary.

The insurer assumes no responsibility for the validity of any beneficiary designation. If no beneficiary designation has been made, all amounts payable at death are issued to the member's estate.

RULES OF MINIMAL PARTICIPATION OF ELIGIBLE EMPLOYEES

A minimum of two (2) members at all times is required to maintain this contract in force.

Any employee that satisfies the eligibility provisions stipulated in the summary of benefits and who subscribes to the insurance plan must remain insured under the provisions of the policy.

In addition, for each member and for each benefit, the policyowner must pay at least the proportion on the premium indicated in the "Summary of Benefits".

An "insurance premium", for the purpose of this article, excludes the premium for any additional insurance benefit.

TERMINATION OF AN MEMBER'S INSURANCE

A member's insurance under the present contract or under one of its benefits or services terminates at midnight on the earliest of the following dates:

- a)** the date of cancellation of the present contract or of the relevant benefit;
- b)** the date the member ceases to be an employee or ceases to be in a class of employees' eligible for insurance;
- c)** the date the insurer receives a written notice from the policyowner requesting termination of an member's insurance, or any subsequent date mentioned in the notice;
- d)** the date on which the insured attains the maximum age for the relevant benefit for any such insurance;

- e) the due date of any premium, if on that date the member's premium is not paid, unless a request for waiver of premiums due to disability has been made and accepted;
- f) the date of the member's death, subject to the payment of benefits that are due.

TERMINATION OF DEPENDANT INSURANCE

A dependant's insurance under the present contract or under one of its benefits or services terminates at midnight on the earliest of the following dates:

- a) the date of cancellation of the present contract or of the implied benefits;
- b) the date the member ceases to be an employee or ceases to be in a class of employees' eligible for insurance;
- c) the date the insurance for the member ceases;
- d) the date a dependant no longer meets requirements mentioned in the definition of dependant;
- e) the due date of any premium, if on that date the dependant's premium is not paid, unless a request for waiver of premiums in the event of disability has been made and accepted;
- f) the date of the dependant's death subject to the payment of benefits that is due.

ERROR AND FALSE DECLARATION

A false declaration of age does not lead to the annulment of the insurance. In this situation, the true date of birth, established to the insurer's satisfaction, serves as the basis of premium calculation and an equitable adjustment of premiums and insured amount, if necessary, will be made.

The insurer is justified in requesting that the life insurance be null and void when the insured's age at issue was outside the age limits set by the insurer's rates. The insurer must act within three (3) years of the issue of the insured's certificate, providing it does so while the insured is living and within sixty (60) days of becoming aware of the error.

An error concerning the insured's age cannot prolong any amount of insurance beyond the date these amounts would have terminated, taking into account the insured's actual age.

INCONTESTABILITY

In the absence of fraud, a false declaration or a withholding of information may not be invoked as sufficient reason to terminate or reduce the insurance if it has been in force for more than two (2) years. However, this rule does not apply to disability insurance if said disability started during the first two (2) years of insurance.

INFORMATION TO MEMBERS

The insurer provides the policyowner with a written summary the insured's rights and obligations under the present contract, as well as a certificate of proof of coverage for insured employees.

The policyowner must forward this information to the member. Its purpose is to advise the member of his rights and obligations. In the event of litigation, only the contract may be invoked.

The member may consult the contract at the policyowner's business address and make a copy at his own expense.

LAWS THAT GOVERN THIS CONTRACT

For the purpose of this policy, reference to a law signifies the effective law in force at that particular time, or if repealed, the new law that replaces it or any law of the same nature with the same end result.

FILE ACCESS

In order to maintain the confidential nature of personal information on the insured, the insurer agrees to the following:

To create an individual insurance file that contains information on the insured relating to the application, as well as any information relating to the claim.

Access to the file is restricted solely to the insurer's employees, legal advisors or representatives responsible for the underwriting, investigations and evidence of insurability.

The insured's file is kept by the Union Life, Mutual Insurance Company.

The insured has the right to be informed of the personal information in of this file and if applicable, may have the file corrected by making a written request to the insurer. All requests are to be sent to the access information officer.

WAIVER OF PREMIUMS BENEFIT

PURPOSE

Waiver of premiums applies to each benefit indicated in the "Summary of Benefits". The purpose is to continue coverage of the insurance benefits in force at the beginning of disability. Disability must begin before the insured's sixtieth (60th) birthday in order for him to be eligible for waiver of premiums. Total disability must be as described in the definition of the "General Provisions" section of the present policy.

ELIMINATION PERIOD

The elimination period is the period that commences at the beginning of a total disability period and for which no disability payment is payable under this benefit.

The elimination period is stipulated in the "Summary of Benefits". Premiums are waived starting from the 1st day of the month following or coinciding with the date on which the elimination period is completed.

REMISSION PERIOD PERMITTED

A period less than one hundred and eighty (180) days immediately following the date a person who was totally disabled ceases to be.

PREMIUMS TO BE WAIVED

The premiums to be waived are those for insured benefits under the present contract at the beginning of disability as stipulated in the "Summary of Benefits". A retroactive refund of premiums will not exceed six (6) months from the date of approval of the claim for waiver by the insurer.

PROOF OF DISABILITY

To prove his disability or its continuance, the member must submit to the insurer a medical certificate by using the appropriate forms provided by the insurer. The insurer may, at its own expense, and as often as deemed necessary, have the insured undergo a medical examination by a physician chosen by the insurer, if it judges that the proof submitted by the member is unsatisfactory.

TERMINATION OF WAIVER OF PREMIUMS

In addition to the reasons of termination of insurance for the member in the section entitled "General Provisions" of the present policy, the waiver of premiums for an insured ceases when he is no longer disabled or when he cannot provide proof of his total disability or refuses to submit such proof.

In addition, waiver of premiums cease at midnight on the earliest of the following dates:

- the termination date or age limit stipulated in the "Summary of Benefits";
- his retirement date, if earlier.

EXCLUSIONS

The insurance provided by the present waiver of premiums benefit does not apply and the insurer assumes no responsibility if disability is the result:

- a)** of the insured's participation in a criminal act or an attempted criminal act, or;
- b)** of the insured's active participation in a civil commotion, riot, insurrection or military operation during war, whether war is declared or not, or;
- c)** of the insured's participation in an aerial flight other than as a fare paying passenger on a regular or chartered flight, or;
- d)** of an attempted suicide or self-inflicted wound or mutilation, regardless of the insured's state of mind, or;
- e)** of the fact of having suffered body lesions while driving a vehicle with diminished faculties due to alcohol or drug consumption (criminal act), or;
- f)** of the insured's participation in land or water motor vehicle races, scuba diving, parachute jumping, free-fall or otherwise, bungee jumping, gliding or sail flights, or any other dangerous similar activities or sports, or;
- g)** of intoxication by or while under the influence of alcohol or drugs, or;
- h)** of lumbago or back pain whose diagnosis can only be made subjectively by the insured's description of symptoms and cannot be supported by appropriate tests prescribed by a physician, or;
- i)** of disability that began prior to the effective date of insurance.

LIFE INSURANCE BENEFIT FOR THE MEMBER

PURPOSE

The purpose is to pay a death benefit when the member's death occurs while this insurance benefit is in force.

BENEFIT AMOUNT

The benefit amount is equal to the amount specified in the "Summary of Benefits" and is subject, if applicable, to reduction due to the member's age.

EXTENSION

Upon receipt and acceptance of required documents establishing to the satisfaction of the insurer, that an member was totally disabled while covered under the present contract and that the member:

- a) remained totally disabled up to the date of his death and died from the same condition as his disability, and;
- b) died before his sixty-fifth (65th) birthday and before the end of a six (6) month period calculated from the date he stopped working due to his disability, and;
- c) was not covered by another insurer under an insurance contract with a similar benefit.

The insurer pays the insurance amount to which the member was entitled as stipulated in the present contract without however, exceeding the amount that was in force on his life on the date he left his employment.

ANTICIPATED DEATH BENEFIT

Provided that the present benefit is in force in accordance with the provisions foreseen for the "Waiver of premiums" benefit of the present contract and a member's life expectancy is not more than twelve (12) months, he has the right to an anticipated death benefit payment. The amount is the lesser of twenty-five thousand dollars (\$25,000) or fifty per cent (50%) of the amount of life insurance in force.

The written request to the insurer must include satisfactory proof that the member's life expectancy does not exceed twelve (12) months as of the date requested.

Upon the member's death, the amount payable to the beneficiary by the insurer is reduced by the amount paid to the insured under the present right, increased by interest accrued since the date of the payment of this benefit at an annual rate of ten per cent (10%).

EVIDENCE OF INSURABILITY

When the amount of insurance exceeds the maximum amount of insurance without evidence of insurability stipulated in the "Summary of Benefits", the member is covered for the excess only if he submits proof satisfactory to the insurer. Subsequently, any increase in the amount of insurance will become effective only after the required evidence of insurability has been accepted by the insurer.

CONVERSION PRIVILEGE

If, before the member attains age sixty-five (65) the insurance on his life terminates due to the termination of his employment or the loss of a membership in an insured group, the member may convert all or part of the insurance amount lost into an individual life policy, without having to prove his insurability. The amount of insurance converted for the same insured cannot exceed the amount of benefit of the present benefit at the date of conversion, subject to the higher of a minimum of five thousand dollars (\$5,000) or twenty-five per cent 25% of the member's insurance amount, and a maximum of two hundred thousand dollars (\$200,000) or the difference between the amount of insurance lost under the present contract and the amount of insurance provided for by another contract under which the member became eligible at the time of exercising his conversion privilege.

In addition, upon termination of the present contract, on the condition that the member was covered for at least five (5) years and the contract was not replaced by another under which he became eligible, the member may convert, totally or partially the insurance volume lost to an individual permanent life insurance without evidence of insurability.

To convert, the member must make a written request to the insurer on the form provided by the insurer, and pay the insurer the amount of premium for the proposed contract, within thirty-one (31) days as of the termination of the insurance.

If the member dies during the thirty-one (31) day conversion privilege period, the insurer will pay the maximum amount of life insurance the insured could have been converted.

The member can subscribe to any one of the following individual insurance contracts:

- 1) a one (1) year term insurance, convertible at the end of the year to a term insurance to age sixty-five (65) or a whole life insurance contract;
- 2) a term insurance to age sixty-five (65);
- 3) a whole life insurance.

No additional benefit may be added to this insurance unless anticipated for specifically elsewhere in this contract.

The premium rate for the individual insurance contract is the rate in use by the insurer according to the amount converted, the plan chosen, and the member's gender and age at the time of conversion. If the member is already subjected to an increased premium or exclusion under the present benefit, the insurer will increase the premium or reinstate the exclusion for the individual insurance in a similar way. Any premium mode typically offered by the insurer may be selected. In the first year of conversion, insurance premiums may be paid quarterly. The individual contract

will become effective thirty-one (31) days after the termination of the insurance with regards to the present contract.

A decreased amount do to age or a change of category of the member does not give the member the right to convert his insurance.

The member who has used his conversion privilege is no longer eligible for insurance under the present contract, unless satisfactory evidence of insurability accepted by the insurer. The conversion privilege of the present contract, once exercised, is no longer available.

TERMINATION OF THE MEMBER'S INSURANCE

In addition to the reasons for the termination of the member's insurance stipulated in the section entitled "General Provisions" of the present policy, the insurance for this benefit will terminate at the earliest of the following dates at midnight:

- the termination date or age limit stipulated in the "Summary of Benefits";
- the member's retirement date, if earlier.

LIFE INSURANCE BENEFIT FOR DEPENDANTS

PURPOSE

the purpose is to pay a death benefit upon death of a member's dependant, if death occurs while this insurance benefit is in force.

AMOUNT OF BENEFIT

The amount of the benefit payable upon death of the spouse or a dependant child is specified in the "Summary of Benefits".

EXTENSION

If upon the member's death dependants are insured under this benefit, the dependants' life insurance is extended without payment of premiums up to the earliest of the following dates:

- a) twenty-four (24) months after the member's death;
- b) the termination date of the life insurance benefit for dependants had the member been living;
- c) the termination date of the present benefit.

TERMINATION OF INSURANCE

In addition to the reasons for the termination of the dependants' insurance benefit stipulated in the section entitled "General Provisions" of the present policy, the insurance for this benefit will terminate at the earliest of the following dates at midnight:

- the termination date or age limit stipulated in the "Summary of Benefits";
- the member's retirement date, if earlier;
- when the spouse or child no longer meets the definition of dependant.

SHORT-TERM DISABILITY BENEFIT

PURPOSE

The purpose of coverage is to temporarily replace and in part the employment income loss for a member during a period of total disability starting after the effective date of this benefit.

EXCLUSIVITY OF BENEFIT

Once the long-term disability benefits have started, a return to the short-term disability benefits is not possible for the same or related causes, until the total disability period giving rise to the claim has terminated.

ELIGIBILITY

To be eligible for the short-term disability benefit, an employee must be covered under the life insurance benefit.

ELIMINATION PERIOD

The elimination period for the present benefit corresponds to the number of days indicated in the "Summary of Benefits", separately for total disability resulting from an illness, an accident or a hospitalization.

The elimination period in the event of an illness applies for any total disability period beginning more than thirty (30) days after the date of the accident causing the disability.

The elimination period in the event of hospitalization begins at the date of hospitalization. In addition, the elimination period for hospitalization applies on the condition that the date of hospitalization precedes the date the elimination period for an illness ends.

In the present article, hospitalization means occupying a hospital room for a minimum period of eighteen (18) consecutive hours, or to have been admitted to the hospital for less than one day for surgery requiring anaesthesia.

REMISSION PERIOD PERMITTED

A period less than fifteen (15) days.

MAXIMUM ELIGIBLE WEEKLY INCOME

When the maximum eligible weekly income is as defined by the Canada employment insurance act, this expression is designated by M.E.W.I. in the "Summary of Benefits".

BENEFIT AMOUNT

The amount of disability benefits is payable according to the frequency indicated in the "Summary of Benefits".

BENEFIT PAYMENTS

Benefits become payable after the elimination period.

The amount of disability benefit is divided, if applicable, by one-fifth (1/5) of the amount provided for a complete week, for each working day of a normal work week, or by one-seventh (1/7) for each day of absence during the week as specified in the "Summary of Benefits".

Benefits are payable for provided that total disability persists without exceeding the maximum number of weeks specified in the "Summary of Benefits".

In addition, notwithstanding the maximum age specified in the "Summary of Benefits" which indicates the end of payment of benefits, it is stipulated that the said payment continues, with proof of disability satisfactory to the insurer, until the member has received at least fifteen (15) weeks of benefits in total including benefits paid before the maximum age. However, benefits end as soon as the member is able to resume work or as soon as he elects retirement, whichever period is shorter.

No disability period may start after the maximum age as specified in the "Summary of Benefits".

REHABILITATION

The insurer may assist the member in any manner to encourage him to return to his regular occupation or any other remunerative occupation compatible with his state of health.

In the case of a rehabilitation program accepted by the insurer, if a gradual return to work is appropriate considering the state of health, the amount of the payable benefit will be adjusted, taking into account the period worked.

REDUCTION OF BENEFIT DUE TO INTEGRATION OF BENEFITS

Under the present article, the insurer pays a weekly disability benefit according to the lesser of the amounts calculated under paragraphs A) or B) that follow:

a) DIRECT INTEGRATION OF BENEFITS

The member is only eligible for disability benefits of the present benefit and those provided for by government plans.

The amount of disability benefits payable by the insurer is reduced by the amount of initial basic benefits; without regard to subsequent increases due to indexation, payable under the following laws or plans, such as:

- 1)** the Quebec Pension Plan or the Canada Pension Plan;
- 2)** the Occupational Health and Safety Commission;
- 3)** the Automobile Insurance Act in Quebec or Ontario.

However, this article only refers to the above-mentioned benefits whose payment started at the beginning or after the beginning of total disability.

If an member refuses or neglects to submit a request for benefits under the laws or plans mentioned above, when informed by the insurer that he could be eligible for such benefits, the insurer reserves the right to reduce from

the benefits payable an estimate of benefits that could be provided by these laws or plans.

b) INDIRECT INTEGRATION OF BENEFITS

The member is eligible for additional disability benefits and those foreseen in the preceding paragraph a).

If the member receives disability income that is greater than the maximum percentage of income permitted, as specified in the "Summary of Benefits" and based on the member's income at the beginning of disability, the disability benefit is reduced so that the total amount of disability income does not exceed the maximum employment income at the beginning of disability. In calculating the maximum, only initial amounts of benefits will be considered without regard to subsequent increases due to indexation.

Other income amounts that are considered in the calculation mentioned in the preceding paragraph are:

- 1) Any remuneration paid by an employer due to a salary continuation policy, holidays, sick days or any other benefits program established by the employer;
- 2) all annuities or disability benefits payable under the following laws:
 - the Quebec Pension Plan or the Canada Pension Plan;
 - the Occupational Health and Safety Commission;
 - the Automobile Insurance Act in the province of residence.
- 3) any disability benefits payable under a group insurance contract or a retirement plan from the employer.

At all times, the total disability income payable under the present benefit and the other above-mentioned sources, cannot exceed the maximum amount equal to one hundred per cent (100%) of the member's net income at the beginning of his disability. (100% of the gross income if the benefit payable is taxable).

If a member refuses or neglects to submit a request for benefits under the laws mentioned above, when informed by the insurer that he could be eligible for such benefits, the insurer reserves the right to reduce from the benefits payable an estimate of benefits that could be provided by these laws.

EXCLUSIONS

No benefit is payable in the following cases:

- a) the member's participation in a criminal act or attempted criminal act;
- b) the member's active participation in a civil commotion, riot, insurrection or military operation during war, whether war is declared or not;
- c) self-inflicted wound or mutilation, regardless of the member's state of mind;
- d) the fact of having suffered from body lesions while his ability to drive was impaired, because of diminished faculties due to the consumption of alcohol or drugs;

- e) surgery not necessary for the member's health, for cosmetic or non-medically required care;
- f) during a period where an member stays more than 15 days outside of Canada;
- g) during a maternity leave provided for under provincial or federal law or of an agreement with the employer;
- h) period during which the member is not under the regular care of a specialist able to treat his illness, or if he does not receive proper therapy for his condition, or refuses such therapy;
- i) period during which the member is not under the care of a physician; the period of total disability may not start before the date of the first medical visit for the disability in question;
- j) disability that began before the effective date of insurance;
- k) disability as a result of a work related accident or occupational illness, unless otherwise stipulated in the "Summary of Benefits".

PROOF OF DISABILITY

To prove his disability and its continuance, the member must submit to the insurer a medical certificate using the insurer's forms.

The insurer may have the member undergo a medical examination by a physician of the insurer's choice and at the insurer's expense, as often as it judges necessary, if the proof submitted is not satisfactory to the insurer.

EXTENSION OF BENEFITS

Unless otherwise specifically mentioned for a particular benefit, the insurer pays the disability benefits provided in the present benefit for the entire disability period which began when the benefit was in force, and for provided that disability persists, and the conditions of the contract are met. If the benefit is terminated, benefits will continue to be paid as if the benefit had remained in force subject to the terms of the present benefit, as well as the laws in force.

DEDUCTION AT SOURCE

The insurer deducts from each benefit payment the amounts imposed by the Tax Act.

TERMINATION OF BENEFITS

Benefits terminate on the first of the following dates:

- a) the date of the member's death;
- b) the date on which the member ceases to be disabled;
- c) the date on which the member is unable to provide proof of his disability or refuses to provide such proof;

- d)** the date on which the member refuses or neglects to submit to a medical examination as requested by the insurer;
- e)** the date the member begins a remunerative occupation, unless he has the insurer's authorisation for rehabilitative employment, or the date on which he accomplishes one of the duties of his regular occupation other than through a rehabilitation program;
- f)** the date on which the member refuses without good reason totally or partially to participate in a rehabilitation program established and funded by the insurer to facilitate his return to the labour market and which the insurer's physicians and rehabilitation professionals deem reasonable and appropriate;
- g)** the date on which the member receives a retirement income, other than the one he was receiving at the beginning of disability while he was actively at work.

TERMINATION OF INSURANCE

In addition to the reasons for the termination of the member's insurance benefit stipulated in the section entitled "General Provisions" of the present policy, the insurance for this benefit will terminate at the earliest of the following dates at midnight:

- a)** the termination date or age limit stipulated in the "Summary of Benefits";
- b)** the member's retirement date, if earlier.

LONG-TERM DISABILITY BENEFIT

PURPOSE

The purpose of coverage is to replace in part the employment income loss incurred by an member during a period of total disability starting after the effective date of this benefit.

EXCLUSIVITY OF BENEFIT

No long-term disability benefits are payable until short-term disability benefits have expired.

ELIGIBILITY

To be eligible to the long-term disability benefit, an employee must be covered under the life insurance benefit.

ELIMINATION PERIOD

The elimination period is the period stipulated in the "Summary of Benefits" of the present policy.

REMISSION PERIOD PERMITTED

A period of one hundred and eighty (180) days immediately following the date a person ceases to be totally disabled.

BENEFIT AMOUNT

The benefit amount for each month of disability is stipulated in the "Summary of Benefits".

INDEXATION OF BENEFITS

When the disability benefit is indexed, the amount of benefit payable will be adjusted on the first day of January of each year following the first complete year of disability, excluding the elimination period, as per the indexation rate defined by the Quebec Pension Plan up to the maximum annual indexation rate indicated in the "Summary of Benefits".

EVIDENCE OF INSURABILITY

When the amount of monthly benefit exceeds the maximum amount of insurance without evidence of insurability stipulated in the "Summary of Benefits", the member is covered for the excess only if he submits proof satisfactory to the insurer. Subsequently, any increase in the amount of benefit will become effective only after the required evidence of insurability has been accepted by the insurer.

REDUCTION OF BENEFIT DUE TO INTEGRATION OF BENEFITS

Under the present article, the insurer pays a monthly disability benefit according to the lesser amount under paragraphs A) and B) that follow:

a) DIRECT INTEGRATION OF BENEFITS

The member is eligible only for disability benefits of the present benefit and those provided for by government plans.

The amount of disability benefits payable by the insurer is reduced by the amount of the initial basic benefits; without regard to subsequent increases due to indexation, payable under the following laws or plans, such as:

- the Quebec pension Plan or the Canada Pension Plan;
- the Occupational health and Safety Commission;

- the Automobile insurance Act in Quebec or Ontario;
- any other law providing income in case of disability.

However, this article only refers to the above-mentioned benefits whose payment started at the beginning or after the beginning of total disability.

If an member refuses or neglects to submit a request for benefits under the laws or plans mentioned above, when informed by the insurer that he could be eligible for such benefits, the insurer reserves the right to reduce from the benefits payable an estimate of benefits that could be provided by these laws or plans.

b) INDIRECT INTEGRATION OF BENEFITS

The member is eligible for additional disability benefits other than those of the preceding paragraph a).

If the member receives disability income that is greater than the maximum percentage of income permitted as specified in the "Summary of Benefits" and based on the member's income at the beginning of disability, the disability benefit is reduced so that the total amount of disability income does not exceed the maximum employment income at the beginning of disability. In calculating the maximum only the initial amounts of benefits will be considered without regard to subsequent increases due to indexation.

Other disability income amounts that are considered in the calculation mentioned in the preceding paragraph are:

- 1) any remuneration paid by an employer due to a salary continuation policy, holidays, sick days or any other benefits program established by the employer.
- 2) all annuities or benefits payable under the following laws or plans, such as:
 - the Quebec Pension Plan or the Canada Pension Plan;
 - the Occupational Health and Safety Commission;
 - the Automobile Insurance Act in the province of residence;
 - any other law providing income in case of disability.
- 3) any disability benefits payable under an insurance contract or a retirement plan.

MAXIMUM DISABILITY INCOME

For the purpose of this article, the maximum disability income is calculated by applying the percentage stipulated in the "Summary of Benefits":

- a) to the employee's gross income, if benefits payable by the insurer are taxable;
- b) the employee's net income, if benefits payable by the insurer are non taxable.

If an member refuses or neglects to submit a request for benefits with regards to such laws when eligible to such benefits, the insurer reserves the right to reduce from benefits payable an estimate of benefits that could be provided by these laws.

BENEFITS PAYMENT

Disability benefits are payable at the end of each month of disability, after the expiry of the elimination period.

For a period of disability that is less than one (1) month, the insurer pays one thirtieth (1/30th) of the monthly benefit for each day of total disability.

Benefits are payable for as long as the total disability period persists, without however, exceeding the maximal duration or the age limit as stipulated in the "Summary of Benefits".

REHABILITATION ASSISTANCE

If an member who has been totally disabled during at least the elimination period submits to a rehabilitation program approved by the insurer, he may retain the monthly disability benefits, in addition to any remuneration paid under the rehabilitation program. The rehabilitation status may be granted for a maximum period of twenty-four (24) months.

The monthly rehabilitation allowance is equal to the amount of the monthly benefits minus an amount equal to 50 % of the work income attained during the rehabilitation program.

The sum of income from the rehabilitation program and the monthly benefits may not, however, exceed one hundred per cent (100%) of the member's earned income at the beginning of disability; the benefits payable under this benefit will be reduced by any amount in excess of one hundred per cent (100%) of the member's earned income. The earned income is the employee's gross salary if the benefit is taxable or the net salary if the benefit is non-taxable.

The insurer may assist the member in any manner to encourage him to return to his regular occupation or any other remunerative occupation compatible with his state of health.

EXTENSION OF BENEFITS

Unless otherwise specifically mentioned for a particular benefit, the insurer pays the disability benefits provided in the present benefit for the entire disability period which began when the benefit was in force and for provided that disability persists, and the conditions of the contract are met. If the benefit is terminated, benefits will continue to be paid as if the benefit had remained in force, subject to the terms of the present benefit, as well as the laws in force.

DEDUCTION AT SOURCE

The insurer deducts each benefit payment the amounts imposed by the Income Tax Act.

EXCLUSIONS

No benefit is payable in the following cases:

- a) the member's participation in a criminal act or attempted criminal act;
- b) the member's active participation in a civil commotion, riot, insurrection or military operation during war, whether war is declared or not;
- c) the member's participation in an aerial flight, other than as a fare-paying passenger on a regular or chartered flight;

- d) a disability caused by a self-inflicted wound or mutilation, regardless of the member's state of mind;
- e) the fact of having suffered from body lesions while his ability to drive was impaired, because of diminished faculties due to the consumption of alcohol or drugs;
- f) the member's participation in land or water motor vehicle races, scuba diving, parachute jumping, free-fall or otherwise, bungee jumping, gliding or sail flights, or any other dangerous similar activity or sport;
- g) surgery not necessary for the member's health, for cosmetic or non-medically required care;
- h) during a period where an member stays more than fifteen (15) days outside of Canada;
- i) disability that occurs during a maternity leave provided for under provincial or federal law or an agreement with the employer;
- j) lumbago or back pain which diagnosis can only be made subjectively by the member's description of symptoms and cannot be supported by appropriate tests prescribed by a physician;
- k) period during which the member is not under the regular care of a specialist able to treat his illness, or if he does not receive proper therapy for his condition, or refuses such therapy;
- l) period during which the member is not under the care of a physician; the period of total disability may not start before the date of the first medical visit for the disability in question;
- m) disability that began before the effective date of the insurance;
- n) disability resulting from a work related accident or occupational illness unless otherwise stipulated in the "Summary of Benefits".

RESTRICTIONS

The amount of monthly benefits payable under the present benefit as well as disability benefits from all other sources cannot exceed the maximum percentage of the net income when benefits are non-taxable or the maximum gross income when benefits are taxable, as stipulated in the "Summary of Benefits".

When the member was not covered by an equivalent benefit and total disability begins within the twelve (12) month period following the effective date of the present benefit, no benefit is payable for an illness or an accident for which the member consulted a physician or other health professional, or received a medical treatment, or underwent an examination or diagnostic tests, or took medication, during the ninety (90) day period immediately preceding the effective date of the present benefit for an member.

TERMINATION OF BENEFITS

Benefits terminate on the first of the following dates:

- a) upon the member's death;
- b) the date the member ceases to be disabled;

- c) the date on which the member is unable to provide proof of his disability or refuses to provide such proof;
- d) the date on which the member refuses or neglects to submit to a medical examination as requested by the insurer;
- e) the date the member begins a remunerative occupation, unless he has the insurer's authorisation for rehabilitative employment, or the date on which he accomplishes one of the duties his regular occupation other than through a rehabilitation program;
- f) the date on which the member refuses without good reason totally or partially to participate in a rehabilitation program established and funded by the insurer to facilitate his return to the labour market and which the insurer's physicians and rehabilitation professionals deem reasonable and appropriate;
- g) the date on which the member receives a retirement income, other than the one he was receiving at the beginning of disability while he was actively at work.

TERMINATION OF INSURANCE

In addition to the reasons for the termination of the member's insurance benefit stipulated in the section entitled "General Provisions" of the present policy, the insurance for this benefit will terminate at the earliest of the following dates at midnight:

- a) the termination date or age limit stipulated in the "Summary of Benefits";
- b) the member's retirement date, if earlier.

HEALTH INSURANCE BENEFIT

This benefit includes hospitalization insurance and Medical and Paramedical Expenses Insurance.

PURPOSE

The purpose of coverage is to refund eligible expenses following hospitalization and medical and paramedical expenses incurred following an accident or illness by an insured while this benefit is in force.

ELIGIBILITY

Only persons covered by the governmental health insurance program of their province are eligible for the health insurance benefit.

HOSPITALIZATION

The purpose of hospitalization insurance is to refund an amount for each day that an insured person, due to illness or injury, spends in a hospital or a rehabilitation centre upon recommendation of a physician.

a) SHORT-TERM HOSPITALIZATION

The cost to stay in a hospital room as stipulated in the "Summary of Benefits" in a hospital for short-term care, less the fees that are refunded or refundable by a governmental insurance plan.

Eligible short-term care includes prevention, medical diagnosis and medical treatment for acute illnesses.

b) CONVALESCENCE AND PHYSICAL REHABILITATION

The cost to stay in a hospital room as stipulated in the "Summary of Benefits" in a physical rehabilitation centre or in a hospital, part of which is reserved for convalescence or physical rehabilitation care, less the fees that are refunded or refundable under a governmental insurance plan.

The insured person must be admitted within fourteen (14) days after leaving the hospital for which he was receiving short-term care or had been admitted for less than one (1) day for an operation requiring local anaesthesia. Eligible expenses are limited to a maximum period as stipulated in the "Summary of Benefits" for convalescence and physical rehabilitation combined.

DEFINITIONS OF INSTITUTIONS

a) HOSPITAL

Means a hospital center for short-term or long-term care as established by the laws in force, excluding part of such centre reserved for prolonged care.

b) REHABILITATION CENTRE FOR PHYSICAL DEFICIENCY

Means a centre offering physical rehabilitation services as established by the laws in force, excluding centres that are reserved for persons with a mental deficiency, or for youths or mothers with difficulties to adapt, or for alcoholics and drug abusers.

A hospital or rehabilitation centre for physical deficiency does not include a local centre for community services, a centre for youth and child protection, a lodging house or long-term care centre, a clinic, a hospital for the care of psychiatric illnesses or tuberculosis, a sanatorium, a home for the elderly, a rest or retirement home, a thermal station, a centre for AIDS victims or any other establishment whose main function is custodial care.

AMOUNT OF BENEFITS FOR HOSPITALIZATION

Eligible hospital or rehabilitation centre expenses are refunded at one hundred per cent (100%) without any deductible.

a) HOSPITALIZATION IN THE INSURED'S PROVINCE OF RESIDENCE

If the insured person is hospitalized in his province of residence, the insurer refunds, for each day in hospital, an amount equal to the cost of room and board charged by the hospital without, however, exceeding the cost of the type of room stipulated in the "Summary of Benefits" provided by the Quebec Hospitalization Act, including annual indexation.

The number of days in a hospital that is refundable in a period of twelve (12) consecutive months for a particular illness or accident is stipulated in the "Summary of Benefits".

b) HOSPITALIZATION OUTSIDE THE INSURED'S PROVINCE OF RESIDENCE

If the insured person is hospitalized outside his province of residence, the insurer refunds for each day in hospital, an amount equal to the cost for room and board requested by the hospital, without, however, exceeding the cost of a semi-private room, less any amount provided under the Quebec Hospitalization Act, including annual indexation.

The number of days in a hospital that is refundable in a period of twelve (12) consecutive months for a particular illness or accident, is stipulated in the "Summary of Benefits".

MEDICAL AND PARAMEDICAL EXPENSES

The purpose of medical and paramedical expenses insurance is to refund, in part, eligible expenses incurred for medical and paramedical treatments following an accidental injury, an illness or pregnancy.

For each insured person under the present benefit, the percentage of refund is applied on each amount of incurred expenses for treatment, visit or purchase of supplies as well as on each maximum amount per policy year for the medical and paramedical expenses enumerated in the article "Eligible medical and paramedical expenses" of this section.

BENEFIT AMOUNT

The benefit amount is derived by deducting the deductible from the eligible expenses and by multiplying the difference by the percentage of refund. The maximum amount of eligible benefits for medical and paramedical expenses are specified in the "Summary of Benefits".

ELIGIBLE MEDICAL AND PARAMEDICAL EXPENSES

The following expenses, excluding paramedical care, are covered on the condition that they are prescribed by a physician and are necessary for treatment of an illness or an accident and are normal and reasonable with current medical procedures. When a medical recommendation is required for paramedical care, a note is inscribed in the “Summary of Benefits”.

- a) If the “Summary of Benefits” stipulates “enlarged list”, only drugs obtained with the prescription of a physician or dentist are refundable.

If the “Summary of Benefits” stipulates “restrictive list”, only drugs that require the prescription of a physician are refundable.

If the “Summary of Benefits” stipulates “RAMQ list”, only the drugs published on the list of the Régie d’assurance maladie du Québec are refundable. Some of these drugs are however only refundable under the conditions and therapeutic indications determined by rules published by the RAMQ.

Also eligible are drugs prescribed by a physician where the therapeutic need is directly related to the following pathological conditions:

- cardiac problems;
- pulmonary problems;
- diabetes;
- arthritis;
- Parkinson's disease;
- epilepsy;
- cystic fibrosis;
- glaucoma.

In the event of a lay-off, a strike or a lock-out, the coverage for drug insurance is extended for a thirty (30) day period following the starting date of the lay-off, the strike or the lock-out. The premium corresponding to this extension period must be paid to the insurer.

An insured living in Quebec who has attained the age of sixty-five (65) may choose to be insured under the public plan provided for in the Loi de l’assurance médicaments du Québec rather than remaining insured under the present benefit. If this is the case, the insured is no longer eligible for benefits under the present contract and he may no longer be reinstated to the group insurance plan with regards to drug insurance.

- b) the purchase of one IUD per calendar year;
- c) the purchase of reactive sticks, syringes and needles for diabetics;
- d) the purchase of miscellaneous items necessary following colostomy, ileostomy or ureterostomy;
- e) in emergency situations, the cost of transportation to a hospital in a duly authorised ambulance, as well as transportation by railway or by air to the nearest hospital, if the insured person cannot be transported in any other manner;

- f) care by a licensed nurse at the insured person's home, upon presentation of a medical report, eligible up to a maximum amount and the period indicated in the "Summary of Benefits";
- g) the purchase of made-to-measure orthopaedic shoes, sold by a specialised orthopaedic laboratory. In any calendar year, these purchases are limited to the number of pairs and eligible maximum amount indicated in the "Summary of Benefits", as well as for a child less than or over sixteen (16) years of age, subject to the overall eligible maximum indicated in the "Summary of Benefits". These articles may also be prescribed by a podiatrist;
- h) the purchase of corrective items added to ordinary shoes, orthoses or plantar supports, eligible up to a maximum eligible amount and period indicated in the "Summary of Benefits". These items must be sold by a specialised orthopaedic laboratory and may also be prescribed by a podiatrist;
- i) the purchase of elastic stockings sold by a specialty house, up to the number and period indicated in the "Summary of Benefits";
- j) the purchase or repair of a hearing aid, up to the maximum eligible amount and period indicated in the "Summary of Benefits";
- k) the purchase of external mammary prosthesis necessary following mastectomy, in excess of the amount covered by a governmental plan, up to the maximum amount and period indicated in the "Summary of Benefits";
- l) the purchase of an initial capillary prosthesis necessary following chemotherapy, eligible up to the maximum amount and period indicated in the "Summary of Benefits";
- m) rental or purchase, whichever is deemed more economical by the insurer of a basic manual wheelchair, a manual hospital bed and crutches, when required for temporary therapeutic use. The insured must obtain the insurer's authorisation to purchase or rent any equipment. Failure to obtain authorisation from the insurer may result in the refusal of the claim;
- n) the initial purchase (not the replacement) or rental, not exceeding the initial cost of prosthesis (other than dental), as defined by the Régie de l'assurance maladie du Québec, eligible up to the maximum amount and period indicated in the "Summary of Benefits";
- o) blood transfusions or its derivatives, dressings;
- p) anaesthetic products;
- q) expenses for eye examination performed by an ophthalmologist or by a licensed optometrist for insured persons between the ages of eighteen (18) and sixty-four (64), eligible up to a maximum amount and period indicated in the "Summary of Benefits";
- r) when deemed necessary for prevention or diagnosis, the following expenses are refundable:
 - laboratory analysis, subjected to a maximum eligible amount of \$150 per calendar year;

- x-ray tests such as computer tomographies (scanners), ultrasounds, electrocardiograms, mammograms, x-rays (except for teeth and orthosis), subjected to a maximum eligible amount of \$300 per calendar year;
 - nuclear magnetic resonance imaging, subject to a maximum eligible amount of \$500 per calendar year;
- s)** the purchase or repair of an appliance to measure the rate of glucose in the blood of an insulin-dependent diabetic is payable upon presentation of a physician's complete report attesting to the insured's insulin dependency, eligible up to the maximum amount and period indicated in the "Summary of Benefits";
- t)** paramedical treatments; the fees for paramedical services given by:
- chiropractor;
 - psychologist, psychoanalyst, psychiatrist, social worker;
 - physiotherapist, ergotherapist, orthotherapist;
 - audiologist, orthophonist, osteopath, podiatrist, naturopath;
 - acupuncturist;
 - dietician;
 - massotherapist.

The maximum amount and number of visits per calendar year for each above-mentioned specialist or each grouping of specialists are indicated in the "Summary of Benefits";

In addition, eligible expenses per insured person are limited to one (1) visit per day per specialist. Specialists must be members of their professional association and provide services that fall within their specialty;

- u)** x-rays taken by a chiropractor for an insured person are limited per calendar year to the maximum amount indicated in the "Summary of Benefits";
- v)** nursing care services rendered at the insured's home required after a hospitalization or surgical intervention requiring local anaesthesia performed at the hospital. Expenses are refunded up to the eligible maximum amount and period indicated in the "Summary of Benefits". The nurse must be a member of the l'Ordre des infirmiers du Québec (OIIQ) or infirmier en pratique privée du Québec (IIPPQ);
- w)** the purchase or hernial bandages, corsets or orthopaedic bandages, splints, casts;
- x)** rental or purchase, whichever is deemed more economical by the insurer, of a breathing assistance apparatus and oxygen. The insured must obtain authorisation from the insurer before making any purchase or rental. Failure to obtain this authorisation may result in the insurer's refusal of the claim. The maximum eligible amount and period are indicated in the "Summary of Benefits";
- y)** rental or purchase, whichever is deemed more economical by the insurer, of a transcutaneous electric neurostimulator apparatus (tens). The insured must obtain authorisation from the insurer before making any purchase or

rental. Failure to obtain this authorisation may result in the insurer's refusal of the claim. The maximum eligible amount and period are indicated in the "Summary of Benefits";

- z)** fees for the substance used in medically required sclerosant injections administered by a physician. The maximum amount and period are indicated in the "Summary of Benefits".

DENTAL CARE AS A RESULT OF AN ACCIDENT

Expenses for dental care provided by a dental surgeon, outside a hospital when necessary following an accidental injury to natural, healthy and whole teeth, that occur while the person is insured and providing that treatment is given within twelve (12) months of the accident. Fees must be incurred in the province of residence and are eligible up to the maximum amount indicated in the "Summary of Benefits".

PROOF OF CLAIM

Eligible expenses are refundable upon presentation of original receipts.

To establish proof of claim, the insured must submit to the insurer original receipts from the suppliers providing treatments or products.

The insured must submit to a medical examination when the insurer is justified in requesting it considering the type of treatments that are required by the insured person's state of health. In the event of a medical examination, the physician is designated and paid by the insurer.

The insurer may also request, at the insured's expense, a report from the health professional that is treating the insured person. The insurer may request declarations from the person claiming benefits, as well as the use of the insurer's forms.

EXTENSION

Upon the member's death, the health insurance for insured dependants under the present benefit is extended without payment of premiums, up to the earliest of the following dates:

- a)** twenty-four (24) months after the member's death;
- b)** the date a dependant no longer meets the requirements mentioned in the definition of a dependant;
- c)** the termination date of the present benefit.

TREATMENTS OUTSIDE OF THE INSURED'S PROVINCE OF RESIDENCE

a) REQUIRED CONDITIONS

To be eligible, expenses for care outside the province of residence must meet the following conditions:

- 1)** In case of a medical consultation or hospitalization following an accident or sudden illness, the insured must communicate with the

medical assistance service, failure to do so may result in the refusal of the claim;

- 2) treatments are necessary following an emergency situation resulting from an accident or sudden illness occurring outside the insured's province of residence and the situation was not reasonably foreseeable at departure;
- 3) on the day of departure, the insured person must be less than seventy (70) years of age, nor be retired, nor be more than seven (7) months pregnant;
- 4) at departure, the anticipated stay outside of the insured's province of residence is less than ninety (90) days, and the insured must be covered by the government health plan of his province of residence. However, the stay may be prolonged provided that the reason is due to an illness or of an accident that occurred within the ninety (90) day period and due to justifiable medical reasons the return to his province of residence is impossible;
- 5) the expenses that are incurred due to a sudden illness or accident must occur within ninety (90) days following the departure date;
- 6) expenses are no longer admissible as of the date the patient is able to return to his province of residence by his own means or can be repatriated under medical supervision;
- 7) for an insured aged sixty-five (65) or over, treatments must not be related to a medical condition for which the insured person was hospitalized, has received or was prescribed a medical treatment or has consulted a physician in the ninety (90) days preceding the date of departure, unless proof satisfactory to the insurer is given that the condition affecting the insured person is stable. A change in medication, its posology or use is considered to be a medical treatment.

b) BENEFIT AMOUNT

Notwithstanding the percentage of refund of eligible expenses indicated in the "Summary of Benefits", eligible expenses outside the insured's province of residence for hospitalization, medical and surgical care including drugs that require a prescription from a physician, are refundable at one hundred per cent (100%).

c) THE MAXIMUM PAYABLE

The maximum amount of eligible expenses refunded by the insurer for outside the insured's province of residence is limited to one million dollars (\$1,000,000) during the insured's lifetime.

REDUCTION OF BENEFITS DUE TO COORDINATION OF BENEFITS

In an insured covered under another insurance contract for part or all of the expenses foreseen in the present contract, the benefits payable by the insurer will be adjusted so that the total amount of benefits under all contracts does not exceed one hundred per cent (100%) of eligible expenses under the present benefit.

In addition, the priority of payment of benefits will be determined in the following manner:

- a) if another contract does not contain the coordination of benefits clause, the benefits of this other contract are to be paid before benefits of the present contract;
- b) if another contract has the coordination of benefits clause, priority of payment will be given to the contract under which the person who is entitled to benefits:
 - 1) is not a dependant, or;
 - 2) is an member's dependant whose day and month of birth is first to occur in the calendar year.

If it is impossible to determine the priority of payment under the manner stipulated above, benefits under all contracts will be subjected to a proportional calculation based on the amounts that would have been paid under each contract, as if only one contract had existed.

EXCLUSIONS

No benefit is payable for losses resulting from the following causes or incidents:

- a) the insured person's participation in a criminal act or attempted criminal act;
- b) injury or illness resulting from the insured person's active participation in a civil commotion, riot, insurrection or military operation during war, whether war is declared or not;
- c) the insured person's participation in an aerial flight, other than as a fare-paying passenger on a regular or chartered flight;
- d) suicide or any self-inflicted wound or mutilation, regardless of the insured person's state of mind;
- e) the fact of having suffered from body lesions while driving a vehicle with diminished faculties due to the consumption of alcohol or drugs;
- f) the insured person's participation in land or water motor vehicle races, scuba diving, parachute jumping, free-fall or otherwise, bungee jumping, gliding or sail flights, or any other dangerous similar activity or sport;
- g) incurred expenses for surgery or an elective or non-urgent treatment, or when a trip outside the province of residence was undertaken with the intention of receiving a medical treatment or hospital services, regardless of whether the trip was recommended by a physician or not;
- h) incurred expenses for treatment not medically required, or for cosmetic purposes or treatments that exceeds usual care normally applied for therapeutic purposes;
- i) all expenses that are payable or refundable under any governmental insurance plan or normally would be, or private plan;

- j) all expenses in excess of those considered reasonable, taking into consideration the importance of the situation, the normal rates in the region and the procedure that is normally used;
 - k) all treatments or services that are provided free of charge or that would be free in the absence of insurance or that are not at the insured's expense;
 - l) expenses incurred for a health trip, a rest cure, diet purposes or weight-loss treatments;
 - m) treatments or services given by a member of the insured person's immediate family;
 - n) medical expenses resulting from illness or injury caused by employment or occupation for pay or profit, unless the member benefits from professional risk insurance coverage with regards to the present benefit;
 - o) expenses for varicose vein injections in the lower limbs, regardless of whether they are for medical purposes or not;
 - p) any drug that is available to the general public without a medical prescription.
- N.B.** Exclusions a) and b) do not apply to refundable drugs published on the list of the Régie d'assurance-maladie du Québec (RAMQ).

The following are not considered as drugs for the purpose of this benefit and are therefore not refundable:

- aa) milk, regardless of its nature, or milk substitutes;
- bb) proteins, dietary supplements, food, homeopathic or so called natural products;
- cc) products for aesthetic or cosmetic care;
- dd) products, hormones and injections for cellulites or obesity treatment, including anorexiant;
- ee) products or medication used for eliminating the use of tobacco;
- ff) mineral waters;
- gg) disinfectants, lubricating eye drops and solutions for contact lenses;
- hh) soaps, oils, shampoos and other hair products, emollients, creams and cough drops;
- ii) vitamins;
- jj) drugs administered for preventive measures. Under this exclusion, a drug used to stabilise or regulate a pathological state diagnosed by a physician is not considered as a preventive drug;
- kk) drugs or substances used in the treatment of infertility or impotence;
- ll) all substances used for insemination or or contraceptive gels or foams;
- mm) anabolic steroids, growth hormones or experimentally administered drugs;

- nn)** all expenses arising from an illness or accident falling under the authority of the CSST or the Société de l'assurance automobile du Québec (SAAQ);
- oo)** drugs provided during hospitalization.

The insurer reserves the right to exclude or modify the premium on the date Health Canada approves any new drug having a significant effect on the cost of the benefit.

N.B. Notwithstanding the preceding, all medical expenses payable by the RAMQ list are also payable under this policy. Some of these expenses are however only covered under the therapeutic cases, conditions and indications determined by the rules published by the RAMQ.

TERMINATION OF INSURANCE

In addition to the reasons for the termination of the insured's insurance stipulated in the section entitled "General provisions" of the present policy, the insured's insurance for this benefit will terminate on the earliest of the following dates at midnight:

- a)** the termination date or age limit stipulated in the "Summary of Benefits";
- b)** the retirement date, if earlier;
- c)** for a dependant, on the date he no longer meets the definition of a dependant.

TRAVEL ASSISTANCE SERVICE AND TRIP CANCELLATION

TRAVEL ASSISTANCE SERVICE

PURPOSE

The purpose of this service is to offer an insured travel assistance service during a trip outside the province of residence and to refund the eligible expenses.

Hospital, medical or paramedical and drug expenses incurred outside the insured's province of residence are refundable under the terms of the health insurance benefit and not under the present service.

The insurer, in collaboration with the medical assistance service and its coordination centres, offers the services described hereafter which are complementary to those offered under the health insurance benefit providing that these charges are not excluded under the article entitled "Exclusions" of the health insurance benefit.

ELIGIBILITY

An insured covered under the health insurance benefit of the present policy is automatically eligible for Travel Assistance Service, provided that he is under seventy (70) years of age.

THE SERVICE

a) TELEPHONE SERVICE

Telephone access, toll free, to coordination centres, twenty-four (24) hours per day and seven (7) days per week, for the following multilingual assistance services, following an emergency while the insured person is travelling outside the province of residence.

b) MEDICAL ASSISTANCE

Following an accident or sudden illness, if the insured person must consult a physician or be hospitalized, he must immediately call the medical assistance service, which will make the necessary arrangements in order to provide the following services:

- for the state of Florida, direct the insured to an appropriate clinic or hospital, member of the Preferred Patient Care network;
- for all other destinations, direct the insured to an appropriate clinic or hospital and advance funds to the hospital, if necessary;
- confirm the medical insurance coverage so that the insured does not have to pay a substantial deposit;
- follow up on the medical file and communicate with the family physician;
- coordinate the insured's claim with the governmental health insurance plan of his province of residence and, if applicable, the automobile insurance plan of his province of residence.

c) MEDICAL TRANSFER

Following the recommendation and at the sole discretion of the physician designated by the medical assistance service, in consultation with a local attending physician signalling the necessity of transferring the insured to another hospital or treatment centre, or to repatriate the insured to his province of residence to receive treatment, the medical assistance service will make the necessary arrangements, and pay the cost, to transfer the insured, under proper medical supervision. Any repatriation refusal cancels all rights to benefits and a termination notice to the insured will be sufficient.

The decision as to the necessity of transferring or repatriating an insured is the exclusive medical decision of the designated physician appointed by the medical assistance service.

The decisions related to the means or dates of transfer of medical appliances, of medical supplies, of medical staff to be used for the transfer and the final destination of the insured, are also considered medical decisions exclusive to the physician appointed by the medical assistance service.

RESTRICTIONS

The insurer and the medical assistance service are not responsible for the availability or the quality of medical and hospital care administered, or the impossibility of obtaining such care.

ELIGIBLE EXPENSES

a) IN THE EVENT OF DEATH

In the event of death of an insured, the medical assistance service will be responsible for all the necessary formalities and will arrange for the transportation of the deceased to his province of residence. The refundable amount is limited to three thousand dollars (\$3,000), excluding the cost of embalming, coffin and funeral.

The cost of cremation or burial at the place of death is limited to one thousand five hundred dollars (\$1,500).

b) RETURN OF DEPENDANT CHILDREN

If an insured is hospitalized or dies leaving his dependant children who accompanied him without supervision, the necessary arrangements will be taken to organise supervision and settle their transport in economy class, accompanied when required, to their residence in Canada. If the children's travel tickets have not expired, only the additional cost of the return trip ticket will be refunded. If, on the other hand, the travel tickets have expired, necessary arrangements will be taken for the return trip by the most economical means. This cost is limited to two thousand dollars (\$2,000) for all children.

c) RETURN OF A TRAVELLING COMPANION

If an insured dies, or is hospitalized for one day or more, resulting in his travelling companion having to change his return flight, the necessary arrangements will be taken to organise and settle his transport in economy class for his return to his original destination in the insured's province of residence. If the travelling companion's travel ticket is not expired, only the additional cost of the return trip ticket will be refunded. If, on the other hand, the travel ticket is expired, necessary arrangements will be taken for the return trip by the most economical means. This cost is limited to one thousand five hundred dollars (\$1,500).

d) VISIT BY A FAMILY MEMBER

If an insured who travels alone dies, or is hospitalized for seven (7) or more consecutive days, the medical assistance service will make the necessary travel arrangements according to the most economical return trip, to have a family member visit the insured at the hospital where he is staying or to identify the deceased prior to transport. These costs are limited to one thousand five hundred dollars (\$1,500), and to one visitor only.

e) RETURN OF A VEHICLE

If an insured travelling with his personal vehicle is unable to use his vehicle due to sickness or accident, the medical assistance service will organise and settle the return of the vehicle to the insured's residence. These costs are limited to seven hundred and fifty dollars (\$750).

f) SUBSISTENCE ALLOWANCE

If, following the insured's hospitalization for a period of more than twenty-four (24) hours, or following his death, costs for room and meals are incurred by the insured person or his travelling companions, because of a change in departure, or due to a visiting family member, these costs are reimbursed up to one hundred and fifty (\$150) per day and a total maximum of one thousand two hundred (\$1,200) for all persons covered.

g) LEGAL ASSISTANCE OR BAIL

When necessary, the medical assistance service will intervene to facilitate the organisation and depositing of funds for bail raised amongst family members or friends of the insured. The medical assistance service will assist any insured person with legal counsel when involved in a highway accident or guilty of offences to the highway code or any other legal infractions excluding criminal acts. However, the insured is responsible for choosing his lawyer, and the legal fees.

Health professionals or legal advisors recommended or designated by the medical assistance service are neither their employees nor their agents. Consequently, neither the medical assistance service nor the insurer may be held responsible for any negligence or omissions committed by these professionals or advisors.

BENEFIT REDUCTION DUE TO COORDINATION OF BENEFITS

If an insured is entitled to similar benefits under any other insurance contract, the benefits payable will be limited to the insurer's proportional share of the total eligible incurred expenses.

INSURED'S OBLIGATION

If, following an accident or sudden illness, the insured must contact the medical assistance service or one of its coordination centres as soon as possible. Failure to do so may result in claims being denied.

RESTRICTIONS

- a) The medical assistance service reserves the right to interrupt, shorten or restrict travel assistance services in any part of the world, in the event of rebellion, riot, military insurrection, war, work conflict or strike, nuclear accident, natural disaster, or in the event when the country's authorities forbid the medical assistance service to offer services. However, the medical assistance service will do everything that is possible to provide services under such circumstances.
- b) In the absence of medical contraindication, the insurer may require repatriation of any insured person or his transfer to other medical facilities. Refusal of repatriation by the insured person ends the insurance and notice or termination to the insured will be sufficient.
- c) No fees will be paid nor any assistance provided to an insured by the insurer or the medical assistance service when expenses are incurred as the result of a trip in his province of residence.

PROOF OF CLAIM

Eligible expenses are refundable upon presentation of original receipts.

To establish proof of claim, the insured must submit to the insurer original notes or bills from the suppliers of care or products.

In the event where the medical assistance service settles different accounts, they will submit to the insurer medical bills paid for the insured.

The insured must submit to a medical examination by a physician of the insurer's choice and at the insurer's expense, when the request is justified with regards to the nature of treatments required for the insured's state of health.

The insurer may also request, at the insured's expense, a report from the health professional treating the insured person. The insurer may require declarations from the insured presenting a claim and require the use of company forms.

TRIP CANCELLATION

TRIP CANCELLATION INSURANCE BENEFIT

a) REQUIRED CONDITIONS

To be eligible, the fees for the trip cancellation must meet the following conditions:

- 1) They are paid in advance by the insured while this benefit is in force;
- 2) At the time to finalise the arrangements for travel, the insured is not aware of the event that could reasonably lead to the cancellation or interruption of the planned trip;
- 3) The present benefit is in force at the time of the planned trip period;

b) BENEFIT AMOUNT

The insurer reimburses one hundred percent (100%) of the eligible fees up to five thousand dollars (\$5,000) per insured per trip.

c) SPECIFIC DEFINITIONS TO THE TRIP CANCELLATION INSURANCE

In the present policy, unless one of the benefits, a change, an amendment or the Summary of Benefits stipulates otherwise, we hereby define:

1) ACTIVITY OF A COMMERCIAL NATURE

Meeting, congress, convention, exhibition, show or seminar, of a professional or commercial nature, such activity must be public, under the responsibility of an official organisation and in compliance with the laws, regulations and policies in effect in the region in which the activity is scheduled to be held, and which is the only reason for the planned trip.

2) BUSINESS ASSOCIATE

The person with whom the insured is associated within a company of 4 co-shareholders or less, or for profit-sharing society of 4 associates or less.

3) TRAVELING COMPANION

The person with whom the insured shares the room or apartment at the destination or whose expenses were paid with those of the insured.

4) TRAVEL EXPENSES PAID IN ADVANCE

Amount paid by the insured for the purchase of a package deal, a ticket from a public carrier or for the rental of a motorised vehicle from an accredited agency. The following amounts are also eligible:

- Amount paid relating to reservations for trip arrangements usually included in a package deal;
- Amount paid relating to registration fees for an activity of a commercial nature.

5) HOST AT DESTINATION

The person whose main residence must serve as the place of accommodations for the insured in accordance with a prior agreement.

d) ELIGIBLE CAUSES OF CANCELLATION OR INTERRUPTION

The trip must be cancelled or interrupted for one of the following causes:

- 1) An illness or accident preventing the insured or close family member, his traveling companion or his business associate from performing his usual activities and which is reasonably serious to justify the cancellation or interruption of the trip;
- 2) The death of the insured, of a close family member, of his traveling companion or of his business associate. The funeral must take place during the planned period of the trip or within the 14 days preceding it;
- 3) The death or emergency hospitalisation of the host at destination;
- 4) The notification of the insured or of his traveling companion to report for jury duty or their subpoena to appear as a witness in a trial to be heard during the period of the trip. The person convened must undertake the necessary steps to obtain a postponement the case to be heard. A summons to appear is not considered eligible for cancellation of the trip when the person concerned is the party prosecuted or intent to take proceedings;
- 5) The hijacking of the airplane in which the insured is traveling;
- 6) The putting of the insured into quarantine, except if such quarantine ends more than 7 days prior to the planned date of departure;
- 7) A loss making uninhabitable the main residence of the insured or the host at destination, providing that the residence must be uninhabitable 7 days or less prior to the planned date of departure or that the loss occurs during the trip;
- 8) The transferring of the insured for the same employer, 175 or more kilometres from his present domicile, within 30 days preceding the planned departure date;
- 9) A situation in the country where the insured is traveling that prompts the Canadian government to issue a recommendation not to travel to that country. This recommendation shall be in force for the period of travel and have been issued after the insured has finalised arrangements for the trip;
- 10) A loss occurring at the place of business or on the physical premises where an activity of a commercial nature is scheduled to be held and thereby making impossible the holding of the activity such that a written notice cancelling the activity is issued by the official organisation in charge of organising it;
- 11) The cancellation of a business meeting or an activity of a commercial nature following the death or hospitalisation of the person with whom

the insured took prior arrangements for the meeting or the activity of a commercial nature. A written proof of those arrangements is necessary;

- 12) A departure missed due to a delay in the means of transportation used to get to the departure point or the departure point for a connection after the scheduled departure. The means of transportation used should include an arrival at least 3 hours before the departure. The cause for the delay must be mechanical difficulties (except for a private automobile), by a traffic accident or by the emergency closing of a road. Each of the last two causes must be backed up by a police report;
- 13) The atmospheric conditions delaying the departure of the public carrier used by the insured, at the scheduled point of departure, at least 30% (48 hours minimum) of the planned duration of the trip or preventing the insured from making a planned connection with another carrier insofar as this latter carrier be delayed for at least 30% (48 hours minimum) of the planned duration of the trip.

e) ELIGIBLE EXPENSES

1) IN THE EVENT OF CANCELLATION PRIOR TO DEPARTURE

- a) The non-refundable portion of the planned trip expenses paid in advance;
- b) The additional expenses incurred by the insured who decides to travel alone in the event where his traveling companion must cancel his trip for one of the reasons provided by this benefit. The fees are refundable up to the amount of the penalty for cancellation applicable to the insured at the time when his traveling companion must make the cancellation;
- c) The non-refundable portion of the travel fees paid in advance, up to 70% of the said fees, if the departure of the insured is delayed due to atmospheric conditions and that he decides not to make the trip.

2) IN THE EVENT OF A MISSED DEPARTURE OR TRIP INTERRUPTION

The additional cost the most economical required by a public carrier (train, bus or air line) for a single ticket, with the fixed schedule, by most direct route, up to the planned destination.

The insured's departure must be missed due to a delay in the means of transportation as described in section 9.17 d) 13-.

The trip must be temporarily interrupted due to an illness or an accident sustained by the insured or his traveling companion, as described in section 9.17 d) 1-.

3) IF THE EVENT OF AN ADVANCED OR DELAYED RETURN

- a)** The additional cost the most economical required by a public carrier (train, bus or air line) for a single ticket, with the fixed schedule, by most direct route, up to the destination initially planned. These expenses must be agreed to in advance with the insurer;
- b)** The unused and non-refundable portion of the land part of travel fees paid in advance.

If the insured's return is delayed for more than 7 days following an illness or accident sustained by the insured or his traveling companion, incurred expenses are covered insofar as the person involved has been admitted to a hospital centre as an in-patient for more than 48 hours within the said 7 day period.

f) REDUCTION OF BENEFITS DUE TO COORDINATION OF BENEFITS

If an insured covered under another insurance contract for part or all of the expenses foreseen in the present contract, the benefits payable by the insurer will be adjusted so that the total amount of benefits under all contracts does not exceed one hundred percent (100%) of eligible expenses under the present benefit.

In addition, the priority of payment of benefits will be determined in the following manner:

- a)** if another contract does not contain the coordination of benefits clause, the benefits of this other contract are to be paid before benefits of the present contract;
- b)** If another contract has the coordination of benefits clause, priority of payment will be given to the contract under which the person who is entitled to benefits:
 - 1)** is not a dependant, or;
 - 2)** is a member's dependant whose day and month of birth is first to occur in the calendar.

If it is impossible to determine the priority of payment under the manner stipulated above, benefits under all contracts will be subject to a proportional calculation based on the amounts that would have been paid under each contract, as if only one contract had existed.

g) DEADLINE FOR REQUESTING CANCELLATION

In the event of cancellation prior to the departure, the trip must be cancelled with the travel agency or the carrier within a maximum delay of 48 hours, or if it is a holiday, the next business day. The insurer must be notified at the same time.

The insurer's liability is limited to the cancellation fees stipulated in the travel contract 48 hours after the date of the cause of cancellation, or on the first business day if it is a holiday.

However, this limitation does not apply if the insured and his spouse show, to the satisfaction of the insurer that they were in the total and absolute inability to act. In that case, the trip must be cancelled as soon as one of them is able to do so. The insurer's liability is then limited to the cancellation fees stipulated in the travel contract on that date.

h) SPECIFIC EXCLUSIONS APPLYING TO THE TRAVEL CANCELLATION INSURANCE BENEFIT

No benefit is payable for losses resulting from the following causes or incidents:

- 1) the insured or traveling companion's participation in a criminal act or attempted criminal act;
- 2) injury or illness resulting from the active participation of the insured or his traveling companion to a public confrontation, in a riot, insurrection or military operation, whether war is declared or not;
- 3) suicide or any injury or damage that the insured has inflicted, whether sane or insane;
- 4) the fact of having suffered from body lesions while driving a vehicle with diminished faculties due to the consumption of alcohol or drugs;
- 5) the insured's participation in a sport for consideration, in land or water motor vehicle races, scuba diving, parachute jumping, free-fall or otherwise, bungee jumping, gliding or sail flights, or any other dangerous similar sport or activity, ;
- 6) the trip is undertaken with the intention of receiving medical treatment or hospitalisation services, whether the trip has been recommended or not by a physician;
- 7) the trip has been undertaken for purposes of visiting a person who is ill or has had an accident and the cancellation or interruption of the trip results from the death or deterioration of the medical condition of such person;
- 8) all the fees that are payable or refundable under any governmental insurance plan or normally would be, or private plan;
- 9) all treatments or services that are provided free of charge or that would be free in the absence of insurance or that are not at the insured's expense;
- 10) at the time of finalising the trip arrangements, the insured is aware of an event that could reasonably cause the trip's cancellation or interruption;
- 11) declared or undeclared war or act of war, in Canada or in a foreign country, if the Canadian government recommends not staying in the country. This exclusion does not apply to the insured present in a foreign country at the time where war or an act of war is declared and that the Canadian government then recommends leaving the country.

The insured must however make the necessary arrangements in order to leave the country in the best delay;

- 12) the insured's abusive absorption of medication, drugs or alcohol;
- 13) pregnancy, miscarriage, childbirth or related complications when these expenses are incurred within twelve weeks of the expected date of birth.

i) PROOF OF CLAIM

The insured must submit to the insurer the required proof in the 90 days following the event. It is the insured's responsibility to assume all expenses incurred for proof satisfactory to the insurer. The following required documents are then necessary:

- 1) The unused transportation tickets;
- 2) The official receipts for the cost of additional transportations;
- 3) The receipts for the travel arrangements. The receipts must include the contracts that were officially issued through the travel agency or an accredited company, and must indicate the amounts not refunded in the event of cancellation. A written proof of the benefits request or cancellation and the travel agency or carrier's response must be submitted to the insurer;
- 4) The official documents stating the cause of cancellation. If the cancellation is due to medical reasons, the insured must provide a medical certificate from the attending physician practicing in the region where the accident or illness occurred. The medical certificate must indicate the complete diagnosis and specify the exact reasons why the trip had to be cancelled, delayed or interrupted;
- 5) A police report when the means of transportation used by the insured is delayed due to a traffic accident or the emergency closing of a road;
- 6) the official report issued by the concerned authority relating to the weather conditions;
- 7) The written notice attesting the cancellation of an activity of a commercial nature or a business reunion issued by the official organization indicating the precise reasons that justify the event's cancellation.;
- 8) The insurer can require statements from the insured, or any other report allowing the benefits request justification.

LEGAL ADVISOR

THE SERVICE

A service providing the member or his/her dependants with legal information with a simple phone call.

UV Insurance covers the telephone consultation fees given for the service of “Legal Advisor” on the aspects of law concerning:

Family and People’s Rights
(e.g.: divorce motives)

Consumer Rights
(e.g.: debts and loans)

Residential Lease
(e.g.: renewal)

Wills and Estate
(e.g.: settling of an estate)

Real Estate Rights
(e.g.: worker’s compensation board appeals)

Real Estate Rights
(e.g.: appeal for hidden defects, flaws)

Business law
(e.g.: patent, copyright and trademark)

Youth Protection
(e.g.: abused children)

The service is offered from 9:00 am to 8:00 pm Monday to Friday and 9:00 am to 5:00 pm Saturday, except on public holidays, using the following telephone numbers:

(514) 871-3263 1-800-550-3263

This service is available on an information basis only. It is not to be construed as a replacement of the usual legal advisor.

OPTIONAL LIFE INSURANCE BENEFIT FOR THE INSURED INCLUDING ACCIDENTAL DEATH OR DISMEMBERMENT BENEFIT

PURPOSE

The purpose of this benefit is to pay a death benefit upon death of an insured, when death occurs when the present life insurance benefit is in force.

SPECIFIC DEFINITIONS TO THE OPTIONAL LIFE INSURANCE BENEFIT FOR THE INSURED INCLUDING ACCIDENTAL DEATH OR DISMEMBERMENT BENEFIT

In the present policy, unless one of the benefits, a change, an amendment or the Summary of Benefits stipulates otherwise, we hereby define:

INSURED

A member or his spouse.

ELIGIBILITY

An insured is eligible for insurance under the present benefit, provided that he is under sixty-five (65) years of age and if he is already covered under the basic life insurance benefit.

To be insured, an eligible employee or his spouse must first submit a written request on the forms provided by the insurer.

AMOUNT OF INSURANCE

The amount of insurance for the present benefit is indicated hereinafter and, if applicable, according to the option selected by the member on the optional life insurance form:

MEMBER

- According to the number of \$1 000 units chosen by the member;
- Minimum amount: \$10 000;
- Maximum amount: \$1 000 000 including the life insurance benefit basic amount.

SPOUSE

- According to the number of \$1 000 units chosen by the member;
- Minimum amount: \$5 000;
- Maximum amount: \$100 000 including the life insurance benefit basic amount.

EVIDENCE OF INSURABILITY

All optional life insurance amounts become effective once the insurer has approved the evidence of insurability provided by the member or his spouse.

MAXIMUM AGE

The insurance for the present benefit cannot extend beyond the insured's sixty-fifth (65th) birthday.

SUICIDE

Should death occur within the twenty-four (24) month period following the beginning or the increase of the optional life insurance, and if death is by means of suicide, whether the insured is sane or not, the amount of optional life insurance or the increased amount is not payable, and the insurer's only responsibility is to refund the premiums.

FALSE DECLARATION

If the insurer issues an optional life insurance certificate with non-smoker rates, following the insured's declaration that he has not smoked during the preceding twelve (12) month period, and it is later proven that this declaration is false, the optional life insurance certificate becomes null and void, and the insurer's responsibility is limited to the refund of paid premiums, should death occur.

AGE ERROR

If the insured's declared age is found to be incorrect after the insured's death, the amount of insurance is adjusted in proportion to the premium received to the one that corresponds to the insured's true age, without, however, exceeding the amount of insurance that the insured would have been entitled to for his true age.

PREMIUM

The monthly insurance premium for the present benefit is established according to the gender, age group, and smoker or non-smoker status and is applicable to each thousand dollars (\$1,000) of insurance. The insured's age is the one attained on his birthday which is the closest to the date of the last contract renewal.

DEFINITION OF NON-SMOKER

A non-smoker is a person who has not used tobacco or other products containing nicotine during the twelve (12) months preceding the signature of the application for insurance or the review of his status, and in addition, this person has not consumed any illegal drugs during this same period. The insurer reserves the right to require a signed declaration with regards to his non-smoker status at each renewal.

ACCIDENTAL DEATH OR DISMEMBERMENT BENEFIT INCLUDED WITH THE OPTIONAL LIFE INSURANCE BENEFIT FOR THE INSURED

The benefit amount of the accidental death or dismemberment is the same amount as the optional life insurance benefit for the insured. Conditions and restrictions applicable to the present benefit are those indicated in the Section entitled "Accidental death or dismemberment benefit included with optional life insurance benefit for the insured" of the present contract.

MONTHLY COST PER \$1 000 UNITS :

Attained age	Male		Female	
	Non-smoker	Smoker	Non-smoker	Smoker
Less than 30	\$0,147	\$0,177	\$0,090	\$0,104
30 to 34	\$0,160	\$0,213	\$0,102	\$0,132
35 to 39	\$0,162	\$0,238	\$0,118	\$0,176
40 to 44	\$0,182	\$0,309	\$0,146	\$0,255
45 to 49	\$0,237	\$0,471	\$0,176	\$0,347
50 to 54	\$0,343	\$0,793	\$0,235	\$0,502
55 to 59	\$0,526	\$1,331	\$0,344	\$0,746
60 to 64	\$0,856	\$2,179	\$0,547	\$1,127

ACCIDENTAL DEATH OR DISMEMBERMENT BENEFIT INCLUDED WITH OPTIONAL LIFE INSURANCE BENEFIT FOR THE INSURED

PURPOSE

The purpose of coverage is to pay the insured an indemnity when he incurs a loss as described in the article Eligible losses of the present benefit, and this loss is by accidental means and occurs while the optional life insurance benefit for the insured is in force.

SPECIFIC DEFINITIONS TO THE ACCIDENTAL DEATH OR DISMEMBERMENT BENEFIT INCLUDED WITH OPTIONAL LIFE INSURANCE BENEFIT FOR THE INSURED

In the present policy, unless one of the benefits, a change, an amendment or the Summary of Benefits stipulates otherwise, we hereby define:

INSURED

A member or his spouse.

AMOUNT OF INDEMNITY

The amount of indemnity is equal to the product (a x b):

- a) the amount of insurance in force for the optional life insurance benefit for the insured including accidental death or dismemberment benefit;
- b) the relative value of the loss according to the table of losses, hereinafter.

ELIGIBLE LOSSES

Eligible losses are the ones listed in the table below; they must be the result of an accident and the loss must occur within three hundred and sixty-five (365) days of the accident.

TABLE OF LOSSES AND PERCENTAGE OF INDEMNITY	
LOSSES	PERCENTAGES
Quadriplegia, hemiplegia or paraplegia	200%
Life	100%
Two hands or two feet	100%
One eye and one hand or one foot	100%
Two eyes	100%
One hand and one foot	100%
Speech and hearing in both ears	100%
One arm or one leg	75%
One hand or one foot or one eye	66,67%
Speech	66,67%
Hearing in both ears	66,67%
Four fingers of the same hand	33,33%
The thumb and index of the same hand	33,33%
All the toes of the same foot	33,33%
Hearing in one ear	12,50%

Loss of an eye means total and permanent loss of sight of the eye.

Loss of speech must be total and permanent.

Loss of one hand or one foot means the amputation at the wrist or ankle joint or above, or the loss of its use.

Loss of one arm or one leg means the amputation at the elbow joint or knee joint or above, or the loss of its use.

Loss of hearing means total and permanent loss of hearing.

Loss of one finger means amputation at the joint between the finger and the hand or above, or the loss of its use.

Loss of one toe means amputation at the joint between the toe and the foot or the loss of its use.

Loss of use of a limb means total and permanent loss of each and all of the functions of the limb.

RESTRICTIONS

If the insured suffers more than one loss from the same accident, only one indemnity is paid, being indemnity for the most severe loss suffered.

In the case of quadriplegia, hemiplegia or paraplegia if the insured dies within ninety (90) days of the accident, the benefit payable is limited to one hundred per cent (100%) of the amount of insurance.

EXPOSURE AND DISAPPEARANCE

If, following an accident, the insured is inevitably exposed to natural elements causing a loss which would normally give rise to an indemnity; such loss will be covered under the provisions of the present benefit.

If the insured is not found within the year following his disappearance, due to a wreck or destruction of the means of transportation in which he was travelling at the time of the accident, loss of life due to bodily injury will be presumed after a period of three hundred and sixty-five (365) days following the date of the accident.

EXCLUSIONS

No indemnity will be payable if the loss is the result:

- a) of the insured's participation in a criminal act or attempted criminal act;
- b) of the insured's active participation in a civil commotion, riot, insurrection or military operation during war, whether war is declared or not;
- c) of the insured's participation in an aerial flight, other than as a fare-paying passenger on a regular chartered flight;
- d) of suicide or self-inflicted wound or mutilation, regardless of the insured's state of mind;

- e)** of death or having suffered from body lesions while his ability to drive is impaired according to the law, because of diminished faculties due to the consumption of alcohol or drugs;
- f)** of the insured's participation in land or water motor vehicle races, scuba diving, parachute jumping, free-fall or otherwise, bungee jumping, gliding or sail flights, or any other dangerous similar activity or sport;
- g)** of intoxication by or while under the influence of alcohol or drugs;
- h)** of an injury that does not show any visible trauma or external wounds, except for drowning or internal lesions discovered by autopsy;
- i)** of a physical or mental infirmity, or any kind of illness;
- j)** of poisoning or infection, except for an infection resulting from a wound or accidental cut;
- k)** of inhalation of toxic gas, except when inhalation is the result of an accident related to the insured's employment;
- l)** of service with the military, naval or air forces or with any other auxiliary or armed forces of any country, whether war is declared or not;
- m)** of a medical or dental treatment, surgery or anaesthesia.

Group Insurance Plan

OLYMEL ST-DAMASE ET SYNDICAT TUAC - LOCAL 1991-P

Group: 4160

Issued for class:

2 - PRE-RETIRES EMPLOYEES

Issued:

Dec 7, 2022

Negotiated through:

**AZUR SERVICES CONSEIL
1540 BOULEVARD MARIE-VICTORIN
LONGUEUIL QC
J4G 1A4
Tel: (450) 640-1900
Fax: (450) 640-1901**

This explanatory brochure constitutes a useful and important guide.

This document contains texts briefly describing group insurance benefits of your plan. However, these texts do not confer any contractual rights and do not alter in any manner benefits of the plan. In all instances, the provisions and stipulations of the policy issued to the contract owner shall prevail.

We urge you to read it carefully and to save it for future reference whenever required.

Filing of claim

You can submit your claims by Internet on our secured site or by mail.

You can access our *online services* on our secured site at www.uvinsurance.ca under the **My Universe Login - Group Insurance - Member** section.

To send your claims by mail, you must include your original receipts and a completed form available from your group insurance plan administrator or online at www.uvinsurance.ca under the **Group Insurance - Learn more - Forms** section.



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www.uvinsurance.ca

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SUMMARY OF BENEFITS

CONTRACT NO.: 4160, CLASS 2 - PRE-RETIREEES EMPLOYEES

LIFE INSURANCE BENEFIT FOR THE MEMBER

Effective date: Nov 1, 2022

INSURABLE AMOUNT:

The insurable amount is a fixed amount of \$ 40 000.

Maximum amount without proof: \$ 40 000

Maximum amount with proofs: \$ 40 000

Reduction of 50 % at the member's 65th birthday, for a maximum amount of: \$ 20 000

Reduction of 100 % at the member's 70th birthday.

Reduction of 100 % at retirement.

WAIVER OF PREMIUMS:

Waiver of premiums in the event of disability of the member up to age 65, after a waiting period of 6 months.

SUMMARY OF BENEFITS

CONTRACT NO.: 4160, CLASS 2 - PRE-RETIREEES EMPLOYEES

LIFE INSURANCE BENEFIT FOR DEPENDANTS

Effective date: Nov 1, 2022

INSURABLE AMOUNT:

	SPOUSE	CHILD(REN)*	CHILD(REN)**	CHILD(REN)***
Family coverage:	\$ 10 000	\$ 10 000	\$ 10 000	\$ 10 000

* Per child aged 24 hours to 14 days

** Per child aged 15 days to 6 months

*** Per child over 6 months

TERMINATION:

The maximum age for a dependent child is 21 years, or 26 years if a full time student.

Termination of benefit at age 70 for the member.

Termination of benefit upon retirement of the member.

WAIVER OF PREMIUMS:

Waiver of premiums in the event of disability of the member up to age 65, after a waiting period of 6 months.

SUMMARY OF BENEFITS

CONTRACT NO.: 4160, CLASS 2 - PRE-RETIREE EMPLOYEES

SHORT-TERM DISABILITY BENEFIT

Effective date: Nov 1, 2022

INSURABLE AMOUNT:

Weekly insurable amount: 66.670 % of the salary rounded to the next dollar.

Maximum insurable amount: Is equal to HRDC

Taxation of the insurable amount: Taxable

The maximum of disability income: 100 % of the gross salary

WAITING PERIOD:

For an accident: 0 day

For an illness: 5 business days

For hospitalisation: 0 day

BENEFIT:

The maximum duration of benefits: 26 weeks

Frequency of cheques: Every 7 days, payable on a 5-day week basis.

Termination of benefit at: Age 65 for the member

WAIVER OF PREMIUMS:

Waiver of premiums in the event of disability of the member up to age 65, after a waiting period of 6 months.

REMARK(S) FOR SHORT-TERM DISABILITY INSURANCE:

NOTWITHSTANDING THE FOREGOING:

THE AMOUNT OF DISABILITY BENEFIT SPLITS AT THE RATE FOR THE AMOUNT INTENDED FOR A COMPLETE WEEK DIVIDED BY THE NUMBER OF WORKED DAYS DURING THE NORMAL WORK WEEK, FOR EACH DAY OF ABSENCE DURING THE NORMAL WORK WEEK.

THE ELIMINATION PERIOD FOR THIS BENEFIT CORRESPONDS TO 5 NORMAL WORKED DAYS FOR TOTAL DISABILITY RESULTING FROM AN ILLNESS.

SUMMARY OF BENEFITS

CONTRACT NO.: 4160, CLASS 2 - PRE-RETIREEES EMPLOYEES

LONG-TERM DISABILITY INSURANCE BENEFIT

Effective date: Nov 1, 2022

INSURABLE AMOUNT:

Monthly insurable amount: 75.000 % of the salary rounded to the next dollar.

Maximum insurable amount without proof: \$ 2 000

Maximum insurable amount with proof: \$ 2 000

Taxation of the insurable amount: Taxable

Maximum percentage of disability income: 75 % of the gross salary

WAITING PERIOD:

For an accident: 182 days

For an illness: 189 days

For hospitalisation: 182 days

BENEFIT:

The maximum duration of benefits: Age 65 for the member

Frequency of cheques: 1 per month

The definition of own occupation is: The inability to accomplish own occupation for 3 years.

Termination of benefit at: Age 65 for the member

WAIVER OF PREMIUMS:

Waiver of premiums in the event of disability of the member up to age 65, after a waiting period of 6 months.

REMARK(S) FOR LONG-TERM DISABILITY INSURANCE BENEFIT:

NOTWITHSTANDING THE FOREGOING:

THE ELIMINATION PERIOD FOR THE PRESENT BENEFIT CORRESPONDS TO 26 NORMAL WORK WEEKS FOR A TOTAL DISABILITY RESULTING FROM AN ACCIDENT OR A HOSPITALIZATION AND 27 NORMAL WORK WEEKS FOR A TOTAL DISABILITY RESULTING FROM AN ILLNESS.

SUMMARY OF BENEFITS

CONTRACT NO.: 4160, CLASS 2 - PRE-RETIRES EMPLOYEES

HEALTH INSURANCE BENEFIT

Effective date: Nov 1, 2022

TOTAL AMOUNT PAYABLE:

The total amount payable for health insurance has no limit.

DEDUCTIBLE:

Individual coverage: \$ 25*

Family coverage: \$ 25*

Combined deductible: Yes, with drug insurance

**The deductible is applicable by calendar year.*

ELIGIBLE FEES:

Description	Refund	-----Per Period-----			Maximum	Type	Deductible	Max Age
		Frequency	No.	Visit				
HOSPITALISATION:								
HOSP. PROV. RESIDENCE [*]	100%	See contract			See contract	(E)	No	99
HOSP. OUT PROV. RES. [*]	100%	See contract			See contract	(P)	No	99
CONVALESCENCE HOME [*]	100%	Calendar Year	180		See contract	(E)	No	99
SUBSTANCE ABUSE TR. [*]	90%	See contract		\$80	\$2 500	(E)	Yes	99
[*] Semi-private room								
PARAMEDICAL EXPENSES:								
AUDIOLOGIST	90%	Calendar Year	11	\$40		(E)	Yes	99
CHIROPRACTOR	90%	Calendar Year	11	\$40		(E)	Yes	99
X-RAY (CHIROPRACTOR)	90%	Calendar Year		\$25	\$100	(E)	Yes	99
MASSOTHERAPIST [1]	90%	Calendar Year	11	\$40		(E)	Yes	99
NATUROPATH	90%	Calendar Year	11	\$40		(E)	Yes	99
NATUROTHERAPIST	90%	Calendar Year	11	\$40		(E)	Yes	99
ORTHOPHONIST	90%	Calendar Year	11	\$40		(E)	Yes	99
ORTHOTHERAPIST [1]	90%	Calendar Year	11	\$40		(E)	Yes	99
OSTEOPATH	90%	Calendar Year	11	\$40		(E)	Yes	99
PHYSIOTHERAPIST [2]	90%	Calendar Year	11	\$40		(E)	Yes	99
PODIATRIST	90%	Calendar Year	11	\$40		(E)	Yes	99
PSYCHOANALYST [3]	90%	Calendar Year	11	\$40		(E)	Yes	99
PSYCHOLOGIST [3]	90%	Calendar Year	11	\$40		(E)	Yes	99
READAPTATION THERAP. [2]	90%	Calendar Year	11	\$40		(E)	Yes	99
SOCIAL WORKER [3]	90%	Calendar Year	11	\$40		(E)	Yes	99

Maximum amounts are combined for overall fees for each whole group.

These groups are: [1], [2], [3] and [4]

Type (E) = maximum eligible amount, Type (P) = maximum payable amount

[R] = medical recommendation required for these paramedical expenses

SUMMARY OF BENEFITS

CONTRACT NO.: 4160, CLASS 2 - PRE-RETIRES EMPLOYEES

HEALTH INSURANCE BENEFIT

ELIGIBLE FEES (CONTINUED):

DESCRIPTION	Refund	-----Per Period-----			Maximum	Type	Deductible	Max Age
		Frequency	No.	Visit				
OTHER FEES:								
COLOSTOMY AND AL.	90%	See contract			Unlimited	(E)	Yes	99
AMBULANCE	90%	See contract			Unlimited	(E)	Yes	99
LAB TEST/DIAGNOSIS	90%	Calendar Year			\$1 000	(E)	Yes	99
ANESTHETIC	90%	See contract			Unlimited	(E)	Yes	99
HEARING AID	90%	48 months			\$600	(E)	Yes	99
RESP. APPRAR./OXYGEN	90%	Lifetime			\$10 000	(E)	Yes	99
BANDAGE / SPLINT	90%	See contract			Unlimited	(E)	Yes	99
OTHER PROSTHESIS	90%	See contract			\$5 000	(E)	Yes	99
DYN. ORTHOSIS / CORS.	90%	See contract			Unlimited	(E)	Yes	99
ELASTIC STOCKINGS	90%	Calendar Year	3		Unlimited	(E)	Yes	99
ORTHOPEDIC SHOES#1 [4]	75%	12 months	2		\$300	(E)	Yes	16
ORTHOPEDIC SHOES#2 [4]	75%	12 months	1		\$300	(E)	Yes	99
DENTAL ACCIDENT	90%	See contract			\$5 000	(E)	Yes	99
FOOT ORTHOSIS	90%	12 months			\$495	(E)	Yes	99
EYE EXAM	90%	24 months			\$75	(E)	Yes	65
MEDICAL SUPPLIES	90%	See contract			Unlimited	(E)	Yes	99
GLUCOMETER	90%	36 months			\$300	(E)	Yes	99
NURSE	90%	12 months		\$300	\$10 000	(E)	Yes	99
REGISTERED NURSE	90%	12 months			\$200	(E)	Yes	99
SCLER. INJEC. DRUGS	90%	Calendar Year		\$20		(E)	Yes	99
RENTAL (CHAIR/BED)	90%	See contract			Unlimited	(E)	Yes	99
CAPILLARY PROSTHESIS	90%	Lifetime		1	\$300	(E)	Yes	99
MAMMARY PROSTHESIS	90%	24 months			\$1 000	(E)	Yes	99
X-RAY	90%	Calendar Year			\$1 000	(P)	Yes	99
MAG. RESONANCE (MRI)	100%	Calendar Year			\$1 000	(P)	Yes	99
CARE OUT PROV.	100%	See contract			See contract	(P)	No	99
I.U.D.	90%	Calendar Year		1		(E)	Yes	99
TENS	90%	60 months			\$1 000	(E)	Yes	99
TRANSFUSION	90%	See contract			Unlimited	(E)	Yes	99

Maximum amounts are combined for overall fees for each whole group.

These groups are: [1], [2], [3] and [4]

Type (E) = maximum eligible amount, Type (P) = maximum payable amount

SUMMARY OF BENEFITS

CONTRACT NO.: 4160, CLASS 2 - PRE-RETIREE EMPLOYEES

HEALTH INSURANCE BENEFIT

TERMINATION:

The maximum age for a dependent child is 21 years, or 26 years if a full time student.
Travel assistance as per the contract terminates at age 99 for the member.

WAIVER OF PREMIUMS:

Waiver of premiums in the event of disability of the member up to age 65, after a waiting period of 6 months. The waiver of premium terminates on the earliest of the following dates: The date this benefit terminates or the date this policy terminates.

REMARK(S) FOR HEALTH INSURANCE BENEFIT:

THE MAXIMUM AMOUNT OF ELIGIBLE EXPENSES REFUNDED BY THE INSURER FOR OUTSIDE THE INSURED'S PROVINCE OF RESIDENCE IS LIMITED TO FIVE MILLION DOLLARS (\$5,000,000) DURING THE INSURED'S LIFETIME.

TRIP CANCELLATION IS INCLUDED, REFER TO THE CONTRACT TRAVEL ASSISTANCE SERVICE SECTION.

OTHER PARAMEDICAL EXPENSES INCLUDED :

- KINESITHERAPIST COMBINED WITH MASSOTHERAPIST AND ORTHOTHERAPIST.
- NATUROPATH COMBINED WITH NATUROTHERAPIST.
- CHIROPODIST COMBINED WITH PODIATRIST.
- PSYCHOEDUCATOR COMBINED WITH PSYCHOANALYST AND SOCIAL WORKER.

OTHER ELEGIBLE FEES :

- REPLACEMENT MASK COMBINED WITH RESP.APPRAR/OXYGEN.
- DEEP SHOES: MAXIMUM PAYABLE AMOUNT OF \$ 100.00 PER CALENDAR YEAR.
- INSULIN PUMP : MAXIMUM PAYABLE AMOUNT OF \$ 7 500.00 PER 60 MONTH-PERIOD.
- SUPPLIES FOR THE INSULIN PUMP : MAXIMUM PAYABLE AMOUNT OF \$ 10 000.00 PER 60 MONTH-PERIOD.
- RX CHIROPODIST, RX PODIATRIST, RX NATUROPATH AND RX OSTEOPATH COMBINED WITH X-RAY.
- LABORATORY ANALYSIS: MAXIMUM PAYABLE AMOUNT OF \$ 1000.00 PER CALENDAR YEAR.
- POST-MASTECTOMY BRASSIERES SOLD BY A SPECIALIZED LABORATORY: MAXIMUM LIFETIME PAYABLE AMOUNT OF \$ 200.00.
- CONTACT LENSES OR INTRAOCULAR LENSES FOLLOWING A CATARACT SURGERY: MAXIMUM LIFETIME PAYABLE AMOUNT OF \$ 1000.00.
- THERAPEUTIC DEVICES: MAXIMUM LIFETIME PAYABLE AMOUNT OF \$ 10 000.00.
- TOMODENSITOMETRY: MAXIMUM PAYABLE AMOUNT OF \$ 1000.00 PER CALENDAR YEAR.
- ELECTROCARDIOGRAM: MAXIMUM PAYABLE AMOUNT OF \$ 1000.00 PER CALENDAR YEAR.
- ECHOGRAPHY: MAXIMUM PAYABLE AMOUNT OF \$ 300.00 PER CALENDAR YEAR.
- EXPENSES OF SURGERY NECESSARY TO THE REPAIR OF AN ESTHETIC DAMAGE ASCRIBABLE WITH AN ACCIDENT WHICH HAS OCCURRED WHEREAS THIS INSURANCE IS IN FORCE, WITH CONDITION WHICH THE SERVICES WERE DONE IN THE 36 MONTHS OF THE

SUMMARY OF BENEFITS

CONTRACT NO.: 4160, CLASS 2 - PRE-RETIREEES EMPLOYEES

HEALTH INSURANCE BENEFIT

DATE OF ACCIDENT: MAXIMUM PAYABLE AMOUNT OF 5000.00\$ BY ACCIDENT.

- SCREENING TESTS DURING PREGNANCY ARE COVERED UNDER LABORATORY ANALYSIS.

SUMMARY OF BENEFITS

CONTRACT NO.: 4160, CLASS 2 - PRE-RETIRES EMPLOYEES

DRUG INSURANCE BENEFIT

Effective date: Nov 1, 2021

DEDUCTIBLE:

Individual coverage: \$ 25*

Family coverage: \$ 25*

Combined deductible: Yes, with health insurance

**The deductible is applicable by calendar year.*

REIMBURSEMENT:

For drugs prescribed in the province of residence according to the RESTRICTIVE drugs list.

Eligible innovator drugs: 90 %**

Eligible generic drugs: 90 %**

Eligible brand drugs: 90 %**

Drug card: Direct payment

*** After satisfying the deductible*

EMPLOYEE'S CONTRIBUTION:

Each year, the maximum an insured contributes for drug fees with respect to the deductible and the percentage of reimbursement is equal to the most recent amount determined by the "Régie de l'assurance maladie du Québec". This maximum applies to the total amount of drug fees incurred by the insured and their insured dependants. The maximum contribution does not apply to the drug cost that the member has to pay outside Quebec and to members residing outside Quebec.

TERMINATION:

The maximum age for a dependent child is 21 years, or 26 years if a full time student.

WAIVER OF PREMIUMS:

Waiver of premiums in the event of disability of the member up to age 65, after a waiting period of 6 months. The waiver of premium terminates on the earliest of the following dates: The date this benefit terminates or the date this policy terminates.

GENERAL PROVISIONS

DEFINITIONS

In the present policy, unless one of the benefits, a modification, an amendment or the “Summary of Benefits” stipulates otherwise, we hereby define:

a) ACCIDENT

A corporal blow diagnosed by a physician, arising directly and independently of all other causes, from the sudden, violent and unforeseeable action of an external cause.

b) MEMBER

An eligible and insured employee under this contract.

c) 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.

d) INSURED

A member or one of his dependants.

e) SPOUSE

A person with whom the insured is living. The union must be a marriage duly recognised by Quebec legislation or the common-law state of a single, widowed or divorced person having resided permanently for more than one year with a person who is also single, widowed or divorced, who is publicly presented as a spouse. The stated delay is not applicable if a child is born of the union. The dissolution of a marriage by divorce as well as legal separation results in the loss of the marital status. The same loss of marital status results in the event of any de facto separation of more than three (3) months, in the case of a non-legally contracted union.

The spouse is the one designated by the insured. Only one person may be insured as a spouse at any given time.

f) ELIMINATION PERIOD

A continuous period beginning at the start of a total disability during which no disability benefit is payable under this benefit.

g) DRUGS

Controlled or limited usage drugs including medication or narcotics as defined in the Food and Drugs Act and Narcotic Control Act.

h) EMPLOYEE

A person residing in Canada who works for an employer or duly registered member of the policyowner.

i) EMPLOYER

The policyowner or a subsidiary associated or affiliated company whose name appears in the “Summary of Benefits”.

j) CHILD

Any single child of the insured or of his spouse, including any legally adopted child, residing in Canada and who meets one of the following conditions:

- is under twenty-one (21) years of age, or;
- is under twenty-six (26) years of age and duly registered as a full time student at a recognised teaching institution, or;
- is totally disabled and became totally disabled while one of the two (2) preceding conditions existed, and resides with the member.

With regards to life insurance for dependants, the infant must be at least twenty-four (24) hours of age.

k) IMMEDIATE FAMILY

The insured, his spouse, his children, his father, his mother, his grandparents, his brothers, his sisters and his grand-children at least 18 years of age.

l) DEDUCTIBLE

The deductible is the part of eligible expenses that must be paid by the insured in each calendar year before a benefit is payable. If applicable, the deductible amount is specified in the "Summary of Benefits".

If the present contract replaces another, the fees disbursed between January 1st and the effective date of the contract will be applied toward the deductible.

In the event where there is no previous insurer, for the first year of insurance, the deductible is proportional to the number of months between the effective date and the end of the calendar year, unless otherwise agreed differently between the insurer and the policyowner.

m) TOTAL DISABILITY

For the elimination period stipulated in the "Summary of Benefits" and the twenty-four (24) months that follow, the inability of a person, due to illness or an accidental injury, to perform all the duties of his regular occupation; subsequently, the inability to perform any remunerative occupation that could reasonably be performed when taking into consideration the education, training or experience of that person, regardless of the availability of employment in the region of the member's place of residence.

n) ILLNESS

A deterioration of health or disorder of the organism diagnosed by a physician specialised in the treatment of the illness. Pregnancy is not considered to be an illness; only major complications due to pregnancy are considered to be a deterioration of health.

o) PHYSICIAN

Any legally authorised person who practices medicine in his field of specialty. The physician must not be the insured, or a member of his immediate family.

p) REGULAR OCCUPATION

All the functions, as a whole, that a person performs relating to his occupation.

q) TOTAL DISABILITY PERIOD

A continuous period of total disability or successive periods of total disability resulting from the same cause or from related causes and separated by one or several recurrence periods shorter than the recurrence period allowed under the said benefit. A new period of total disability begins when the insured returns to work on a full-time basis at full salary for at least one day and the disability is the result of a cause completely independent of the first disability.

r) RECURRENCE

A period immediately following the date a person ceases to be totally disabled.

s) DEPENDANT

The member's spouse or child taken individually in accordance with the definitions of spouse or child in the present contract. It is noted that the following persons are not to be considered as the member's dependants:

- 1) a child who is not depending on the member for financial support or who has a full-time job;
- 2) a child with a spouse.

t) REIMBURSEMENT PERCENTAGE

The percentage of admissible fees that can be reimbursed after deducting the deductible, as specified in the "Summary of Benefits".

u) POLICYOWNER

A corporate body or physical person stipulated in the face page of this policy or in the "Summary of Benefits". The policyowner is the owner of the contract. The policyowner may or may not be the employer.

v) RETIREMENT

Date on which a member ceases to work for reason of retirement or early retirement.

w) PROFESSIONAL RISK

Any risk related to a job, occupation, trade or profession.

x) GROSS EARNED INCOME

The regular gross earned income excluding bonuses, payments for overtime, fees, allowances for lodging and meals, isolation payments and any lump sum occasional payments which are not part of the regular remuneration.

For the members whose income derives totally or partially from commissions or performance bonuses, salary means the average percentage of the employee's pay, paid by the employer, including commissions indicated on the employee's T4 and T4A income tax forms during the two (2) preceding years. In the event where the employee has not completed two years of continued service with the same employer, but at least one year, an income average will be established based on the full duration of service. However, if the employee has been employed for less than one year, salary means the average percentage of the employee's pay as is declared by the employer.

However, for the short-term disability benefit, income represents the insurable remuneration as established by the Canadian employment insurance legislation if the plan is duly registered with the Human Resources and Social Development Canada (HRDC).

y) NET INCOME

For a salaried employee, net income is earned income less provincial and federal income taxes, contributions to unemployment insurance, Quebec Pension Plan and Canada Pension Plan deducted from the salary.

EMPLOYEE ELIGIBILITY

An employee becomes eligible for insurance:

- a) on the effective date of the contract if he meets the eligibility provisions stipulated in the "Summary of Benefits", or;
- b) after the effective date, from the date he meets the eligibility provisions stipulated in the "Summary of Benefits".

Seasonal employees or part-time employees (i.e. those working less than nine (9) months per year) and partial part-time employees (i.e. those who work less than twenty (20) hours per week) are eligible only if designated in the "Summary of Benefits".

DEPENDANT ELIGIBILITY

An employee's dependants become eligible for insurance on the later of the following dates:

- a) the date when the employee becomes eligible, or;
- b) the date when they become dependants as per the definition of a dependant stipulated in the present contract.

APPLICATION FOR INSURANCE

To be insured under this contract, an eligible employee must submit a written request by completing an application form provided by the insurer.

To insure his dependants, an employee must list them on his application form. For subsequent coverage, the employee must advise the policyowner, who must then complete the required form and forward it to the insurer without further delay.

EFFECTIVE DATE OF INSURANCE FOR THE EMPLOYEE

An employee's insurance becomes effective:

- a) on his date of eligibility, if the insurer has received the request for insurance on or before this date, or;
- b) on the date the insurer receives the request for insurance, if this date is within the thirty (30) day period following his eligibility date, or;

- c) on the date the insurer accepts the evidence of insurability that the employee must provide at his expense and which is satisfactory to the insurer, if the form requesting the insurance is received more than thirty (30) days after the eligibility date.

Notwithstanding the foregoing, any insurance that is subject to evidence of insurability becomes effective only on the date of acceptance of such proof by the insurer.

If the day on which the insurance becomes effective is a working day and the employee is not at work on that day for reasons other than a scheduled vacation period, his insurance becomes effective the day he returns to work full-time and is able to accomplish all the duties of his regular occupation.

If the day on which the insurance becomes effective is not a working day, the insurance becomes effective:

- a) on that date, provided the employee was actually at work on the last previous working day, otherwise;
- b) the day he returns to work full-time and is able to accomplish all the duties of his regular occupation.

EFFECTIVE DATE OF INSURANCE FOR A DEPENDANT

The insurance for a dependant becomes effective:

- a) on the date of eligibility of a dependant if the insurer has received the written request on or before that date; or
- b) on the date the insurer receives the request for insurance, if this date is within the thirty (30) day period following the dependant eligibility date; or
- c) on the date the insurer accepts the evidence of insurability that the employee must provide at his expense and which is satisfactory to the insurer, if the form requesting the insurance is received more than thirty (30) days after the dependant's eligibility date.

Any new dependant child of the member whose other dependants are already insured becomes rightfully and immediately insured. The name and date of birth of the new child must however be communicated to the insurer by means of a written notice for the processing of future claims.

However, with the exception of any newborn, if a dependant is hospitalised on the effective date of his own life, such insurance becomes effective only on the day after leaving the hospital.

CLAIMS

a) FILING A CLAIM

Any claim for benefits under this contract must be filed with the insurer within thirty (30) days thereafter.

b) PROOF OF CLAIM

The insured must submit to the insurer the required proof according to the benefit in the ninety (90) days following the event. It is the insured's

responsibility to assume all expenses incurred for proof satisfactory to the insurer.

c) ADDITIONAL DELAY

Failure in filing a claim or submitting proof within the specified period will not invalidate a claim under the contract if proven that it was impossible for the insured to file the claim on time, and the claim was filed or the proof was submitted within twelve (12) months following the date of the event giving rise to the claim.

d) PAYMENT

The insurer must pay claims within thirty (30) days following the date of receipt of all required proof.

All amounts become payable to the member, if living. Otherwise, the amounts are payable to the designated beneficiary.

e) BENEFICIARY

Providing it is not contrary to law and where no irrevocable beneficiary designation has been made, an insured may, by giving a written notice to the insurer, designate or revoke any beneficiary.

The insurer assumes no responsibility for the validity of any beneficiary designation. If no beneficiary designation has been made, all amounts payable at death are issued to the member's estate.

RULES OF MINIMAL PARTICIPATION OF ELIGIBLE EMPLOYEES

A minimum of two (2) members at all times is required to maintain this contract in force.

Any employee that satisfies the eligibility provisions stipulated in the summary of benefits and who subscribes to the insurance plan must remain insured under the provisions of the policy.

In addition, for each member and for each benefit, the policyowner must pay at least the proportion on the premium indicated in the "Summary of Benefits".

An "insurance premium", for the purpose of this article, excludes the premium for any additional insurance benefit.

TERMINATION OF AN MEMBER'S INSURANCE

A member's insurance under the present contract or under one of its benefits or services terminates at midnight on the earliest of the following dates:

- a)** the date of cancellation of the present contract or of the relevant benefit;
- b)** the date the member ceases to be an employee or ceases to be in a class of employees' eligible for insurance;
- c)** the date the insurer receives a written notice from the policyowner requesting termination of an member's insurance, or any subsequent date mentioned in the notice;
- d)** the date on which the insured attains the maximum age for the relevant benefit for any such insurance;

- e) the due date of any premium, if on that date the member's premium is not paid, unless a request for waiver of premiums due to disability has been made and accepted;
- f) the date of the member's death, subject to the payment of benefits that are due.

TERMINATION OF DEPENDANT INSURANCE

A dependant's insurance under the present contract or under one of its benefits or services terminates at midnight on the earliest of the following dates:

- a) the date of cancellation of the present contract or of the implied benefits;
- b) the date the member ceases to be an employee or ceases to be in a class of employees' eligible for insurance;
- c) the date the insurance for the member ceases;
- d) the date a dependant no longer meets requirements mentioned in the definition of dependant;
- e) the due date of any premium, if on that date the dependant's premium is not paid, unless a request for waiver of premiums in the event of disability has been made and accepted;
- f) the date of the dependant's death subject to the payment of benefits that is due.

ERROR AND FALSE DECLARATION

A false declaration of age does not lead to the annulment of the insurance. In this situation, the true date of birth, established to the insurer's satisfaction, serves as the basis of premium calculation and an equitable adjustment of premiums and insured amount, if necessary, will be made.

The insurer is justified in requesting that the life insurance be null and void when the insured's age at issue was outside the age limits set by the insurer's rates. The insurer must act within three (3) years of the issue of the insured's certificate, providing it does so while the insured is living and within sixty (60) days of becoming aware of the error.

An error concerning the insured's age cannot prolong any amount of insurance beyond the date these amounts would have terminated, taking into account the insured's actual age.

INCONTESTABILITY

In the absence of fraud, a false declaration or a withholding of information may not be invoked as sufficient reason to terminate or reduce the insurance if it has been in force for more than two (2) years. However, this rule does not apply to disability insurance if said disability started during the first two (2) years of insurance.

INFORMATION TO MEMBERS

The insurer provides the policyowner with a written summary the insured's rights and obligations under the present contract, as well as a certificate of proof of coverage for insured employees.

The policyowner must forward this information to the member. Its purpose is to advise the member of his rights and obligations. In the event of litigation, only the contract may be invoked.

The member may consult the contract at the policyowner's business address and make a copy at his own expense.

LAWS THAT GOVERN THIS CONTRACT

For the purpose of this policy, reference to a law signifies the effective law in force at that particular time, or if repealed, the new law that replaces it or any law of the same nature with the same end result.

FILE ACCESS

In order to maintain the confidential nature of personal information on the insured, the insurer agrees to the following:

To create an individual insurance file that contains information on the insured relating to the application, as well as any information relating to the claim.

Access to the file is restricted solely to the insurer's employees, legal advisors or representatives responsible for the underwriting, investigations and evidence of insurability.

The insured's file is kept by the Union Life, Mutual Insurance Company.

The insured has the right to be informed of the personal information in of this file and if applicable, may have the file corrected by making a written request to the insurer. All requests are to be sent to the access information officer.

WAIVER OF PREMIUMS BENEFIT

PURPOSE

Waiver of premiums applies to each benefit indicated in the "Summary of Benefits". The purpose is to continue coverage of the insurance benefits in force at the beginning of disability. Disability must begin before the insured's sixtieth (60th) birthday in order for him to be eligible for waiver of premiums. Total disability must be as described in the definition of the "General Provisions" section of the present policy.

ELIMINATION PERIOD

The elimination period is the period that commences at the beginning of a total disability period and for which no disability payment is payable under this benefit.

The elimination period is stipulated in the "Summary of Benefits". Premiums are waived starting from the 1st day of the month following or coinciding with the date on which the elimination period is completed.

REMISSION PERIOD PERMITTED

A period less than one hundred and eighty (180) days immediately following the date a person who was totally disabled ceases to be.

PREMIUMS TO BE WAIVED

The premiums to be waived are those for insured benefits under the present contract at the beginning of disability as stipulated in the "Summary of Benefits". A retroactive refund of premiums will not exceed six (6) months from the date of approval of the claim for waiver by the insurer.

PROOF OF DISABILITY

To prove his disability or its continuance, the member must submit to the insurer a medical certificate by using the appropriate forms provided by the insurer. The insurer may, at its own expense, and as often as deemed necessary, have the insured undergo a medical examination by a physician chosen by the insurer, if it judges that the proof submitted by the member is unsatisfactory.

TERMINATION OF WAIVER OF PREMIUMS

In addition to the reasons of termination of insurance for the member in the section entitled "General Provisions" of the present policy, the waiver of premiums for an insured ceases when he is no longer disabled or when he cannot provide proof of his total disability or refuses to submit such proof.

In addition, waiver of premiums cease at midnight on the earliest of the following dates:

- the termination date or age limit stipulated in the "Summary of Benefits";
- his retirement date, if earlier.

EXCLUSIONS

The insurance provided by the present waiver of premiums benefit does not apply and the insurer assumes no responsibility if disability is the result:

- a)** of the insured's participation in a criminal act or an attempted criminal act, or;
- b)** of the insured's active participation in a civil commotion, riot, insurrection or military operation during war, whether war is declared or not, or;
- c)** of the insured's participation in an aerial flight other than as a fare paying passenger on a regular or chartered flight, or;
- d)** of an attempted suicide or self-inflicted wound or mutilation, regardless of the insured's state of mind, or;
- e)** of the fact of having suffered body lesions while driving a vehicle with diminished faculties due to alcohol or drug consumption (criminal act), or;
- f)** of the insured's participation in land or water motor vehicle races, scuba diving, parachute jumping, free-fall or otherwise, bungee jumping, gliding or sail flights, or any other dangerous similar activities or sports, or;
- g)** of intoxication by or while under the influence of alcohol or drugs, or;
- h)** of lumbago or back pain whose diagnosis can only be made subjectively by the insured's description of symptoms and cannot be supported by appropriate tests prescribed by a physician, or;
- i)** of disability that began prior to the effective date of insurance.

LIFE INSURANCE BENEFIT FOR THE MEMBER

PURPOSE

The purpose is to pay a death benefit when the member's death occurs while this insurance benefit is in force.

BENEFIT AMOUNT

The benefit amount is equal to the amount specified in the "Summary of Benefits" and is subject, if applicable, to reduction due to the member's age.

EXTENSION

Upon receipt and acceptance of required documents establishing to the satisfaction of the insurer, that an member was totally disabled while covered under the present contract and that the member:

- a) remained totally disabled up to the date of his death and died from the same condition as his disability, and;
- b) died before his sixty-fifth (65th) birthday and before the end of a six (6) month period calculated from the date he stopped working due to his disability, and;
- c) was not covered by another insurer under an insurance contract with a similar benefit.

The insurer pays the insurance amount to which the member was entitled as stipulated in the present contract without however, exceeding the amount that was in force on his life on the date he left his employment.

ANTICIPATED DEATH BENEFIT

Provided that the present benefit is in force in accordance with the provisions foreseen for the "Waiver of premiums" benefit of the present contract and a member's life expectancy is not more than twelve (12) months, he has the right to an anticipated death benefit payment. The amount is the lesser of twenty-five thousand dollars (\$25,000) or fifty per cent (50%) of the amount of life insurance in force.

The written request to the insurer must include satisfactory proof that the member's life expectancy does not exceed twelve (12) months as of the date requested.

Upon the member's death, the amount payable to the beneficiary by the insurer is reduced by the amount paid to the insured under the present right, increased by interest accrued since the date of the payment of this benefit at an annual rate of ten per cent (10%).

EVIDENCE OF INSURABILITY

When the amount of insurance exceeds the maximum amount of insurance without evidence of insurability stipulated in the "Summary of Benefits", the member is covered for the excess only if he submits proof satisfactory to the insurer. Subsequently, any increase in the amount of insurance will become effective only after the required evidence of insurability has been accepted by the insurer.

CONVERSION PRIVILEGE

If, before the member attains age sixty-five (65) the insurance on his life terminates due to the termination of his employment or the loss of a membership in an insured group, the member may convert all or part of the insurance amount lost into an individual life policy, without having to prove his insurability. The amount of insurance converted for the same insured cannot exceed the amount of benefit of the present benefit at the date of conversion, subject to the higher of a minimum of five thousand dollars (\$5,000) or twenty-five per cent 25% of the member's insurance amount, and a maximum of two hundred thousand dollars (\$200,000) or the difference between the amount of insurance lost under the present contract and the amount of insurance provided for by another contract under which the member became eligible at the time of exercising his conversion privilege.

In addition, upon termination of the present contract, on the condition that the member was covered for at least five (5) years and the contract was not replaced by another under which he became eligible, the member may convert, totally or partially the insurance volume lost to an individual permanent life insurance without evidence of insurability.

To convert, the member must make a written request to the insurer on the form provided by the insurer, and pay the insurer the amount of premium for the proposed contract, within thirty-one (31) days as of the termination of the insurance.

If the member dies during the thirty-one (31) day conversion privilege period, the insurer will pay the maximum amount of life insurance the insured could have been converted.

The member can subscribe to any one of the following individual insurance contracts:

- 1) a one (1) year term insurance, convertible at the end of the year to a term insurance to age sixty-five (65) or a whole life insurance contract;
- 2) a term insurance to age sixty-five (65);
- 3) a whole life insurance.

No additional benefit may be added to this insurance unless anticipated for specifically elsewhere in this contract.

The premium rate for the individual insurance contract is the rate in use by the insurer according to the amount converted, the plan chosen, and the member's gender and age at the time of conversion. If the member is already subjected to an increased premium or exclusion under the present benefit, the insurer will increase the premium or reinstate the exclusion for the individual insurance in a similar way. Any premium mode typically offered by the insurer may be selected. In the first year of conversion, insurance premiums may be paid quarterly. The individual contract

will become effective thirty-one (31) days after the termination of the insurance with regards to the present contract.

A decreased amount do to age or a change of category of the member does not give the member the right to convert his insurance.

The member who has used his conversion privilege is no longer eligible for insurance under the present contract, unless satisfactory evidence of insurability accepted by the insurer. The conversion privilege of the present contract, once exercised, is no longer available.

TERMINATION OF THE MEMBER'S INSURANCE

In addition to the reasons for the termination of the member's insurance stipulated in the section entitled "General Provisions" of the present policy, the insurance for this benefit will terminate at the earliest of the following dates at midnight:

- the termination date or age limit stipulated in the "Summary of Benefits";
- the member's retirement date, if earlier.

LIFE INSURANCE BENEFIT FOR DEPENDANTS

PURPOSE

the purpose is to pay a death benefit upon death of a member's dependant, if death occurs while this insurance benefit is in force.

AMOUNT OF BENEFIT

The amount of the benefit payable upon death of the spouse or a dependant child is specified in the "Summary of Benefits".

EXTENSION

If upon the member's death dependants are insured under this benefit, the dependants' life insurance is extended without payment of premiums up to the earliest of the following dates:

- a) twenty-four (24) months after the member's death;
- b) the termination date of the life insurance benefit for dependants had the member been living;
- c) the termination date of the present benefit.

TERMINATION OF INSURANCE

In addition to the reasons for the termination of the dependants' insurance benefit stipulated in the section entitled "General Provisions" of the present policy, the insurance for this benefit will terminate at the earliest of the following dates at midnight:

- the termination date or age limit stipulated in the "Summary of Benefits";
- the member's retirement date, if earlier;
- when the spouse or child no longer meets the definition of dependant.

SHORT-TERM DISABILITY BENEFIT

PURPOSE

The purpose of coverage is to temporarily replace and in part the employment income loss for a member during a period of total disability starting after the effective date of this benefit.

EXCLUSIVITY OF BENEFIT

Once the long-term disability benefits have started, a return to the short-term disability benefits is not possible for the same or related causes, until the total disability period giving rise to the claim has terminated.

ELIGIBILITY

To be eligible for the short-term disability benefit, an employee must be covered under the life insurance benefit.

ELIMINATION PERIOD

The elimination period for the present benefit corresponds to the number of days indicated in the "Summary of Benefits", separately for total disability resulting from an illness, an accident or a hospitalization.

The elimination period in the event of an illness applies for any total disability period beginning more than thirty (30) days after the date of the accident causing the disability.

The elimination period in the event of hospitalization begins at the date of hospitalization. In addition, the elimination period for hospitalization applies on the condition that the date of hospitalization precedes the date the elimination period for an illness ends.

In the present article, hospitalization means occupying a hospital room for a minimum period of eighteen (18) consecutive hours, or to have been admitted to the hospital for less than one day for surgery requiring anaesthesia.

REMISSION PERIOD PERMITTED

A period less than fifteen (15) days.

MAXIMUM ELIGIBLE WEEKLY INCOME

When the maximum eligible weekly income is as defined by the Canada employment insurance act, this expression is designated by M.E.W.I. in the "Summary of Benefits".

BENEFIT AMOUNT

The amount of disability benefits is payable according to the frequency indicated in the "Summary of Benefits".

BENEFIT PAYMENTS

Benefits become payable after the elimination period.

The amount of disability benefit is divided, if applicable, by one-fifth (1/5) of the amount provided for a complete week, for each working day of a normal work week, or by one-seventh (1/7) for each day of absence during the week as specified in the "Summary of Benefits".

Benefits are payable for provided that total disability persists without exceeding the maximum number of weeks specified in the "Summary of Benefits".

In addition, notwithstanding the maximum age specified in the "Summary of Benefits" which indicates the end of payment of benefits, it is stipulated that the said payment continues, with proof of disability satisfactory to the insurer, until the member has received at least fifteen (15) weeks of benefits in total including benefits paid before the maximum age. However, benefits end as soon as the member is able to resume work or as soon as he elects retirement, whichever period is shorter.

No disability period may start after the maximum age as specified in the "Summary of Benefits".

REHABILITATION

The insurer may assist the member in any manner to encourage him to return to his regular occupation or any other remunerative occupation compatible with his state of health.

In the case of a rehabilitation program accepted by the insurer, if a gradual return to work is appropriate considering the state of health, the amount of the payable benefit will be adjusted, taking into account the period worked.

REDUCTION OF BENEFIT DUE TO INTEGRATION OF BENEFITS

Under the present article, the insurer pays a weekly disability benefit according to the lesser of the amounts calculated under paragraphs A) or B) that follow:

a) DIRECT INTEGRATION OF BENEFITS

The member is only eligible for disability benefits of the present benefit and those provided for by government plans.

The amount of disability benefits payable by the insurer is reduced by the amount of initial basic benefits; without regard to subsequent increases due to indexation, payable under the following laws or plans, such as:

- 1)** the Quebec Pension Plan or the Canada Pension Plan;
- 2)** the Occupational Health and Safety Commission;
- 3)** the Automobile Insurance Act in Quebec or Ontario.

However, this article only refers to the above-mentioned benefits whose payment started at the beginning or after the beginning of total disability.

If an member refuses or neglects to submit a request for benefits under the laws or plans mentioned above, when informed by the insurer that he could be eligible for such benefits, the insurer reserves the right to reduce from

the benefits payable an estimate of benefits that could be provided by these laws or plans.

b) INDIRECT INTEGRATION OF BENEFITS

The member is eligible for additional disability benefits and those foreseen in the preceding paragraph a).

If the member receives disability income that is greater than the maximum percentage of income permitted, as specified in the "Summary of Benefits" and based on the member's income at the beginning of disability, the disability benefit is reduced so that the total amount of disability income does not exceed the maximum employment income at the beginning of disability. In calculating the maximum, only initial amounts of benefits will be considered without regard to subsequent increases due to indexation.

Other income amounts that are considered in the calculation mentioned in the preceding paragraph are:

- 1) Any remuneration paid by an employer due to a salary continuation policy, holidays, sick days or any other benefits program established by the employer;
- 2) all annuities or disability benefits payable under the following laws:
 - the Quebec Pension Plan or the Canada Pension Plan;
 - the Occupational Health and Safety Commission;
 - the Automobile Insurance Act in the province of residence.
- 3) any disability benefits payable under a group insurance contract or a retirement plan from the employer.

At all times, the total disability income payable under the present benefit and the other above-mentioned sources, cannot exceed the maximum amount equal to one hundred per cent (100%) of the member's net income at the beginning of his disability. (100% of the gross income if the benefit payable is taxable).

If a member refuses or neglects to submit a request for benefits under the laws mentioned above, when informed by the insurer that he could be eligible for such benefits, the insurer reserves the right to reduce from the benefits payable an estimate of benefits that could be provided by these laws.

EXCLUSIONS

No benefit is payable in the following cases:

- a) the member's participation in a criminal act or attempted criminal act;
- b) the member's active participation in a civil commotion, riot, insurrection or military operation during war, whether war is declared or not;
- c) self-inflicted wound or mutilation, regardless of the member's state of mind;
- d) the fact of having suffered from body lesions while his ability to drive was impaired, because of diminished faculties due to the consumption of alcohol or drugs;

- e) surgery not necessary for the member's health, for cosmetic or non-medically required care;
- f) during a period where an member stays more than 15 days outside of Canada;
- g) during a maternity leave provided for under provincial or federal law or of an agreement with the employer;
- h) period during which the member is not under the regular care of a specialist able to treat his illness, or if he does not receive proper therapy for his condition, or refuses such therapy;
- i) period during which the member is not under the care of a physician; the period of total disability may not start before the date of the first medical visit for the disability in question;
- j) disability that began before the effective date of insurance;
- k) disability as a result of a work related accident or occupational illness, unless otherwise stipulated in the "Summary of Benefits".

PROOF OF DISABILITY

To prove his disability and its continuance, the member must submit to the insurer a medical certificate using the insurer's forms.

The insurer may have the member undergo a medical examination by a physician of the insurer's choice and at the insurer's expense, as often as it judges necessary, if the proof submitted is not satisfactory to the insurer.

EXTENSION OF BENEFITS

Unless otherwise specifically mentioned for a particular benefit, the insurer pays the disability benefits provided in the present benefit for the entire disability period which began when the benefit was in force, and for provided that disability persists, and the conditions of the contract are met. If the benefit is terminated, benefits will continue to be paid as if the benefit had remained in force subject to the terms of the present benefit, as well as the laws in force.

DEDUCTION AT SOURCE

The insurer deducts from each benefit payment the amounts imposed by the Tax Act.

TERMINATION OF BENEFITS

Benefits terminate on the first of the following dates:

- a) the date of the member's death;
- b) the date on which the member ceases to be disabled;
- c) the date on which the member is unable to provide proof of his disability or refuses to provide such proof;

- d)** the date on which the member refuses or neglects to submit to a medical examination as requested by the insurer;
- e)** the date the member begins a remunerative occupation, unless he has the insurer's authorisation for rehabilitative employment, or the date on which he accomplishes one of the duties of his regular occupation other than through a rehabilitation program;
- f)** the date on which the member refuses without good reason totally or partially to participate in a rehabilitation program established and funded by the insurer to facilitate his return to the labour market and which the insurer's physicians and rehabilitation professionals deem reasonable and appropriate;
- g)** the date on which the member receives a retirement income, other than the one he was receiving at the beginning of disability while he was actively at work.

TERMINATION OF INSURANCE

In addition to the reasons for the termination of the member's insurance benefit stipulated in the section entitled "General Provisions" of the present policy, the insurance for this benefit will terminate at the earliest of the following dates at midnight:

- a)** the termination date or age limit stipulated in the "Summary of Benefits";
- b)** the member's retirement date, if earlier.

LONG-TERM DISABILITY BENEFIT

PURPOSE

The purpose of coverage is to replace in part the employment income loss incurred by an member during a period of total disability starting after the effective date of this benefit.

EXCLUSIVITY OF BENEFIT

No long-term disability benefits are payable until short-term disability benefits have expired.

ELIGIBILITY

To be eligible to the long-term disability benefit, an employee must be covered under the life insurance benefit.

ELIMINATION PERIOD

The elimination period is the period stipulated in the "Summary of Benefits" of the present policy.

REMISSION PERIOD PERMITTED

A period of one hundred and eighty (180) days immediately following the date a person ceases to be totally disabled.

BENEFIT AMOUNT

The benefit amount for each month of disability is stipulated in the "Summary of Benefits".

INDEXATION OF BENEFITS

When the disability benefit is indexed, the amount of benefit payable will be adjusted on the first day of January of each year following the first complete year of disability, excluding the elimination period, as per the indexation rate defined by the Quebec Pension Plan up to the maximum annual indexation rate indicated in the "Summary of Benefits".

EVIDENCE OF INSURABILITY

When the amount of monthly benefit exceeds the maximum amount of insurance without evidence of insurability stipulated in the "Summary of Benefits", the member is covered for the excess only if he submits proof satisfactory to the insurer. Subsequently, any increase in the amount of benefit will become effective only after the required evidence of insurability has been accepted by the insurer.

REDUCTION OF BENEFIT DUE TO INTEGRATION OF BENEFITS

Under the present article, the insurer pays a monthly disability benefit according to the lesser amount under paragraphs A) and B) that follow:

a) DIRECT INTEGRATION OF BENEFITS

The member is eligible only for disability benefits of the present benefit and those provided for by government plans.

The amount of disability benefits payable by the insurer is reduced by the amount of the initial basic benefits; without regard to subsequent increases due to indexation, payable under the following laws or plans, such as:

- the Quebec pension Plan or the Canada Pension Plan;
- the Occupational health and Safety Commission;

- the Automobile insurance Act in Quebec or Ontario;
- any other law providing income in case of disability.

However, this article only refers to the above-mentioned benefits whose payment started at the beginning or after the beginning of total disability.

If an member refuses or neglects to submit a request for benefits under the laws or plans mentioned above, when informed by the insurer that he could be eligible for such benefits, the insurer reserves the right to reduce from the benefits payable an estimate of benefits that could be provided by these laws or plans.

b) INDIRECT INTEGRATION OF BENEFITS

The member is eligible for additional disability benefits other than those of the preceding paragraph a).

If the member receives disability income that is greater than the maximum percentage of income permitted as specified in the "Summary of Benefits" and based on the member's income at the beginning of disability, the disability benefit is reduced so that the total amount of disability income does not exceed the maximum employment income at the beginning of disability. In calculating the maximum only the initial amounts of benefits will be considered without regard to subsequent increases due to indexation.

Other disability income amounts that are considered in the calculation mentioned in the preceding paragraph are:

- 1) any remuneration paid by an employer due to a salary continuation policy, holidays, sick days or any other benefits program established by the employer.
- 2) all annuities or benefits payable under the following laws or plans, such as:
 - the Quebec Pension Plan or the Canada Pension Plan;
 - the Occupational Health and Safety Commission;
 - the Automobile Insurance Act in the province of residence;
 - any other law providing income in case of disability.
- 3) any disability benefits payable under an insurance contract or a retirement plan.

MAXIMUM DISABILITY INCOME

For the purpose of this article, the maximum disability income is calculated by applying the percentage stipulated in the "Summary of Benefits":

- a) to the employee's gross income, if benefits payable by the insurer are taxable;
- b) the employee's net income, if benefits payable by the insurer are non taxable.

If an member refuses or neglects to submit a request for benefits with regards to such laws when eligible to such benefits, the insurer reserves the right to reduce from benefits payable an estimate of benefits that could be provided by these laws.

BENEFITS PAYMENT

Disability benefits are payable at the end of each month of disability, after the expiry of the elimination period.

For a period of disability that is less than one (1) month, the insurer pays one thirtieth (1/30th) of the monthly benefit for each day of total disability.

Benefits are payable for as long as the total disability period persists, without however, exceeding the maximal duration or the age limit as stipulated in the "Summary of Benefits".

REHABILITATION ASSISTANCE

If an member who has been totally disabled during at least the elimination period submits to a rehabilitation program approved by the insurer, he may retain the monthly disability benefits, in addition to any remuneration paid under the rehabilitation program. The rehabilitation status may be granted for a maximum period of twenty-four (24) months.

The monthly rehabilitation allowance is equal to the amount of the monthly benefits minus an amount equal to 50 % of the work income attained during the rehabilitation program.

The sum of income from the rehabilitation program and the monthly benefits may not, however, exceed one hundred per cent (100%) of the member's earned income at the beginning of disability; the benefits payable under this benefit will be reduced by any amount in excess of one hundred per cent (100%) of the member's earned income. The earned income is the employee's gross salary if the benefit is taxable or the net salary if the benefit is non-taxable.

The insurer may assist the member in any manner to encourage him to return to his regular occupation or any other remunerative occupation compatible with his state of health.

EXTENSION OF BENEFITS

Unless otherwise specifically mentioned for a particular benefit, the insurer pays the disability benefits provided in the present benefit for the entire disability period which began when the benefit was in force and for provided that disability persists, and the conditions of the contract are met. If the benefit is terminated, benefits will continue to be paid as if the benefit had remained in force, subject to the terms of the present benefit, as well as the laws in force.

DEDUCTION AT SOURCE

The insurer deducts each benefit payment the amounts imposed by the Income Tax Act.

EXCLUSIONS

No benefit is payable in the following cases:

- a) the member's participation in a criminal act or attempted criminal act;
- b) the member's active participation in a civil commotion, riot, insurrection or military operation during war, whether war is declared or not;
- c) the member's participation in an aerial flight, other than as a fare-paying passenger on a regular or chartered flight;

- d) a disability caused by a self-inflicted wound or mutilation, regardless of the member's state of mind;
- e) the fact of having suffered from body lesions while his ability to drive was impaired, because of diminished faculties due to the consumption of alcohol or drugs;
- f) the member's participation in land or water motor vehicle races, scuba diving, parachute jumping, free-fall or otherwise, bungee jumping, gliding or sail flights, or any other dangerous similar activity or sport;
- g) surgery not necessary for the member's health, for cosmetic or non-medically required care;
- h) during a period where an member stays more than fifteen (15) days outside of Canada;
- i) disability that occurs during a maternity leave provided for under provincial or federal law or an agreement with the employer;
- j) lumbago or back pain which diagnosis can only be made subjectively by the member's description of symptoms and cannot be supported by appropriate tests prescribed by a physician;
- k) period during which the member is not under the regular care of a specialist able to treat his illness, or if he does not receive proper therapy for his condition, or refuses such therapy;
- l) period during which the member is not under the care of a physician; the period of total disability may not start before the date of the first medical visit for the disability in question;
- m) disability that began before the effective date of the insurance;
- n) disability resulting from a work related accident or occupational illness unless otherwise stipulated in the "Summary of Benefits".

RESTRICTIONS

The amount of monthly benefits payable under the present benefit as well as disability benefits from all other sources cannot exceed the maximum percentage of the net income when benefits are non-taxable or the maximum gross income when benefits are taxable, as stipulated in the "Summary of Benefits".

When the member was not covered by an equivalent benefit and total disability begins within the twelve (12) month period following the effective date of the present benefit, no benefit is payable for an illness or an accident for which the member consulted a physician or other health professional, or received a medical treatment, or underwent an examination or diagnostic tests, or took medication, during the ninety (90) day period immediately preceding the effective date of the present benefit for an member.

TERMINATION OF BENEFITS

Benefits terminate on the first of the following dates:

- a) upon the member's death;
- b) the date the member ceases to be disabled;

- c) the date on which the member is unable to provide proof of his disability or refuses to provide such proof;
- d) the date on which the member refuses or neglects to submit to a medical examination as requested by the insurer;
- e) the date the member begins a remunerative occupation, unless he has the insurer's authorisation for rehabilitative employment, or the date on which he accomplishes one of the duties his regular occupation other than through a rehabilitation program;
- f) the date on which the member refuses without good reason totally or partially to participate in a rehabilitation program established and funded by the insurer to facilitate his return to the labour market and which the insurer's physicians and rehabilitation professionals deem reasonable and appropriate;
- g) the date on which the member receives a retirement income, other than the one he was receiving at the beginning of disability while he was actively at work.

TERMINATION OF INSURANCE

In addition to the reasons for the termination of the member's insurance benefit stipulated in the section entitled "General Provisions" of the present policy, the insurance for this benefit will terminate at the earliest of the following dates at midnight:

- a) the termination date or age limit stipulated in the "Summary of Benefits";
- b) the member's retirement date, if earlier.

HEALTH INSURANCE BENEFIT

This benefit includes hospitalization insurance and Medical and Paramedical Expenses Insurance.

PURPOSE

The purpose of coverage is to refund eligible expenses following hospitalization and medical and paramedical expenses incurred following an accident or illness by an insured while this benefit is in force.

ELIGIBILITY

Only persons covered by the governmental health insurance program of their province are eligible for the health insurance benefit.

HOSPITALIZATION

The purpose of hospitalization insurance is to refund an amount for each day that an insured person, due to illness or injury, spends in a hospital or a rehabilitation centre upon recommendation of a physician.

a) SHORT-TERM HOSPITALIZATION

The cost to stay in a hospital room as stipulated in the "Summary of Benefits" in a hospital for short-term care, less the fees that are refunded or refundable by a governmental insurance plan.

Eligible short-term care includes prevention, medical diagnosis and medical treatment for acute illnesses.

b) CONVALESCENCE AND PHYSICAL REHABILITATION

The cost to stay in a hospital room as stipulated in the "Summary of Benefits" in a physical rehabilitation centre or in a hospital, part of which is reserved for convalescence or physical rehabilitation care, less the fees that are refunded or refundable under a governmental insurance plan.

The insured person must be admitted within fourteen (14) days after leaving the hospital for which he was receiving short-term care or had been admitted for less than one (1) day for an operation requiring local anaesthesia. Eligible expenses are limited to a maximum period as stipulated in the "Summary of Benefits" for convalescence and physical rehabilitation combined.

DEFINITIONS OF INSTITUTIONS

a) HOSPITAL

Means a hospital center for short-term or long-term care as established by the laws in force, excluding part of such centre reserved for prolonged care.

b) REHABILITATION CENTRE FOR PHYSICAL DEFICIENCY

Means a centre offering physical rehabilitation services as established by the laws in force, excluding centres that are reserved for persons with a mental deficiency, or for youths or mothers with difficulties to adapt, or for alcoholics and drug abusers.

A hospital or rehabilitation centre for physical deficiency does not include a local centre for community services, a centre for youth and child protection, a lodging house or long-term care centre, a clinic, a hospital for the care of psychiatric illnesses or tuberculosis, a sanatorium, a home for the elderly, a rest or retirement home, a thermal station, a centre for AIDS victims or any other establishment whose main function is custodial care.

AMOUNT OF BENEFITS FOR HOSPITALIZATION

Eligible hospital or rehabilitation centre expenses are refunded at one hundred per cent (100%) without any deductible.

a) HOSPITALIZATION IN THE INSURED'S PROVINCE OF RESIDENCE

If the insured person is hospitalized in his province of residence, the insurer refunds, for each day in hospital, an amount equal to the cost of room and board charged by the hospital without, however, exceeding the cost of the type of room stipulated in the "Summary of Benefits" provided by the Quebec Hospitalization Act, including annual indexation.

The number of days in a hospital that is refundable in a period of twelve (12) consecutive months for a particular illness or accident is stipulated in the "Summary of Benefits".

b) HOSPITALIZATION OUTSIDE THE INSURED'S PROVINCE OF RESIDENCE

If the insured person is hospitalized outside his province of residence, the insurer refunds for each day in hospital, an amount equal to the cost for room and board requested by the hospital, without, however, exceeding the cost of a semi-private room, less any amount provided under the Quebec Hospitalization Act, including annual indexation.

The number of days in a hospital that is refundable in a period of twelve (12) consecutive months for a particular illness or accident, is stipulated in the "Summary of Benefits".

MEDICAL AND PARAMEDICAL EXPENSES

The purpose of medical and paramedical expenses insurance is to refund, in part, eligible expenses incurred for medical and paramedical treatments following an accidental injury, an illness or pregnancy.

For each insured person under the present benefit, the percentage of refund is applied on each amount of incurred expenses for treatment, visit or purchase of supplies as well as on each maximum amount per policy year for the medical and paramedical expenses enumerated in the article "Eligible medical and paramedical expenses" of this section.

BENEFIT AMOUNT

The benefit amount is derived by deducting the deductible from the eligible expenses and by multiplying the difference by the percentage of refund. The maximum amount of eligible benefits for medical and paramedical expenses are specified in the "Summary of Benefits".

ELIGIBLE MEDICAL AND PARAMEDICAL EXPENSES

The following expenses, excluding paramedical care, are covered on the condition that they are prescribed by a physician and are necessary for treatment of an illness or an accident and are normal and reasonable with current medical procedures. When a medical recommendation is required for paramedical care, a note is inscribed in the “Summary of Benefits”.

- a) If the “Summary of Benefits” stipulates “enlarged list”, only drugs obtained with the prescription of a physician or dentist are refundable.

If the “Summary of Benefits” stipulates “restrictive list”, only drugs that require the prescription of a physician are refundable.

If the “Summary of Benefits” stipulates “RAMQ list”, only the drugs published on the list of the Régie d’assurance maladie du Québec are refundable. Some of these drugs are however only refundable under the conditions and therapeutic indications determined by rules published by the RAMQ.

Also eligible are drugs prescribed by a physician where the therapeutic need is directly related to the following pathological conditions:

- cardiac problems;
- pulmonary problems;
- diabetes;
- arthritis;
- Parkinson's disease;
- epilepsy;
- cystic fibrosis;
- glaucoma.

In the event of a lay-off, a strike or a lock-out, the coverage for drug insurance is extended for a thirty (30) day period following the starting date of the lay-off, the strike or the lock-out. The premium corresponding to this extension period must be paid to the insurer.

An insured living in Quebec who has attained the age of sixty-five (65) may choose to be insured under the public plan provided for in the Loi de l’assurance médicaments du Québec rather than remaining insured under the present benefit. If this is the case, the insured is no longer eligible for benefits under the present contract and he may no longer be reinstated to the group insurance plan with regards to drug insurance.

- b) the purchase of one IUD per calendar year;
- c) the purchase of reactive sticks, syringes and needles for diabetics;
- d) the purchase of miscellaneous items necessary following colostomy, ileostomy or ureterostomy;
- e) in emergency situations, the cost of transportation to a hospital in a duly authorised ambulance, as well as transportation by railway or by air to the nearest hospital, if the insured person cannot be transported in any other manner;

- f) care by a licensed nurse at the insured person's home, upon presentation of a medical report, eligible up to a maximum amount and the period indicated in the "Summary of Benefits";
- g) the purchase of made-to-measure orthopaedic shoes, sold by a specialised orthopaedic laboratory. In any calendar year, these purchases are limited to the number of pairs and eligible maximum amount indicated in the "Summary of Benefits", as well as for a child less than or over sixteen (16) years of age, subject to the overall eligible maximum indicated in the "Summary of Benefits". These articles may also be prescribed by a podiatrist;
- h) the purchase of corrective items added to ordinary shoes, orthoses or plantar supports, eligible up to a maximum eligible amount and period indicated in the "Summary of Benefits". These items must be sold by a specialised orthopaedic laboratory and may also be prescribed by a podiatrist;
- i) the purchase of elastic stockings sold by a specialty house, up to the number and period indicated in the "Summary of Benefits";
- j) the purchase or repair of a hearing aid, up to the maximum eligible amount and period indicated in the "Summary of Benefits";
- k) the purchase of external mammary prosthesis necessary following mastectomy, in excess of the amount covered by a governmental plan, up to the maximum amount and period indicated in the "Summary of Benefits";
- l) the purchase of an initial capillary prosthesis necessary following chemotherapy, eligible up to the maximum amount and period indicated in the "Summary of Benefits";
- m) rental or purchase, whichever is deemed more economical by the insurer of a basic manual wheelchair, a manual hospital bed and crutches, when required for temporary therapeutic use. The insured must obtain the insurer's authorisation to purchase or rent any equipment. Failure to obtain authorisation from the insurer may result in the refusal of the claim;
- n) the initial purchase (not the replacement) or rental, not exceeding the initial cost of prosthesis (other than dental), as defined by the Régie de l'assurance maladie du Québec, eligible up to the maximum amount and period indicated in the "Summary of Benefits";
- o) blood transfusions or its derivatives, dressings;
- p) anaesthetic products;
- q) expenses for eye examination performed by an ophthalmologist or by a licensed optometrist for insured persons between the ages of eighteen (18) and sixty-four (64), eligible up to a maximum amount and period indicated in the "Summary of Benefits";
- r) when deemed necessary for prevention or diagnosis, the following expenses are refundable:
 - laboratory analysis, subjected to a maximum eligible amount of \$150 per calendar year;

- x-ray tests such as computer tomographies (scanners), ultrasounds, electrocardiograms, mammograms, x-rays (except for teeth and orthosis), subjected to a maximum eligible amount of \$300 per calendar year;
 - nuclear magnetic resonance imaging, subject to a maximum eligible amount of \$500 per calendar year;
- s)** the purchase or repair of an appliance to measure the rate of glucose in the blood of an insulin-dependent diabetic is payable upon presentation of a physician's complete report attesting to the insured's insulin dependency, eligible up to the maximum amount and period indicated in the "Summary of Benefits";
- t)** paramedical treatments; the fees for paramedical services given by:
- chiropractor;
 - psychologist, psychoanalyst, psychiatrist, social worker;
 - physiotherapist, ergotherapist, orthotherapist;
 - audiologist, orthophonist, osteopath, podiatrist, naturopath;
 - acupuncturist;
 - dietician;
 - massotherapist.

The maximum amount and number of visits per calendar year for each above-mentioned specialist or each grouping of specialists are indicated in the "Summary of Benefits";

In addition, eligible expenses per insured person are limited to one (1) visit per day per specialist. Specialists must be members of their professional association and provide services that fall within their specialty;

- u)** x-rays taken by a chiropractor for an insured person are limited per calendar year to the maximum amount indicated in the "Summary of Benefits";
- v)** nursing care services rendered at the insured's home required after a hospitalization or surgical intervention requiring local anaesthesia performed at the hospital. Expenses are refunded up to the eligible maximum amount and period indicated in the "Summary of Benefits". The nurse must be a member of the l'Ordre des infirmiers du Québec (OIIQ) or infirmier en pratique privée du Québec (IIPPQ);
- w)** the purchase or hernial bandages, corsets or orthopaedic bandages, splints, casts;
- x)** rental or purchase, whichever is deemed more economical by the insurer, of a breathing assistance apparatus and oxygen. The insured must obtain authorisation from the insurer before making any purchase or rental. Failure to obtain this authorisation may result in the insurer's refusal of the claim. The maximum eligible amount and period are indicated in the "Summary of Benefits";
- y)** rental or purchase, whichever is deemed more economical by the insurer, of a transcutaneous electric neurostimulator apparatus (tens). The insured must obtain authorisation from the insurer before making any purchase or

rental. Failure to obtain this authorisation may result in the insurer's refusal of the claim. The maximum eligible amount and period are indicated in the "Summary of Benefits";

- z)** fees for the substance used in medically required sclerosant injections administered by a physician. The maximum amount and period are indicated in the "Summary of Benefits".

DENTAL CARE AS A RESULT OF AN ACCIDENT

Expenses for dental care provided by a dental surgeon, outside a hospital when necessary following an accidental injury to natural, healthy and whole teeth, that occur while the person is insured and providing that treatment is given within twelve (12) months of the accident. Fees must be incurred in the province of residence and are eligible up to the maximum amount indicated in the "Summary of Benefits".

PROOF OF CLAIM

Eligible expenses are refundable upon presentation of original receipts.

To establish proof of claim, the insured must submit to the insurer original receipts from the suppliers providing treatments or products.

The insured must submit to a medical examination when the insurer is justified in requesting it considering the type of treatments that are required by the insured person's state of health. In the event of a medical examination, the physician is designated and paid by the insurer.

The insurer may also request, at the insured's expense, a report from the health professional that is treating the insured person. The insurer may request declarations from the person claiming benefits, as well as the use of the insurer's forms.

EXTENSION

Upon the member's death, the health insurance for insured dependants under the present benefit is extended without payment of premiums, up to the earliest of the following dates:

- a)** twenty-four (24) months after the member's death;
- b)** the date a dependant no longer meets the requirements mentioned in the definition of a dependant;
- c)** the termination date of the present benefit.

TREATMENTS OUTSIDE OF THE INSURED'S PROVINCE OF RESIDENCE

a) REQUIRED CONDITIONS

To be eligible, expenses for care outside the province of residence must meet the following conditions:

- 1)** In case of a medical consultation or hospitalization following an accident or sudden illness, the insured must communicate with the

medical assistance service, failure to do so may result in the refusal of the claim;

- 2) treatments are necessary following an emergency situation resulting from an accident or sudden illness occurring outside the insured's province of residence and the situation was not reasonably foreseeable at departure;
- 3) on the day of departure, the insured person must be less than seventy (70) years of age, nor be retired, nor be more than seven (7) months pregnant;
- 4) at departure, the anticipated stay outside of the insured's province of residence is less than ninety (90) days, and the insured must be covered by the government health plan of his province of residence. However, the stay may be prolonged provided that the reason is due to an illness or of an accident that occurred within the ninety (90) day period and due to justifiable medical reasons the return to his province of residence is impossible;
- 5) the expenses that are incurred due to a sudden illness or accident must occur within ninety (90) days following the departure date;
- 6) expenses are no longer admissible as of the date the patient is able to return to his province of residence by his own means or can be repatriated under medical supervision;
- 7) for an insured aged sixty-five (65) or over, treatments must not be related to a medical condition for which the insured person was hospitalized, has received or was prescribed a medical treatment or has consulted a physician in the ninety (90) days preceding the date of departure, unless proof satisfactory to the insurer is given that the condition affecting the insured person is stable. A change in medication, its posology or use is considered to be a medical treatment.

b) BENEFIT AMOUNT

Notwithstanding the percentage of refund of eligible expenses indicated in the "Summary of Benefits", eligible expenses outside the insured's province of residence for hospitalization, medical and surgical care including drugs that require a prescription from a physician, are refundable at one hundred per cent (100%).

c) THE MAXIMUM PAYABLE

The maximum amount of eligible expenses refunded by the insurer for outside the insured's province of residence is limited to one million dollars (\$1,000,000) during the insured's lifetime.

REDUCTION OF BENEFITS DUE TO COORDINATION OF BENEFITS

In an insured covered under another insurance contract for part or all of the expenses foreseen in the present contract, the benefits payable by the insurer will be adjusted so that the total amount of benefits under all contracts does not exceed one hundred per cent (100%) of eligible expenses under the present benefit.

In addition, the priority of payment of benefits will be determined in the following manner:

- a) if another contract does not contain the coordination of benefits clause, the benefits of this other contract are to be paid before benefits of the present contract;
- b) if another contract has the coordination of benefits clause, priority of payment will be given to the contract under which the person who is entitled to benefits:
 - 1) is not a dependant, or;
 - 2) is an member's dependant whose day and month of birth is first to occur in the calendar year.

If it is impossible to determine the priority of payment under the manner stipulated above, benefits under all contracts will be subjected to a proportional calculation based on the amounts that would have been paid under each contract, as if only one contract had existed.

EXCLUSIONS

No benefit is payable for losses resulting from the following causes or incidents:

- a) the insured person's participation in a criminal act or attempted criminal act;
- b) injury or illness resulting from the insured person's active participation in a civil commotion, riot, insurrection or military operation during war, whether war is declared or not;
- c) the insured person's participation in an aerial flight, other than as a fare-paying passenger on a regular or chartered flight;
- d) suicide or any self-inflicted wound or mutilation, regardless of the insured person's state of mind;
- e) the fact of having suffered from body lesions while driving a vehicle with diminished faculties due to the consumption of alcohol or drugs;
- f) the insured person's participation in land or water motor vehicle races, scuba diving, parachute jumping, free-fall or otherwise, bungee jumping, gliding or sail flights, or any other dangerous similar activity or sport;
- g) incurred expenses for surgery or an elective or non-urgent treatment, or when a trip outside the province of residence was undertaken with the intention of receiving a medical treatment or hospital services, regardless of whether the trip was recommended by a physician or not;
- h) incurred expenses for treatment not medically required, or for cosmetic purposes or treatments that exceeds usual care normally applied for therapeutic purposes;
- i) all expenses that are payable or refundable under any governmental insurance plan or normally would be, or private plan;

- j) all expenses in excess of those considered reasonable, taking into consideration the importance of the situation, the normal rates in the region and the procedure that is normally used;
 - k) all treatments or services that are provided free of charge or that would be free in the absence of insurance or that are not at the insured's expense;
 - l) expenses incurred for a health trip, a rest cure, diet purposes or weight-loss treatments;
 - m) treatments or services given by a member of the insured person's immediate family;
 - n) medical expenses resulting from illness or injury caused by employment or occupation for pay or profit, unless the member benefits from professional risk insurance coverage with regards to the present benefit;
 - o) expenses for varicose vein injections in the lower limbs, regardless of whether they are for medical purposes or not;
 - p) any drug that is available to the general public without a medical prescription.
- N.B.** Exclusions a) and b) do not apply to refundable drugs published on the list of the Régie d'assurance-maladie du Québec (RAMQ).

The following are not considered as drugs for the purpose of this benefit and are therefore not refundable:

- aa) milk, regardless of its nature, or milk substitutes;
- bb) proteins, dietary supplements, food, homeopathic or so called natural products;
- cc) products for aesthetic or cosmetic care;
- dd) products, hormones and injections for cellulites or obesity treatment, including anorexiant;
- ee) products or medication used for eliminating the use of tobacco;
- ff) mineral waters;
- gg) disinfectants, lubricating eye drops and solutions for contact lenses;
- hh) soaps, oils, shampoos and other hair products, emollients, creams and cough drops;
- ii) vitamins;
- j) drugs administered for preventive measures. Under this exclusion, a drug used to stabilise or regulate a pathological state diagnosed by a physician is not considered as a preventive drug;
- kk) drugs or substances used in the treatment of infertility or impotence;
- ll) all substances used for insemination or contraceptive gels or foams;
- mm) anabolic steroids, growth hormones or experimentally administered drugs;

- nn)** all expenses arising from an illness or accident falling under the authority of the CSST or the Société de l'assurance automobile du Québec (SAAQ);
- oo)** drugs provided during hospitalization.

The insurer reserves the right to exclude or modify the premium on the date Health Canada approves any new drug having a significant effect on the cost of the benefit.

N.B. Notwithstanding the preceding, all medical expenses payable by the RAMQ list are also payable under this policy. Some of these expenses are however only covered under the therapeutic cases, conditions and indications determined by the rules published by the RAMQ.

TERMINATION OF INSURANCE

In addition to the reasons for the termination of the insured's insurance stipulated in the section entitled "General provisions" of the present policy, the insured's insurance for this benefit will terminate on the earliest of the following dates at midnight:

- a)** the termination date or age limit stipulated in the "Summary of Benefits";
- b)** the retirement date, if earlier;
- c)** for a dependant, on the date he no longer meets the definition of a dependant.

TRAVEL ASSISTANCE SERVICE AND TRIP CANCELLATION

TRAVEL ASSISTANCE SERVICE

PURPOSE

The purpose of this service is to offer an insured travel assistance service during a trip outside the province of residence and to refund the eligible expenses.

Hospital, medical or paramedical and drug expenses incurred outside the insured's province of residence are refundable under the terms of the health insurance benefit and not under the present service.

The insurer, in collaboration with the medical assistance service and its coordination centres, offers the services described hereafter which are complementary to those offered under the health insurance benefit providing that these charges are not excluded under the article entitled "Exclusions" of the health insurance benefit.

ELIGIBILITY

An insured covered under the health insurance benefit of the present policy is automatically eligible for Travel Assistance Service, provided that he is under seventy (70) years of age.

THE SERVICE

a) TELEPHONE SERVICE

Telephone access, toll free, to coordination centres, twenty-four (24) hours per day and seven (7) days per week, for the following multilingual assistance services, following an emergency while the insured person is travelling outside the province of residence.

b) MEDICAL ASSISTANCE

Following an accident or sudden illness, if the insured person must consult a physician or be hospitalized, he must immediately call the medical assistance service, which will make the necessary arrangements in order to provide the following services:

- for the state of Florida, direct the insured to an appropriate clinic or hospital, member of the Preferred Patient Care network;
- for all other destinations, direct the insured to an appropriate clinic or hospital and advance funds to the hospital, if necessary;
- confirm the medical insurance coverage so that the insured does not have to pay a substantial deposit;
- follow up on the medical file and communicate with the family physician;
- coordinate the insured's claim with the governmental health insurance plan of his province of residence and, if applicable, the automobile insurance plan of his province of residence.

c) MEDICAL TRANSFER

Following the recommendation and at the sole discretion of the physician designated by the medical assistance service, in consultation with a local attending physician signalling the necessity of transferring the insured to another hospital or treatment centre, or to repatriate the insured to his province of residence to receive treatment, the medical assistance service will make the necessary arrangements, and pay the cost, to transfer the insured, under proper medical supervision. Any repatriation refusal cancels all rights to benefits and a termination notice to the insured will be sufficient.

The decision as to the necessity of transferring or repatriating an insured is the exclusive medical decision of the designated physician appointed by the medical assistance service.

The decisions related to the means or dates of transfer of medical appliances, of medical supplies, of medical staff to be used for the transfer and the final destination of the insured, are also considered medical decisions exclusive to the physician appointed by the medical assistance service.

RESTRICTIONS

The insurer and the medical assistance service are not responsible for the availability or the quality of medical and hospital care administered, or the impossibility of obtaining such care.

ELIGIBLE EXPENSES

a) IN THE EVENT OF DEATH

In the event of death of an insured, the medical assistance service will be responsible for all the necessary formalities and will arrange for the transportation of the deceased to his province of residence. The refundable amount is limited to three thousand dollars (\$3,000), excluding the cost of embalming, coffin and funeral.

The cost of cremation or burial at the place of death is limited to one thousand five hundred dollars (\$1,500).

b) RETURN OF DEPENDANT CHILDREN

If an insured is hospitalized or dies leaving his dependant children who accompanied him without supervision, the necessary arrangements will be taken to organise supervision and settle their transport in economy class, accompanied when required, to their residence in Canada. If the children's travel tickets have not expired, only the additional cost of the return trip ticket will be refunded. If, on the other hand, the travel tickets have expired, necessary arrangements will be taken for the return trip by the most economical means. This cost is limited to two thousand dollars (\$2,000) for all children.

c) RETURN OF A TRAVELLING COMPANION

If an insured dies, or is hospitalized for one day or more, resulting in his travelling companion having to change his return flight, the necessary arrangements will be taken to organise and settle his transport in economy class for his return to his original destination in the insured's province of residence. If the travelling companion's travel ticket is not expired, only the additional cost of the return trip ticket will be refunded. If, on the other hand, the travel ticket is expired, necessary arrangements will be taken for the return trip by the most economical means. This cost is limited to one thousand five hundred dollars (\$1,500).

d) VISIT BY A FAMILY MEMBER

If an insured who travels alone dies, or is hospitalized for seven (7) or more consecutive days, the medical assistance service will make the necessary travel arrangements according to the most economical return trip, to have a family member visit the insured at the hospital where he is staying or to identify the deceased prior to transport. These costs are limited to one thousand five hundred dollars (\$1,500), and to one visitor only.

e) RETURN OF A VEHICLE

If an insured travelling with his personal vehicle is unable to use his vehicle due to sickness or accident, the medical assistance service will organise and settle the return of the vehicle to the insured's residence. These costs are limited to seven hundred and fifty dollars (\$750).

f) SUBSISTENCE ALLOWANCE

If, following the insured's hospitalization for a period of more than twenty-four (24) hours, or following his death, costs for room and meals are incurred by the insured person or his travelling companions, because of a change in departure, or due to a visiting family member, these costs are reimbursed up to one hundred and fifty (\$150) per day and a total maximum of one thousand two hundred (\$1,200) for all persons covered.

g) LEGAL ASSISTANCE OR BAIL

When necessary, the medical assistance service will intervene to facilitate the organisation and depositing of funds for bail raised amongst family members or friends of the insured. The medical assistance service will assist any insured person with legal counsel when involved in a highway accident or guilty of offences to the highway code or any other legal infractions excluding criminal acts. However, the insured is responsible for choosing his lawyer, and the legal fees.

Health professionals or legal advisors recommended or designated by the medical assistance service are neither their employees nor their agents. Consequently, neither the medical assistance service nor the insurer may be held responsible for any negligence or omissions committed by these professionals or advisors.

BENEFIT REDUCTION DUE TO COORDINATION OF BENEFITS

If an insured is entitled to similar benefits under any other insurance contract, the benefits payable will be limited to the insurer's proportional share of the total eligible incurred expenses.

INSURED'S OBLIGATION

If, following an accident or sudden illness, the insured must contact the medical assistance service or one of its coordination centres as soon as possible. Failure to do so may result in claims being denied.

RESTRICTIONS

- a) The medical assistance service reserves the right to interrupt, shorten or restrict travel assistance services in any part of the world, in the event of rebellion, riot, military insurrection, war, work conflict or strike, nuclear accident, natural disaster, or in the event when the country's authorities forbid the medical assistance service to offer services. However, the medical assistance service will do everything that is possible to provide services under such circumstances.
- b) In the absence of medical contraindication, the insurer may require repatriation of any insured person or his transfer to other medical facilities. Refusal of repatriation by the insured person ends the insurance and notice or termination to the insured will be sufficient.
- c) No fees will be paid nor any assistance provided to an insured by the insurer or the medical assistance service when expenses are incurred as the result of a trip in his province of residence.

PROOF OF CLAIM

Eligible expenses are refundable upon presentation of original receipts.

To establish proof of claim, the insured must submit to the insurer original notes or bills from the suppliers of care or products.

In the event where the medical assistance service settles different accounts, they will submit to the insurer medical bills paid for the insured.

The insured must submit to a medical examination by a physician of the insurer's choice and at the insurer's expense, when the request is justified with regards to the nature of treatments required for the insured's state of health.

The insurer may also request, at the insured's expense, a report from the health professional treating the insured person. The insurer may require declarations from the insured presenting a claim and require the use of company forms.

TRIP CANCELLATION

TRIP CANCELLATION INSURANCE BENEFIT

a) REQUIRED CONDITIONS

To be eligible, the fees for the trip cancellation must meet the following conditions:

- 1) They are paid in advance by the insured while this benefit is in force;
- 2) At the time to finalise the arrangements for travel, the insured is not aware of the event that could reasonably lead to the cancellation or interruption of the planned trip;
- 3) The present benefit is in force at the time of the planned trip period;

b) BENEFIT AMOUNT

The insurer reimburses one hundred percent (100%) of the eligible fees up to five thousand dollars (\$5,000) per insured per trip.

c) SPECIFIC DEFINITIONS TO THE TRIP CANCELLATION INSURANCE

In the present policy, unless one of the benefits, a change, an amendment or the Summary of Benefits stipulates otherwise, we hereby define:

1) ACTIVITY OF A COMMERCIAL NATURE

Meeting, congress, convention, exhibition, show or seminar, of a professional or commercial nature, such activity must be public, under the responsibility of an official organisation and in compliance with the laws, regulations and policies in effect in the region in which the activity is scheduled to be held, and which is the only reason for the planned trip.

2) BUSINESS ASSOCIATE

The person with whom the insured is associated within a company of 4 co-shareholders or less, or for profit-sharing society of 4 associates or less.

3) TRAVELING COMPANION

The person with whom the insured shares the room or apartment at the destination or whose expenses were paid with those of the insured.

4) TRAVEL EXPENSES PAID IN ADVANCE

Amount paid by the insured for the purchase of a package deal, a ticket from a public carrier or for the rental of a motorised vehicle from an accredited agency. The following amounts are also eligible:

- Amount paid relating to reservations for trip arrangements usually included in a package deal;
- Amount paid relating to registration fees for an activity of a commercial nature.

5) HOST AT DESTINATION

The person whose main residence must serve as the place of accommodations for the insured in accordance with a prior agreement.

d) ELIGIBLE CAUSES OF CANCELLATION OR INTERRUPTION

The trip must be cancelled or interrupted for one of the following causes:

- 1) An illness or accident preventing the insured or close family member, his traveling companion or his business associate from performing his usual activities and which is reasonably serious to justify the cancellation or interruption of the trip;
- 2) The death of the insured, of a close family member, of his traveling companion or of his business associate. The funeral must take place during the planned period of the trip or within the 14 days preceding it;
- 3) The death or emergency hospitalisation of the host at destination;
- 4) The notification of the insured or of his traveling companion to report for jury duty or their subpoena to appear as a witness in a trial to be heard during the period of the trip. The person convened must undertake the necessary steps to obtain a postponement the case to be heard. A summons to appear is not considered eligible for cancellation of the trip when the person concerned is the party prosecuted or intent to take proceedings;
- 5) The hijacking of the airplane in which the insured is traveling;
- 6) The putting of the insured into quarantine, except if such quarantine ends more than 7 days prior to the planned date of departure;
- 7) A loss making uninhabitable the main residence of the insured or the host at destination, providing that the residence must be uninhabitable 7 days or less prior to the planned date of departure or that the loss occurs during the trip;
- 8) The transferring of the insured for the same employer, 175 or more kilometres from his present domicile, within 30 days preceding the planned departure date;
- 9) A situation in the country where the insured is traveling that prompts the Canadian government to issue a recommendation not to travel to that country. This recommendation shall be in force for the period of travel and have been issued after the insured has finalised arrangements for the trip;
- 10) A loss occurring at the place of business or on the physical premises where an activity of a commercial nature is scheduled to be held and thereby making impossible the holding of the activity such that a written notice cancelling the activity is issued by the official organisation in charge of organising it;
- 11) The cancellation of a business meeting or an activity of a commercial nature following the death or hospitalisation of the person with whom

- the insured took prior arrangements for the meeting or the activity of a commercial nature. A written proof of those arrangements is necessary;
- 12) A departure missed due to a delay in the means of transportation used to get to the departure point or the departure point for a connection after the scheduled departure. The means of transportation used should include an arrival at least 3 hours before the departure. The cause for the delay must be mechanical difficulties (except for a private automobile), by a traffic accident or by the emergency closing of a road. Each of the last two causes must be backed up by a police report;
 - 13) The atmospheric conditions delaying the departure of the public carrier used by the insured, at the scheduled point of departure, at least 30% (48 hours minimum) of the planned duration of the trip or preventing the insured from making a planned connection with another carrier insofar as this latter carrier be delayed for at least 30% (48 hours minimum) of the planned duration of the trip.

e) ELIGIBLE EXPENSES

1) IN THE EVENT OF CANCELLATION PRIOR TO DEPARTURE

- a) The non-refundable portion of the planned trip expenses paid in advance;
- b) The additional expenses incurred by the insured who decides to travel alone in the event where his traveling companion must cancel his trip for one of the reasons provided by this benefit. The fees are refundable up to the amount of the penalty for cancellation applicable to the insured at the time when his traveling companion must make the cancellation;
- c) The non-refundable portion of the travel fees paid in advance, up to 70% of the said fees, if the departure of the insured is delayed due to atmospheric conditions and that he decides not to make the trip.

2) IN THE EVENT OF A MISSED DEPARTURE OR TRIP INTERRUPTION

The additional cost the most economical required by a public carrier (train, bus or air line) for a single ticket, with the fixed schedule, by most direct route, up to the planned destination.

The insured's departure must be missed due to a delay in the means of transportation as described in section 9.17 d) 13-.

The trip must be temporarily interrupted due to an illness or an accident sustained by the insured or his traveling companion, as described in section 9.17 d) 1-.

3) IF THE EVENT OF AN ADVANCED OR DELAYED RETURN

- a)** The additional cost the most economical required by a public carrier (train, bus or air line) for a single ticket, with the fixed schedule, by most direct route, up to the destination initially planned. These expenses must be agreed to in advance with the insurer;
- b)** The unused and non-refundable portion of the land part of travel fees paid in advance.

If the insured's return is delayed for more than 7 days following an illness or accident sustained by the insured or his traveling companion, incurred expenses are covered insofar as the person involved has been admitted to a hospital centre as an in-patient for more than 48 hours within the said 7 day period.

f) REDUCTION OF BENEFITS DUE TO COORDINATION OF BENEFITS

If an insured covered under another insurance contract for part or all of the expenses foreseen in the present contract, the benefits payable by the insurer will be adjusted so that the total amount of benefits under all contracts does not exceed one hundred percent (100%) of eligible expenses under the present benefit.

In addition, the priority of payment of benefits will be determined in the following manner:

- a)** if another contract does not contain the coordination of benefits clause, the benefits of this other contract are to be paid before benefits of the present contract;
- b)** If another contract has the coordination of benefits clause, priority of payment will be given to the contract under which the person who is entitled to benefits:
 - 1)** is not a dependant, or;
 - 2)** is a member's dependant whose day and month of birth is first to occur in the calendar.

If it is impossible to determine the priority of payment under the manner stipulated above, benefits under all contracts will be subject to a proportional calculation based on the amounts that would have been paid under each contract, as if only one contract had existed.

g) DEADLINE FOR REQUESTING CANCELLATION

In the event of cancellation prior to the departure, the trip must be cancelled with the travel agency or the carrier within a maximum delay of 48 hours, or if it is a holiday, the next business day. The insurer must be notified at the same time.

The insurer's liability is limited to the cancellation fees stipulated in the travel contract 48 hours after the date of the cause of cancellation, or on the first business day if it is a holiday.

However, this limitation does not apply if the insured and his spouse show, to the satisfaction of the insurer that they were in the total and absolute inability to act. In that case, the trip must be cancelled as soon as one of them is able to do so. The insurer's liability is then limited to the cancellation fees stipulated in the travel contract on that date.

h) SPECIFIC EXCLUSIONS APPLYING TO THE TRAVEL CANCELLATION INSURANCE BENEFIT

No benefit is payable for losses resulting from the following causes or incidents:

- 1) the insured or traveling companion's participation in a criminal act or attempted criminal act;
- 2) injury or illness resulting from the active participation of the insured or his traveling companion to a public confrontation, in a riot, insurrection or military operation, whether war is declared or not;
- 3) suicide or any injury or damage that the insured has inflicted, whether sane or insane;
- 4) the fact of having suffered from body lesions while driving a vehicle with diminished faculties due to the consumption of alcohol or drugs;
- 5) the insured's participation in a sport for consideration, in land or water motor vehicle races, scuba diving, parachute jumping, free-fall or otherwise, bungee jumping, gliding or sail flights, or any other dangerous similar sport or activity, ;
- 6) the trip is undertaken with the intention of receiving medical treatment or hospitalisation services, whether the trip has been recommended or not by a physician;
- 7) the trip has been undertaken for purposes of visiting a person who is ill or has had an accident and the cancellation or interruption of the trip results from the death or deterioration of the medical condition of such person;
- 8) all the fees that are payable or refundable under any governmental insurance plan or normally would be, or private plan;
- 9) all treatments or services that are provided free of charge or that would be free in the absence of insurance or that are not at the insured's expense;
- 10) at the time of finalising the trip arrangements, the insured is aware of an event that could reasonably cause the trip's cancellation or interruption;
- 11) declared or undeclared war or act of war, in Canada or in a foreign country, if the Canadian government recommends not staying in the country. This exclusion does not apply to the insured present in a foreign country at the time where war or an act of war is declared and that the Canadian government then recommends leaving the country.

The insured must however make the necessary arrangements in order to leave the country in the best delay;

- 12) the insured's abusive absorption of medication, drugs or alcohol;
- 13) pregnancy, miscarriage, childbirth or related complications when these expenses are incurred within twelve weeks of the expected date of birth.

i) PROOF OF CLAIM

The insured must submit to the insurer the required proof in the 90 days following the event. It is the insured's responsibility to assume all expenses incurred for proof satisfactory to the insurer. The following required documents are then necessary:

- 1) The unused transportation tickets;
- 2) The official receipts for the cost of additional transportations;
- 3) The receipts for the travel arrangements. The receipts must include the contracts that were officially issued through the travel agency or an accredited company, and must indicate the amounts not refunded in the event of cancellation. A written proof of the benefits request or cancellation and the travel agency or carrier's response must be submitted to the insurer;
- 4) The official documents stating the cause of cancellation. If the cancellation is due to medical reasons, the insured must provide a medical certificate from the attending physician practicing in the region where the accident or illness occurred. The medical certificate must indicate the complete diagnosis and specify the exact reasons why the trip had to be cancelled, delayed or interrupted;
- 5) A police report when the means of transportation used by the insured is delayed due to a traffic accident or the emergency closing of a road;
- 6) the official report issued by the concerned authority relating to the weather conditions;
- 7) The written notice attesting the cancellation of an activity of a commercial nature or a business reunion issued by the official organization indicating the precise reasons that justify the event's cancellation.;
- 8) The insurer can require statements from the insured, or any other report allowing the benefits request justification.

LEGAL ADVISOR

THE SERVICE

A service providing the member or his/her dependants with legal information with a simple phone call.

UV Insurance covers the telephone consultation fees given for the service of “Legal Advisor” on the aspects of law concerning:

Family and People’s Rights
(e.g.: divorce motives)

Consumer Rights
(e.g.: debts and loans)

Residential Lease
(e.g.: renewal)

Wills and Estate
(e.g.: settling of an estate)

Real Estate Rights
(e.g.: worker’s compensation board appeals)

Real Estate Rights
(e.g.: appeal for hidden defects, flaws)

Business law
(e.g.: patent, copyright and trademark)

Youth Protection
(e.g.: abused children)

The service is offered from 9:00 am to 8:00 pm Monday to Friday and 9:00 am to 5:00 pm Saturday, except on public holidays, using the following telephone numbers:

(514) 871-3263 1-800-550-3263

This service is available on an information basis only. It is not to be construed as a replacement of the usual legal advisor.

OPTIONAL LIFE INSURANCE BENEFIT FOR THE INSURED INCLUDING ACCIDENTAL DEATH OR DISMEMBERMENT BENEFIT

PURPOSE

The purpose of this benefit is to pay a death benefit upon death of an insured, when death occurs when the present life insurance benefit is in force.

SPECIFIC DEFINITIONS TO THE OPTIONAL LIFE INSURANCE BENEFIT FOR THE INSURED INCLUDING ACCIDENTAL DEATH OR DISMEMBERMENT BENEFIT

In the present policy, unless one of the benefits, a change, an amendment or the Summary of Benefits stipulates otherwise, we hereby define:

INSURED

A member or his spouse.

ELIGIBILITY

An insured is eligible for insurance under the present benefit, provided that he is under sixty-five (65) years of age and if he is already covered under the basic life insurance benefit.

To be insured, an eligible employee or his spouse must first submit a written request on the forms provided by the insurer.

AMOUNT OF INSURANCE

The amount of insurance for the present benefit is indicated hereinafter and, if applicable, according to the option selected by the member on the optional life insurance form:

MEMBER

- According to the number of \$1 000 units chosen by the member;
- Minimum amount: \$10 000;
- Maximum amount: \$1 000 000 including the life insurance benefit basic amount.

SPOUSE

- According to the number of \$1 000 units chosen by the member;
- Minimum amount: \$5 000;
- Maximum amount: \$100 000 including the life insurance benefit basic amount.

EVIDENCE OF INSURABILITY

All optional life insurance amounts become effective once the insurer has approved the evidence of insurability provided by the member or his spouse.

MAXIMUM AGE

The insurance for the present benefit cannot extend beyond the insured's sixty-fifth (65th) birthday.

SUICIDE

Should death occur within the twenty-four (24) month period following the beginning or the increase of the optional life insurance, and if death is by means of suicide, whether the insured is sane or not, the amount of optional life insurance or the increased amount is not payable, and the insurer's only responsibility is to refund the premiums.

FALSE DECLARATION

If the insurer issues an optional life insurance certificate with non-smoker rates, following the insured's declaration that he has not smoked during the preceding twelve (12) month period, and it is later proven that this declaration is false, the optional life insurance certificate becomes null and void, and the insurer's responsibility is limited to the refund of paid premiums, should death occur.

AGE ERROR

If the insured's declared age is found to be incorrect after the insured's death, the amount of insurance is adjusted in proportion to the premium received to the one that corresponds to the insured's true age, without, however, exceeding the amount of insurance that the insured would have been entitled to for his true age.

PREMIUM

The monthly insurance premium for the present benefit is established according to the gender, age group, and smoker or non-smoker status and is applicable to each thousand dollars (\$1,000) of insurance. The insured's age is the one attained on his birthday which is the closest to the date of the last contract renewal.

DEFINITION OF NON-SMOKER

A non-smoker is a person who has not used tobacco or other products containing nicotine during the twelve (12) months preceding the signature of the application for insurance or the review of his status, and in addition, this person has not consumed any illegal drugs during this same period. The insurer reserves the right to require a signed declaration with regards to his non-smoker status at each renewal.

ACCIDENTAL DEATH OR DISMEMBERMENT BENEFIT INCLUDED WITH THE OPTIONAL LIFE INSURANCE BENEFIT FOR THE INSURED

The benefit amount of the accidental death or dismemberment is the same amount as the optional life insurance benefit for the insured. Conditions and restrictions applicable to the present benefit are those indicated in the Section entitled "Accidental death or dismemberment benefit included with optional life insurance benefit for the insured" of the present contract.

MONTHLY COST PER \$1 000 UNITS :

Attained age	Male		Female	
	Non-smoker	Smoker	Non-smoker	Smoker
Less than 30	\$0,147	\$0,177	\$0,090	\$0,104
30 to 34	\$0,160	\$0,213	\$0,102	\$0,132
35 to 39	\$0,162	\$0,238	\$0,118	\$0,176
40 to 44	\$0,182	\$0,309	\$0,146	\$0,255
45 to 49	\$0,237	\$0,471	\$0,176	\$0,347
50 to 54	\$0,343	\$0,793	\$0,235	\$0,502
55 to 59	\$0,526	\$1,331	\$0,344	\$0,746
60 to 64	\$0,856	\$2,179	\$0,547	\$1,127

ACCIDENTAL DEATH OR DISMEMBERMENT BENEFIT INCLUDED WITH OPTIONAL LIFE INSURANCE BENEFIT FOR THE INSURED

PURPOSE

The purpose of coverage is to pay the insured an indemnity when he incurs a loss as described in the article Eligible losses of the present benefit, and this loss is by accidental means and occurs while the optional life insurance benefit for the insured is in force.

SPECIFIC DEFINITIONS TO THE ACCIDENTAL DEATH OR DISMEMBERMENT BENEFIT INCLUDED WITH OPTIONAL LIFE INSURANCE BENEFIT FOR THE INSURED

In the present policy, unless one of the benefits, a change, an amendment or the Summary of Benefits stipulates otherwise, we hereby define:

INSURED

A member or his spouse.

AMOUNT OF INDEMNITY

The amount of indemnity is equal to the product (a x b):

- a) the amount of insurance in force for the optional life insurance benefit for the insured including accidental death or dismemberment benefit;
- b) the relative value of the loss according to the table of losses, hereinafter.

ELIGIBLE LOSSES

Eligible losses are the ones listed in the table below; they must be the result of an accident and the loss must occur within three hundred and sixty-five (365) days of the accident.

TABLE OF LOSSES AND PERCENTAGE OF INDEMNITY	
LOSSES	PERCENTAGES
Quadriplegia, hemiplegia or paraplegia	200%
Life	100%
Two hands or two feet	100%
One eye and one hand or one foot	100%
Two eyes	100%
One hand and one foot	100%
Speech and hearing in both ears	100%
One arm or one leg	75%
One hand or one foot or one eye	66,67%
Speech	66,67%
Hearing in both ears	66,67%
Four fingers of the same hand	33,33%
The thumb and index of the same hand	33,33%
All the toes of the same foot	33,33%
Hearing in one ear	12,50%

Loss of an eye means total and permanent loss of sight of the eye.

Loss of speech must be total and permanent.

Loss of one hand or one foot means the amputation at the wrist or ankle joint or above, or the loss of its use.

Loss of one arm or one leg means the amputation at the elbow joint or knee joint or above, or the loss of its use.

Loss of hearing means total and permanent loss of hearing.

Loss of one finger means amputation at the joint between the finger and the hand or above, or the loss of its use.

Loss of one toe means amputation at the joint between the toe and the foot or the loss of its use.

Loss of use of a limb means total and permanent loss of each and all of the functions of the limb.

RESTRICTIONS

If the insured suffers more than one loss from the same accident, only one indemnity is paid, being indemnity for the most severe loss suffered.

In the case of quadriplegia, hemiplegia or paraplegia if the insured dies within ninety (90) days of the accident, the benefit payable is limited to one hundred per cent (100%) of the amount of insurance.

EXPOSURE AND DISAPPEARANCE

If, following an accident, the insured is inevitably exposed to natural elements causing a loss which would normally give rise to an indemnity; such loss will be covered under the provisions of the present benefit.

If the insured is not found within the year following his disappearance, due to a wreck or destruction of the means of transportation in which he was travelling at the time of the accident, loss of life due to bodily injury will be presumed after a period of three hundred and sixty-five (365) days following the date of the accident.

EXCLUSIONS

No indemnity will be payable if the loss is the result:

- a) of the insured's participation in a criminal act or attempted criminal act;
- b) of the insured's active participation in a civil commotion, riot, insurrection or military operation during war, whether war is declared or not;
- c) of the insured's participation in an aerial flight, other than as a fare-paying passenger on a regular chartered flight;
- d) of suicide or self-inflicted wound or mutilation, regardless of the insured's state of mind;

- e)** of death or having suffered from body lesions while his ability to drive is impaired according to the law, because of diminished faculties due to the consumption of alcohol or drugs;
- f)** of the insured's participation in land or water motor vehicle races, scuba diving, parachute jumping, free-fall or otherwise, bungee jumping, gliding or sail flights, or any other dangerous similar activity or sport;
- g)** of intoxication by or while under the influence of alcohol or drugs;
- h)** of an injury that does not show any visible trauma or external wounds, except for drowning or internal lesions discovered by autopsy;
- i)** of a physical or mental infirmity, or any kind of illness;
- j)** of poisoning or infection, except for an infection resulting from a wound or accidental cut;
- k)** of inhalation of toxic gas, except when inhalation is the result of an accident related to the insured's employment;
- l)** of service with the military, naval or air forces or with any other auxiliary or armed forces of any country, whether war is declared or not;
- m)** of a medical or dental treatment, surgery or anaesthesia.

Group Insurance Plan

OLYMEL ST-DAMASE ET SYNDICAT TUAC - LOCAL 1991-P

Group: 4160

Issued for class:

3 - CASUAL UNIONIZED EMPLOYEES

Issued:

Dec 7, 2022

Negotiated through:

**AZUR SERVICES CONSEIL
1540 BOULEVARD MARIE-VICTORIN
LONGUEUIL QC
J4G 1A4
Tel: (450) 640-1900
Fax: (450) 640-1901**

This explanatory brochure constitutes a useful and important guide.

This document contains texts briefly describing group insurance benefits of your plan. However, these texts do not confer any contractual rights and do not alter in any manner benefits of the plan. In all instances, the provisions and stipulations of the policy issued to the contract owner shall prevail.

We urge you to read it carefully and to save it for future reference whenever required.

Filing of claim

You can submit your claims by Internet on our secured site or by mail.

You can access our *online services* on our secured site at www.uvinsurance.ca under the **My Universe Login - Group Insurance - Member** section.

To send your claims by mail, you must include your original receipts and a completed form available from your group insurance plan administrator or online at www.uvinsurance.ca under the **Group Insurance - Learn more - Forms** section.



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SUMMARY OF BENEFITS

CONTRACT NO.: 4160, CLASS 3 - CASUAL UNIONIZED EMPLOYEES

LIFE INSURANCE BENEFIT FOR THE MEMBER

Effective date: Nov 1, 2022

INSURABLE AMOUNT:

The insurable amount is a fixed amount of \$ 40 000.

Maximum amount without proof: \$ 40 000

Maximum amount with proofs: \$ 40 000

Reduction of 50 % at the member's 65th birthday, for a maximum amount of: \$ 20 000

Reduction of 100 % at the member's 70th birthday.

Reduction of 100 % at retirement.

WAIVER OF PREMIUMS:

Waiver of premiums in the event of disability of the member up to age 65, after a waiting period of 6 months.

SUMMARY OF BENEFITS

CONTRACT NO.: 4160, CLASS 3 - CASUAL UNIONIZED EMPLOYEES

LIFE INSURANCE BENEFIT FOR DEPENDANTS

Effective date: Nov 1, 2022

INSURABLE AMOUNT:

	SPOUSE	CHILD(REN)*	CHILD(REN)**	CHILD(REN)***
Family coverage:	\$ 10 000	\$ 10 000	\$ 10 000	\$ 10 000

* Per child aged 24 hours to 14 days

** Per child aged 15 days to 6 months

*** Per child over 6 months

TERMINATION:

The maximum age for a dependent child is 21 years, or 26 years if a full time student.

Termination of benefit at age 70 for the member.

Termination of benefit upon retirement of the member.

WAIVER OF PREMIUMS:

Waiver of premiums in the event of disability of the member up to age 65, after a waiting period of 6 months.

SUMMARY OF BENEFITS

CONTRACT NO.: 4160, CLASS 3 - CASUAL UNIONIZED EMPLOYEES

SHORT-TERM DISABILITY BENEFIT

Effective date: Nov 1, 2022

INSURABLE AMOUNT:

Weekly insurable amount: 66.670 % of the salary rounded to the next dollar.

Maximum insurable amount: Is equal to HRDC

Taxation of the insurable amount: Taxable

The maximum of disability income: 100 % of the gross salary

WAITING PERIOD:

For an accident: 0 day

For an illness: 5 business days

For hospitalisation: 0 day

BENEFIT:

The maximum duration of benefits: 26 weeks

Frequency of cheques: Every 7 days, payable on a 5-day week basis.

Termination of benefit at: Age 65 for the member

WAIVER OF PREMIUMS:

Waiver of premiums in the event of disability of the member up to age 65, after a waiting period of 6 months.

SUMMARY OF BENEFITS

CONTRACT NO.: 4160, CLASS 3 - CASUAL UNIONIZED EMPLOYEES

LONG-TERM DISABILITY INSURANCE BENEFIT

Effective date: Nov 1, 2022

INSURABLE AMOUNT:

Monthly insurable amount: 75.000 % of the salary rounded to the next dollar.

Maximum insurable amount without proof: \$ 2 000

Maximum insurable amount with proof: \$ 2 000

Taxation of the insurable amount: Taxable

Maximum percentage of disability income: 75 % of the gross salary

WAITING PERIOD:

For an accident: 182 days

For an illness: 189 days

For hospitalisation: 182 days

BENEFIT:

The maximum duration of benefits: Age 65 for the member

Frequency of cheques: 1 per month

The definition of own occupation is: The inability to accomplish own occupation for 3 years.

Termination of benefit at: Age 65 for the member

WAIVER OF PREMIUMS:

Waiver of premiums in the event of disability of the member up to age 65, after a waiting period of 6 months.

SUMMARY OF BENEFITS

CONTRACT NO.: 4160, CLASS 3 - CASUAL UNIONIZED EMPLOYEES

HEALTH INSURANCE BENEFIT

Effective date: Nov 1, 2022

TOTAL AMOUNT PAYABLE:

The total amount payable for health insurance has no limit.

DEDUCTIBLE:

Individual coverage: \$ 25*

Family coverage: \$ 25*

Combined deductible: Yes, with drug insurance

**The deductible is applicable by calendar year.*

ELIGIBLE FEES:

Description	Refund	-----Per Period-----			Maximum	Type	Deductible	Max Age
		Frequency	No.	Visit				
HOSPITALISATION:								
HOSP. PROV. RESIDENCE [*]	100%	See contract			See contract	(E)	No	99
HOSP. OUT PROV. RES. [*]	100%	See contract			See contract	(P)	No	99
CONVALESCENCE HOME [*]	100%	Calendar Year	180		See contract	(E)	No	99
SUBSTANCE ABUSE TR. [*]	90%	See contract		\$80	\$2 500	(E)	Yes	99
[*] Semi-private room								
PARAMEDICAL EXPENSES:								
AUDIOLOGIST	90%	Calendar Year	11	\$40		(E)	Yes	99
CHIROPRACTOR	90%	Calendar Year	11	\$40		(E)	Yes	99
X-RAY (CHIROPRACTOR)	90%	Calendar Year		\$25	\$100	(E)	Yes	99
MASSOTHERAPIST [1]	90%	Calendar Year	11	\$40		(E)	Yes	99
NATUROPATH	90%	Calendar Year	11	\$40		(E)	Yes	99
NATUROTHERAPIST	90%	Calendar Year	11	\$40		(E)	Yes	99
ORTHOPHONIST	90%	Calendar Year	11	\$40		(E)	Yes	99
ORTHOTHERAPIST [1]	90%	Calendar Year	11	\$40		(E)	Yes	99
OSTEOPATH	90%	Calendar Year	11	\$40		(E)	Yes	99
PHYSIOTHERAPIST [2]	90%	Calendar Year	11	\$40		(E)	Yes	99
PODIATRIST	90%	Calendar Year	11	\$40		(E)	Yes	99
PSYCHOANALYST [3]	90%	Calendar Year	11	\$40		(E)	Yes	99
PSYCHOLOGIST [3]	90%	Calendar Year	11	\$40		(E)	Yes	99
READAPTATION THERAP. [2]	90%	Calendar Year	11	\$40		(E)	Yes	99
SOCIAL WORKER [3]	90%	Calendar Year	11	\$40		(E)	Yes	99

Maximum amounts are combined for overall fees for each whole group.

These groups are: [1], [2], [3] and [4]

Type (E) = maximum eligible amount, Type (P) = maximum payable amount

[R] = medical recommendation required for these paramedical expenses

SUMMARY OF BENEFITS

CONTRACT NO.: 4160, CLASS 3 - CASUAL UNIONIZED EMPLOYEES

HEALTH INSURANCE BENEFIT

ELIGIBLE FEES (CONTINUED):

DESCRIPTION	Refund	-----Per Period-----			Maximum	Type	Deductible	Max Age
		Frequency	No.	Visit				
OTHER FEES:								
COLOSTOMY AND AL.	90%	See contract			Unlimited	(E)	Yes	99
AMBULANCE	90%	See contract			Unlimited	(E)	Yes	99
LAB TEST/DIAGNOSIS	90%	Calendar Year			\$1 000	(E)	Yes	99
ANESTHETIC	90%	See contract			Unlimited	(E)	Yes	99
HEARING AID	90%	48 months			\$600	(E)	Yes	99
RESP. APPRAR./OXYGEN	90%	Lifetime			\$10 000	(E)	Yes	99
BANDAGE / SPLINT	90%	See contract			Unlimited	(E)	Yes	99
OTHER PROSTHESIS	90%	See contract			\$5 000	(E)	Yes	99
DYN. ORTHOSIS / CORS.	90%	See contract			Unlimited	(E)	Yes	99
ELASTIC STOCKINGS	90%	Calendar Year	3		Unlimited	(E)	Yes	99
ORTHOPEDIC SHOES#1 [4]	75%	12 months	2		\$300	(E)	Yes	16
ORTHOPEDIC SHOES#2 [4]	75%	12 months	1		\$300	(E)	Yes	99
DENTAL ACCIDENT	90%	See contract			\$5 000	(E)	Yes	99
FOOT ORTHOSIS	90%	12 months			\$495	(E)	Yes	99
EYE EXAM	90%	24 months			\$75	(E)	Yes	65
MEDICAL SUPPLIES	90%	See contract			Unlimited	(E)	Yes	99
GLUCOMETER	90%	36 months			\$300	(E)	Yes	99
NURSE	90%	12 months		\$300	\$10 000	(E)	Yes	99
REGISTERED NURSE	90%	12 months			\$200	(E)	Yes	99
SCLER. INJEC. DRUGS	90%	Calendar Year		\$20		(E)	Yes	99
RENTAL (CHAIR/BED)	90%	See contract			Unlimited	(E)	Yes	99
CAPILLARY PROSTHESIS	90%	Lifetime		1	\$300	(E)	Yes	99
MAMMARY PROSTHESIS	90%	24 months			\$1 000	(E)	Yes	99
X-RAY	90%	Calendar Year			\$1 000	(P)	Yes	99
MAG. RESONANCE (MRI)	100%	Calendar Year			\$1 000	(P)	Yes	99
CARE OUT PROV.	100%	See contract			See contract	(P)	No	99
I.U.D.	90%	Calendar Year		1		(E)	Yes	99
TENS	90%	60 months			\$1 000	(E)	Yes	99
TRANSFUSION	90%	See contract			Unlimited	(E)	Yes	99

Maximum amounts are combined for overall fees for each whole group.

These groups are: [1], [2], [3] and [4]

Type (E) = maximum eligible amount, Type (P) = maximum payable amount

SUMMARY OF BENEFITS

CONTRACT NO.: 4160, CLASS 3 - CASUAL UNIONIZED EMPLOYEES

HEALTH INSURANCE BENEFIT

TERMINATION:

The maximum age for a dependent child is 21 years, or 26 years if a full time student.
Travel assistance as per the contract terminates at age 99 for the member.

WAIVER OF PREMIUMS:

Waiver of premiums in the event of disability of the member up to age 65, after a waiting period of 6 months. The waiver of premium terminates on the earliest of the following dates: The date this benefit terminates or the date this policy terminates.

REMARK(S) FOR HEALTH INSURANCE BENEFIT:

THE MAXIMUM AMOUNT OF ELIGIBLE EXPENSES REFUNDED BY THE INSURER FOR OUTSIDE THE INSURED'S PROVINCE OF RESIDENCE IS LIMITED TO FIVE MILLION DOLLARS (\$5,000,000) DURING THE INSURED'S LIFETIME.

TRIP CANCELLATION IS INCLUDED, REFER TO THE CONTRACT TRAVEL ASSISTANCE SERVICE SECTION.

OTHER PARAMEDICAL EXPENSES INCLUDED :

- KINESITHERAPIST COMBINED WITH MASSOTHERAPIST AND ORTHOTHERAPIST.
- NATUROPATH COMBINED WITH NATUROTHERAPIST.
- CHIROPODIST COMBINED WITH PODIATRIST.
- PSYCHOEDUCATOR COMBINED WITH PSYCHOANALYST AND SOCIAL WORKER.

OTHER ELEGIBLE FEES :

- REPLACEMENT MASK COMBINED WITH RESP.APPRAR/OXYGEN.
- DEEP SHOES: MAXIMUM PAYABLE AMOUNT OF \$ 100.00 PER CALENDAR YEAR.
- INSULIN PUMP : MAXIMUM PAYABLE AMOUNT OF \$ 7 500.00 PER 60 MONTH-PERIOD.
- SUPPLIES FOR THE INSULIN PUMP : MAXIMUM PAYABLE AMOUNT OF \$ 10 000.00 PER 60 MONTH-PERIOD.
- RX CHIROPODIST, RX PODIATRIST, RX NATUROPATH AND RX OSTEOPATH COMBINED WITH X-RAY.
- LABORATORY ANALYSIS: MAXIMUM PAYABLE AMOUNT OF \$ 1000.00 PER CALENDAR YEAR.
- POST-MASTECTOMY BRASSIERES SOLD BY A SPECIALIZED LABORATORY: MAXIMUM LIFETIME PAYABLE AMOUNT OF \$ 200.00.
- CONTACT LENSES OR INTRAOCULAR LENSES FOLLOWING A CATARACT SURGERY: MAXIMUM LIFETIME PAYABLE AMOUNT OF \$ 1000.00.
- THERAPEUTIC DEVICES: MAXIMUM LIFETIME PAYABLE AMOUNT OF \$ 10 000.00.
- TOMODENSITOMETRY: MAXIMUM PAYABLE AMOUNT OF \$ 1000.00 PER CALENDAR YEAR.
- ELECTROCARDIOGRAM: MAXIMUM PAYABLE AMOUNT OF \$ 1000.00 PER CALENDAR YEAR.
- ECHOGRAPHY: MAXIMUM PAYABLE AMOUNT OF \$ 300.00 PER CALENDAR YEAR.
- EXPENSES OF SURGERY NECESSARY TO THE REPAIR OF AN ESTHETIC DAMAGE ASCRIBABLE WITH AN ACCIDENT WHICH HAS OCCURRED WHEREAS THIS INSURANCE IS IN FORCE, WITH CONDITION WHICH THE SERVICES WERE DONE IN THE 36 MONTHS OF THE

SUMMARY OF BENEFITS

CONTRACT NO.: 4160, CLASS 3 - CASUAL UNIONIZED EMPLOYEES

HEALTH INSURANCE BENEFIT

DATE OF ACCIDENT: MAXIMUM PAYABLE AMOUNT OF 5000.00\$ BY ACCIDENT.

- SCREENING TESTS DURING PREGNANCY ARE COVERED UNDER LABORATORY ANALYSIS.

SUMMARY OF BENEFITS

CONTRACT NO.: 4160, CLASS 3 - CASUAL UNIONIZED EMPLOYEES

DRUG INSURANCE BENEFIT

Effective date: Nov 1, 2021

DEDUCTIBLE:

Individual coverage: \$ 25*

Family coverage: \$ 25*

Combined deductible: Yes, with health insurance

**The deductible is applicable by calendar year.*

REIMBURSEMENT:

For drugs prescribed in the province of residence according to the RESTRICTIVE drugs list.

Eligible innovator drugs: 90 %**

Eligible generic drugs: 90 %**

Eligible brand drugs: 90 %**

Drug card: Direct payment

*** After satisfying the deductible*

EMPLOYEE'S CONTRIBUTION:

Each year, the maximum an insured contributes for drug fees with respect to the deductible and the percentage of reimbursement is equal to the most recent amount determined by the "Régie de l'assurance maladie du Québec". This maximum applies to the total amount of drug fees incurred by the insured and their insured dependants. The maximum contribution does not apply to the drug cost that the member has to pay outside Quebec and to members residing outside Quebec.

TERMINATION:

The maximum age for a dependent child is 21 years, or 26 years if a full time student.

WAIVER OF PREMIUMS:

Waiver of premiums in the event of disability of the member up to age 65, after a waiting period of 6 months. The waiver of premium terminates on the earliest of the following dates: The date this benefit terminates or the date this policy terminates.

GENERAL PROVISIONS

DEFINITIONS

In the present policy, unless one of the benefits, a modification, an amendment or the “Summary of Benefits” stipulates otherwise, we hereby define:

a) ACCIDENT

A corporal blow diagnosed by a physician, arising directly and independently of all other causes, from the sudden, violent and unforeseeable action of an external cause.

b) MEMBER

An eligible and insured employee under this contract.

c) 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.

d) INSURED

A member or one of his dependants.

e) SPOUSE

A person with whom the insured is living. The union must be a marriage duly recognised by Quebec legislation or the common-law state of a single, widowed or divorced person having resided permanently for more than one year with a person who is also single, widowed or divorced, who is publicly presented as a spouse. The stated delay is not applicable if a child is born of the union. The dissolution of a marriage by divorce as well as legal separation results in the loss of the marital status. The same loss of marital status results in the event of any de facto separation of more than three (3) months, in the case of a non-legally contracted union.

The spouse is the one designated by the insured. Only one person may be insured as a spouse at any given time.

f) ELIMINATION PERIOD

A continuous period beginning at the start of a total disability during which no disability benefit is payable under this benefit.

g) DRUGS

Controlled or limited usage drugs including medication or narcotics as defined in the Food and Drugs Act and Narcotic Control Act.

h) EMPLOYEE

A person residing in Canada who works for an employer or duly registered member of the policyowner.

i) EMPLOYER

The policyowner or a subsidiary associated or affiliated company whose name appears in the “Summary of Benefits”.

j) CHILD

Any single child of the insured or of his spouse, including any legally adopted child, residing in Canada and who meets one of the following conditions:

- is under twenty-one (21) years of age, or;
- is under twenty-six (26) years of age and duly registered as a full time student at a recognised teaching institution, or;
- is totally disabled and became totally disabled while one of the two (2) preceding conditions existed, and resides with the member.

With regards to life insurance for dependants, the infant must be at least twenty-four (24) hours of age.

k) IMMEDIATE FAMILY

The insured, his spouse, his children, his father, his mother, his grandparents, his brothers, his sisters and his grand-children at least 18 years of age.

l) DEDUCTIBLE

The deductible is the part of eligible expenses that must be paid by the insured in each calendar year before a benefit is payable. If applicable, the deductible amount is specified in the "Summary of Benefits".

If the present contract replaces another, the fees disbursed between January 1st and the effective date of the contract will be applied toward the deductible.

In the event where there is no previous insurer, for the first year of insurance, the deductible is proportional to the number of months between the effective date and the end of the calendar year, unless otherwise agreed differently between the insurer and the policyowner.

m) TOTAL DISABILITY

For the elimination period stipulated in the "Summary of Benefits" and the twenty-four (24) months that follow, the inability of a person, due to illness or an accidental injury, to perform all the duties of his regular occupation; subsequently, the inability to perform any remunerative occupation that could reasonably be performed when taking into consideration the education, training or experience of that person, regardless of the availability of employment in the region of the member's place of residence.

n) ILLNESS

A deterioration of health or disorder of the organism diagnosed by a physician specialised in the treatment of the illness. Pregnancy is not considered to be an illness; only major complications due to pregnancy are considered to be a deterioration of health.

o) PHYSICIAN

Any legally authorised person who practices medicine in his field of specialty. The physician must not be the insured, or a member of his immediate family.

p) REGULAR OCCUPATION

All the functions, as a whole, that a person performs relating to his occupation.

q) TOTAL DISABILITY PERIOD

A continuous period of total disability or successive periods of total disability resulting from the same cause or from related causes and separated by one or several recurrence periods shorter than the recurrence period allowed under the said benefit. A new period of total disability begins when the insured returns to work on a full-time basis at full salary for at least one day and the disability is the result of a cause completely independent of the first disability.

r) RECURRENCE

A period immediately following the date a person ceases to be totally disabled.

s) DEPENDANT

The member's spouse or child taken individually in accordance with the definitions of spouse or child in the present contract. It is noted that the following persons are not to be considered as the member's dependants:

- 1) a child who is not depending on the member for financial support or who has a full-time job;
- 2) a child with a spouse.

t) REIMBURSEMENT PERCENTAGE

The percentage of admissible fees that can be reimbursed after deducting the deductible, as specified in the "Summary of Benefits".

u) POLICYOWNER

A corporate body or physical person stipulated in the face page of this policy or in the "Summary of Benefits". The policyowner is the owner of the contract. The policyowner may or may not be the employer.

v) RETIREMENT

Date on which a member ceases to work for reason of retirement or early retirement.

w) PROFESSIONAL RISK

Any risk related to a job, occupation, trade or profession.

x) GROSS EARNED INCOME

The regular gross earned income excluding bonuses, payments for overtime, fees, allowances for lodging and meals, isolation payments and any lump sum occasional payments which are not part of the regular remuneration.

For the members whose income derives totally or partially from commissions or performance bonuses, salary means the average percentage of the employee's pay, paid by the employer, including commissions indicated on the employee's T4 and T4A income tax forms during the two (2) preceding years. In the event where the employee has not completed two years of continued service with the same employer, but at least one year, an income average will be established based on the full duration of service. However, if the employee has been employed for less than one year, salary means the average percentage of the employee's pay as is declared by the employer.

However, for the short-term disability benefit, income represents the insurable remuneration as established by the Canadian employment insurance legislation if the plan is duly registered with the Human Resources and Social Development Canada (HRDC).

y) NET INCOME

For a salaried employee, net income is earned income less provincial and federal income taxes, contributions to unemployment insurance, Quebec Pension Plan and Canada Pension Plan deducted from the salary.

EMPLOYEE ELIGIBILITY

An employee becomes eligible for insurance:

- a) on the effective date of the contract if he meets the eligibility provisions stipulated in the "Summary of Benefits", or;
- b) after the effective date, from the date he meets the eligibility provisions stipulated in the "Summary of Benefits".

Seasonal employees or part-time employees (i.e. those working less than nine (9) months per year) and partial part-time employees (i.e. those who work less than twenty (20) hours per week) are eligible only if designated in the "Summary of Benefits".

DEPENDANT ELIGIBILITY

An employee's dependants become eligible for insurance on the later of the following dates:

- a) the date when the employee becomes eligible, or;
- b) the date when they become dependants as per the definition of a dependant stipulated in the present contract.

APPLICATION FOR INSURANCE

To be insured under this contract, an eligible employee must submit a written request by completing an application form provided by the insurer.

To insure his dependants, an employee must list them on his application form. For subsequent coverage, the employee must advise the policyowner, who must then complete the required form and forward it to the insurer without further delay.

EFFECTIVE DATE OF INSURANCE FOR THE EMPLOYEE

An employee's insurance becomes effective:

- a) on his date of eligibility, if the insurer has received the request for insurance on or before this date, or;
- b) on the date the insurer receives the request for insurance, if this date is within the thirty (30) day period following his eligibility date, or;

- c) on the date the insurer accepts the evidence of insurability that the employee must provide at his expense and which is satisfactory to the insurer, if the form requesting the insurance is received more than thirty (30) days after the eligibility date.

Notwithstanding the foregoing, any insurance that is subject to evidence of insurability becomes effective only on the date of acceptance of such proof by the insurer.

If the day on which the insurance becomes effective is a working day and the employee is not at work on that day for reasons other than a scheduled vacation period, his insurance becomes effective the day he returns to work full-time and is able to accomplish all the duties of his regular occupation.

If the day on which the insurance becomes effective is not a working day, the insurance becomes effective:

- a) on that date, provided the employee was actually at work on the last previous working day, otherwise;
- b) the day he returns to work full-time and is able to accomplish all the duties of his regular occupation.

EFFECTIVE DATE OF INSURANCE FOR A DEPENDANT

The insurance for a dependant becomes effective:

- a) on the date of eligibility of a dependant if the insurer has received the written request on or before that date; or
- b) on the date the insurer receives the request for insurance, if this date is within the thirty (30) day period following the dependant eligibility date; or
- c) on the date the insurer accepts the evidence of insurability that the employee must provide at his expense and which is satisfactory to the insurer, if the form requesting the insurance is received more than thirty (30) days after the dependant's eligibility date.

Any new dependant child of the member whose other dependants are already insured becomes rightfully and immediately insured. The name and date of birth of the new child must however be communicated to the insurer by means of a written notice for the processing of future claims.

However, with the exception of any newborn, if a dependant is hospitalised on the effective date of his own life, such insurance becomes effective only on the day after leaving the hospital.

CLAIMS

a) FILING A CLAIM

Any claim for benefits under this contract must be filed with the insurer within thirty (30) days thereafter.

b) PROOF OF CLAIM

The insured must submit to the insurer the required proof according to the benefit in the ninety (90) days following the event. It is the insured's

responsibility to assume all expenses incurred for proof satisfactory to the insurer.

c) ADDITIONAL DELAY

Failure in filing a claim or submitting proof within the specified period will not invalidate a claim under the contract if proven that it was impossible for the insured to file the claim on time, and the claim was filed or the proof was submitted within twelve (12) months following the date of the event giving rise to the claim.

d) PAYMENT

The insurer must pay claims within thirty (30) days following the date of receipt of all required proof.

All amounts become payable to the member, if living. Otherwise, the amounts are payable to the designated beneficiary.

e) BENEFICIARY

Providing it is not contrary to law and where no irrevocable beneficiary designation has been made, an insured may, by giving a written notice to the insurer, designate or revoke any beneficiary.

The insurer assumes no responsibility for the validity of any beneficiary designation. If no beneficiary designation has been made, all amounts payable at death are issued to the member's estate.

RULES OF MINIMAL PARTICIPATION OF ELIGIBLE EMPLOYEES

A minimum of two (2) members at all times is required to maintain this contract in force.

Any employee that satisfies the eligibility provisions stipulated in the summary of benefits and who subscribes to the insurance plan must remain insured under the provisions of the policy.

In addition, for each member and for each benefit, the policyowner must pay at least the proportion on the premium indicated in the "Summary of Benefits".

An "insurance premium", for the purpose of this article, excludes the premium for any additional insurance benefit.

TERMINATION OF AN MEMBER'S INSURANCE

A member's insurance under the present contract or under one of its benefits or services terminates at midnight on the earliest of the following dates:

- a)** the date of cancellation of the present contract or of the relevant benefit;
- b)** the date the member ceases to be an employee or ceases to be in a class of employees' eligible for insurance;
- c)** the date the insurer receives a written notice from the policyowner requesting termination of an member's insurance, or any subsequent date mentioned in the notice;
- d)** the date on which the insured attains the maximum age for the relevant benefit for any such insurance;

- e) the due date of any premium, if on that date the member's premium is not paid, unless a request for waiver of premiums due to disability has been made and accepted;
- f) the date of the member's death, subject to the payment of benefits that are due.

TERMINATION OF DEPENDANT INSURANCE

A dependant's insurance under the present contract or under one of its benefits or services terminates at midnight on the earliest of the following dates:

- a) the date of cancellation of the present contract or of the implied benefits;
- b) the date the member ceases to be an employee or ceases to be in a class of employees' eligible for insurance;
- c) the date the insurance for the member ceases;
- d) the date a dependant no longer meets requirements mentioned in the definition of dependant;
- e) the due date of any premium, if on that date the dependant's premium is not paid, unless a request for waiver of premiums in the event of disability has been made and accepted;
- f) the date of the dependant's death subject to the payment of benefits that is due.

ERROR AND FALSE DECLARATION

A false declaration of age does not lead to the annulment of the insurance. In this situation, the true date of birth, established to the insurer's satisfaction, serves as the basis of premium calculation and an equitable adjustment of premiums and insured amount, if necessary, will be made.

The insurer is justified in requesting that the life insurance be null and void when the insured's age at issue was outside the age limits set by the insurer's rates. The insurer must act within three (3) years of the issue of the insured's certificate, providing it does so while the insured is living and within sixty (60) days of becoming aware of the error.

An error concerning the insured's age cannot prolong any amount of insurance beyond the date these amounts would have terminated, taking into account the insured's actual age.

INCONTESTABILITY

In the absence of fraud, a false declaration or a withholding of information may not be invoked as sufficient reason to terminate or reduce the insurance if it has been in force for more than two (2) years. However, this rule does not apply to disability insurance if said disability started during the first two (2) years of insurance.

INFORMATION TO MEMBERS

The insurer provides the policyowner with a written summary the insured's rights and obligations under the present contract, as well as a certificate of proof of coverage for insured employees.

The policyowner must forward this information to the member. Its purpose is to advise the member of his rights and obligations. In the event of litigation, only the contract may be invoked.

The member may consult the contract at the policyowner's business address and make a copy at his own expense.

LAWS THAT GOVERN THIS CONTRACT

For the purpose of this policy, reference to a law signifies the effective law in force at that particular time, or if repealed, the new law that replaces it or any law of the same nature with the same end result.

FILE ACCESS

In order to maintain the confidential nature of personal information on the insured, the insurer agrees to the following:

To create an individual insurance file that contains information on the insured relating to the application, as well as any information relating to the claim.

Access to the file is restricted solely to the insurer's employees, legal advisors or representatives responsible for the underwriting, investigations and evidence of insurability.

The insured's file is kept by the Union Life, Mutual Insurance Company.

The insured has the right to be informed of the personal information in of this file and if applicable, may have the file corrected by making a written request to the insurer. All requests are to be sent to the access information officer.

WAIVER OF PREMIUMS BENEFIT

PURPOSE

Waiver of premiums applies to each benefit indicated in the "Summary of Benefits". The purpose is to continue coverage of the insurance benefits in force at the beginning of disability. Disability must begin before the insured's sixtieth (60th) birthday in order for him to be eligible for waiver of premiums. Total disability must be as described in the definition of the "General Provisions" section of the present policy.

ELIMINATION PERIOD

The elimination period is the period that commences at the beginning of a total disability period and for which no disability payment is payable under this benefit.

The elimination period is stipulated in the "Summary of Benefits". Premiums are waived starting from the 1st day of the month following or coinciding with the date on which the elimination period is completed.

REMISSION PERIOD PERMITTED

A period less than one hundred and eighty (180) days immediately following the date a person who was totally disabled ceases to be.

PREMIUMS TO BE WAIVED

The premiums to be waived are those for insured benefits under the present contract at the beginning of disability as stipulated in the "Summary of Benefits". A retroactive refund of premiums will not exceed six (6) months from the date of approval of the claim for waiver by the insurer.

PROOF OF DISABILITY

To prove his disability or its continuance, the member must submit to the insurer a medical certificate by using the appropriate forms provided by the insurer. The insurer may, at its own expense, and as often as deemed necessary, have the insured undergo a medical examination by a physician chosen by the insurer, if it judges that the proof submitted by the member is unsatisfactory.

TERMINATION OF WAIVER OF PREMIUMS

In addition to the reasons of termination of insurance for the member in the section entitled "General Provisions" of the present policy, the waiver of premiums for an insured ceases when he is no longer disabled or when he cannot provide proof of his total disability or refuses to submit such proof.

In addition, waiver of premiums cease at midnight on the earliest of the following dates:

- the termination date or age limit stipulated in the "Summary of Benefits";
- his retirement date, if earlier.

EXCLUSIONS

The insurance provided by the present waiver of premiums benefit does not apply and the insurer assumes no responsibility if disability is the result:

- a)** of the insured's participation in a criminal act or an attempted criminal act, or;
- b)** of the insured's active participation in a civil commotion, riot, insurrection or military operation during war, whether war is declared or not, or;
- c)** of the insured's participation in an aerial flight other than as a fare paying passenger on a regular or chartered flight, or;
- d)** of an attempted suicide or self-inflicted wound or mutilation, regardless of the insured's state of mind, or;
- e)** of the fact of having suffered body lesions while driving a vehicle with diminished faculties due to alcohol or drug consumption (criminal act), or;
- f)** of the insured's participation in land or water motor vehicle races, scuba diving, parachute jumping, free-fall or otherwise, bungee jumping, gliding or sail flights, or any other dangerous similar activities or sports, or;
- g)** of intoxication by or while under the influence of alcohol or drugs, or;
- h)** of lumbago or back pain whose diagnosis can only be made subjectively by the insured's description of symptoms and cannot be supported by appropriate tests prescribed by a physician, or;
- i)** of disability that began prior to the effective date of insurance.

LIFE INSURANCE BENEFIT FOR THE MEMBER

PURPOSE

The purpose is to pay a death benefit when the member's death occurs while this insurance benefit is in force.

BENEFIT AMOUNT

The benefit amount is equal to the amount specified in the "Summary of Benefits" and is subject, if applicable, to reduction due to the member's age.

EXTENSION

Upon receipt and acceptance of required documents establishing to the satisfaction of the insurer, that an member was totally disabled while covered under the present contract and that the member:

- a) remained totally disabled up to the date of his death and died from the same condition as his disability, and;
- b) died before his sixty-fifth (65th) birthday and before the end of a six (6) month period calculated from the date he stopped working due to his disability, and;
- c) was not covered by another insurer under an insurance contract with a similar benefit.

The insurer pays the insurance amount to which the member was entitled as stipulated in the present contract without however, exceeding the amount that was in force on his life on the date he left his employment.

ANTICIPATED DEATH BENEFIT

Provided that the present benefit is in force in accordance with the provisions foreseen for the "Waiver of premiums" benefit of the present contract and a member's life expectancy is not more than twelve (12) months, he has the right to an anticipated death benefit payment. The amount is the lesser of twenty-five thousand dollars (\$25,000) or fifty per cent (50%) of the amount of life insurance in force.

The written request to the insurer must include satisfactory proof that the member's life expectancy does not exceed twelve (12) months as of the date requested.

Upon the member's death, the amount payable to the beneficiary by the insurer is reduced by the amount paid to the insured under the present right, increased by interest accrued since the date of the payment of this benefit at an annual rate of ten per cent (10%).

EVIDENCE OF INSURABILITY

When the amount of insurance exceeds the maximum amount of insurance without evidence of insurability stipulated in the "Summary of Benefits", the member is covered for the excess only if he submits proof satisfactory to the insurer. Subsequently, any increase in the amount of insurance will become effective only after the required evidence of insurability has been accepted by the insurer.

CONVERSION PRIVILEGE

If, before the member attains age sixty-five (65) the insurance on his life terminates due to the termination of his employment or the loss of a membership in an insured group, the member may convert all or part of the insurance amount lost into an individual life policy, without having to prove his insurability. The amount of insurance converted for the same insured cannot exceed the amount of benefit of the present benefit at the date of conversion, subject to the higher of a minimum of five thousand dollars (\$5,000) or twenty-five per cent 25% of the member's insurance amount, and a maximum of two hundred thousand dollars (\$200,000) or the difference between the amount of insurance lost under the present contract and the amount of insurance provided for by another contract under which the member became eligible at the time of exercising his conversion privilege.

In addition, upon termination of the present contract, on the condition that the member was covered for at least five (5) years and the contract was not replaced by another under which he became eligible, the member may convert, totally or partially the insurance volume lost to an individual permanent life insurance without evidence of insurability.

To convert, the member must make a written request to the insurer on the form provided by the insurer, and pay the insurer the amount of premium for the proposed contract, within thirty-one (31) days as of the termination of the insurance.

If the member dies during the thirty-one (31) day conversion privilege period, the insurer will pay the maximum amount of life insurance the insured could have been converted.

The member can subscribe to any one of the following individual insurance contracts:

- 1)** a one (1) year term insurance, convertible at the end of the year to a term insurance to age sixty-five (65) or a whole life insurance contract;
- 2)** a term insurance to age sixty-five (65);
- 3)** a whole life insurance.

No additional benefit may be added to this insurance unless anticipated for specifically elsewhere in this contract.

The premium rate for the individual insurance contract is the rate in use by the insurer according to the amount converted, the plan chosen, and the member's gender and age at the time of conversion. If the member is already subjected to an increased premium or exclusion under the present benefit, the insurer will increase the premium or reinstate the exclusion for the individual insurance in a similar way. Any premium mode typically offered by the insurer may be selected. In the first year of conversion, insurance premiums may be paid quarterly. The individual contract

will become effective thirty-one (31) days after the termination of the insurance with regards to the present contract.

A decreased amount due to age or a change of category of the member does not give the member the right to convert his insurance.

The member who has used his conversion privilege is no longer eligible for insurance under the present contract, unless satisfactory evidence of insurability accepted by the insurer. The conversion privilege of the present contract, once exercised, is no longer available.

TERMINATION OF THE MEMBER'S INSURANCE

In addition to the reasons for the termination of the member's insurance stipulated in the section entitled "General Provisions" of the present policy, the insurance for this benefit will terminate at the earliest of the following dates at midnight:

- the termination date or age limit stipulated in the "Summary of Benefits";
- the member's retirement date, if earlier.

LIFE INSURANCE BENEFIT FOR DEPENDANTS

PURPOSE

the purpose is to pay a death benefit upon death of a member's dependant, if death occurs while this insurance benefit is in force.

AMOUNT OF BENEFIT

The amount of the benefit payable upon death of the spouse or a dependant child is specified in the "Summary of Benefits".

EXTENSION

If upon the member's death dependants are insured under this benefit, the dependants' life insurance is extended without payment of premiums up to the earliest of the following dates:

- a) twenty-four (24) months after the member's death;
- b) the termination date of the life insurance benefit for dependants had the member been living;
- c) the termination date of the present benefit.

TERMINATION OF INSURANCE

In addition to the reasons for the termination of the dependants' insurance benefit stipulated in the section entitled "General Provisions" of the present policy, the insurance for this benefit will terminate at the earliest of the following dates at midnight:

- the termination date or age limit stipulated in the "Summary of Benefits";
- the member's retirement date, if earlier;
- when the spouse or child no longer meets the definition of dependant.

SHORT-TERM DISABILITY BENEFIT

PURPOSE

The purpose of coverage is to temporarily replace and in part the employment income loss for a member during a period of total disability starting after the effective date of this benefit.

EXCLUSIVITY OF BENEFIT

Once the long-term disability benefits have started, a return to the short-term disability benefits is not possible for the same or related causes, until the total disability period giving rise to the claim has terminated.

ELIGIBILITY

To be eligible for the short-term disability benefit, an employee must be covered under the life insurance benefit.

ELIMINATION PERIOD

The elimination period for the present benefit corresponds to the number of days indicated in the "Summary of Benefits", separately for total disability resulting from an illness, an accident or a hospitalization.

The elimination period in the event of an illness applies for any total disability period beginning more than thirty (30) days after the date of the accident causing the disability.

The elimination period in the event of hospitalization begins at the date of hospitalization. In addition, the elimination period for hospitalization applies on the condition that the date of hospitalization precedes the date the elimination period for an illness ends.

In the present article, hospitalization means occupying a hospital room for a minimum period of eighteen (18) consecutive hours, or to have been admitted to the hospital for less than one day for surgery requiring anaesthesia.

REMISSION PERIOD PERMITTED

A period less than fifteen (15) days.

MAXIMUM ELIGIBLE WEEKLY INCOME

When the maximum eligible weekly income is as defined by the Canada employment insurance act, this expression is designated by M.E.W.I. in the "Summary of Benefits".

BENEFIT AMOUNT

The amount of disability benefits is payable according to the frequency indicated in the "Summary of Benefits".

BENEFIT PAYMENTS

Benefits become payable after the elimination period.

The amount of disability benefit is divided, if applicable, by one-fifth (1/5) of the amount provided for a complete week, for each working day of a normal work week, or by one-seventh (1/7) for each day of absence during the week as specified in the "Summary of Benefits".

Benefits are payable for provided that total disability persists without exceeding the maximum number of weeks specified in the "Summary of Benefits".

In addition, notwithstanding the maximum age specified in the "Summary of Benefits" which indicates the end of payment of benefits, it is stipulated that the said payment continues, with proof of disability satisfactory to the insurer, until the member has received at least fifteen (15) weeks of benefits in total including benefits paid before the maximum age. However, benefits end as soon as the member is able to resume work or as soon as he elects retirement, whichever period is shorter.

No disability period may start after the maximum age as specified in the "Summary of Benefits".

REHABILITATION

The insurer may assist the member in any manner to encourage him to return to his regular occupation or any other remunerative occupation compatible with his state of health.

In the case of a rehabilitation program accepted by the insurer, if a gradual return to work is appropriate considering the state of health, the amount of the payable benefit will be adjusted, taking into account the period worked.

REDUCTION OF BENEFIT DUE TO INTEGRATION OF BENEFITS

Under the present article, the insurer pays a weekly disability benefit according to the lesser of the amounts calculated under paragraphs A) or B) that follow:

a) DIRECT INTEGRATION OF BENEFITS

The member is only eligible for disability benefits of the present benefit and those provided for by government plans.

The amount of disability benefits payable by the insurer is reduced by the amount of initial basic benefits; without regard to subsequent increases due to indexation, payable under the following laws or plans, such as:

- 1)** the Quebec Pension Plan or the Canada Pension Plan;
- 2)** the Occupational Health and Safety Commission;
- 3)** the Automobile Insurance Act in Quebec or Ontario.

However, this article only refers to the above-mentioned benefits whose payment started at the beginning or after the beginning of total disability.

If an member refuses or neglects to submit a request for benefits under the laws or plans mentioned above, when informed by the insurer that he could be eligible for such benefits, the insurer reserves the right to reduce from

the benefits payable an estimate of benefits that could be provided by these laws or plans.

b) INDIRECT INTEGRATION OF BENEFITS

The member is eligible for additional disability benefits and those foreseen in the preceding paragraph a).

If the member receives disability income that is greater than the maximum percentage of income permitted, as specified in the "Summary of Benefits" and based on the member's income at the beginning of disability, the disability benefit is reduced so that the total amount of disability income does not exceed the maximum employment income at the beginning of disability. In calculating the maximum, only initial amounts of benefits will be considered without regard to subsequent increases due to indexation.

Other income amounts that are considered in the calculation mentioned in the preceding paragraph are:

- 1) Any remuneration paid by an employer due to a salary continuation policy, holidays, sick days or any other benefits program established by the employer;
- 2) all annuities or disability benefits payable under the following laws:
 - the Quebec Pension Plan or the Canada Pension Plan;
 - the Occupational Health and Safety Commission;
 - the Automobile Insurance Act in the province of residence.
- 3) any disability benefits payable under a group insurance contract or a retirement plan from the employer.

At all times, the total disability income payable under the present benefit and the other above-mentioned sources, cannot exceed the maximum amount equal to one hundred per cent (100%) of the member's net income at the beginning of his disability. (100% of the gross income if the benefit payable is taxable).

If a member refuses or neglects to submit a request for benefits under the laws mentioned above, when informed by the insurer that he could be eligible for such benefits, the insurer reserves the right to reduce from the benefits payable an estimate of benefits that could be provided by these laws.

EXCLUSIONS

No benefit is payable in the following cases:

- a) the member's participation in a criminal act or attempted criminal act;
- b) the member's active participation in a civil commotion, riot, insurrection or military operation during war, whether war is declared or not;
- c) self-inflicted wound or mutilation, regardless of the member's state of mind;
- d) the fact of having suffered from body lesions while his ability to drive was impaired, because of diminished faculties due to the consumption of alcohol or drugs;

- e) surgery not necessary for the member's health, for cosmetic or non-medically required care;
- f) during a period where an member stays more than 15 days outside of Canada;
- g) during a maternity leave provided for under provincial or federal law or of an agreement with the employer;
- h) period during which the member is not under the regular care of a specialist able to treat his illness, or if he does not receive proper therapy for his condition, or refuses such therapy;
- i) period during which the member is not under the care of a physician; the period of total disability may not start before the date of the first medical visit for the disability in question;
- j) disability that began before the effective date of insurance;
- k) disability as a result of a work related accident or occupational illness, unless otherwise stipulated in the "Summary of Benefits".

PROOF OF DISABILITY

To prove his disability and its continuance, the member must submit to the insurer a medical certificate using the insurer's forms.

The insurer may have the member undergo a medical examination by a physician of the insurer's choice and at the insurer's expense, as often as it judges necessary, if the proof submitted is not satisfactory to the insurer.

EXTENSION OF BENEFITS

Unless otherwise specifically mentioned for a particular benefit, the insurer pays the disability benefits provided in the present benefit for the entire disability period which began when the benefit was in force, and for provided that disability persists, and the conditions of the contract are met. If the benefit is terminated, benefits will continue to be paid as if the benefit had remained in force subject to the terms of the present benefit, as well as the laws in force.

DEDUCTION AT SOURCE

The insurer deducts from each benefit payment the amounts imposed by the Tax Act.

TERMINATION OF BENEFITS

Benefits terminate on the first of the following dates:

- a) the date of the member's death;
- b) the date on which the member ceases to be disabled;
- c) the date on which the member is unable to provide proof of his disability or refuses to provide such proof;

- d)** the date on which the member refuses or neglects to submit to a medical examination as requested by the insurer;
- e)** the date the member begins a remunerative occupation, unless he has the insurer's authorisation for rehabilitative employment, or the date on which he accomplishes one of the duties of his regular occupation other than through a rehabilitation program;
- f)** the date on which the member refuses without good reason totally or partially to participate in a rehabilitation program established and funded by the insurer to facilitate his return to the labour market and which the insurer's physicians and rehabilitation professionals deem reasonable and appropriate;
- g)** the date on which the member receives a retirement income, other than the one he was receiving at the beginning of disability while he was actively at work.

TERMINATION OF INSURANCE

In addition to the reasons for the termination of the member's insurance benefit stipulated in the section entitled "General Provisions" of the present policy, the insurance for this benefit will terminate at the earliest of the following dates at midnight:

- a)** the termination date or age limit stipulated in the "Summary of Benefits";
- b)** the member's retirement date, if earlier.

LONG-TERM DISABILITY BENEFIT

PURPOSE

The purpose of coverage is to replace in part the employment income loss incurred by an member during a period of total disability starting after the effective date of this benefit.

EXCLUSIVITY OF BENEFIT

No long-term disability benefits are payable until short-term disability benefits have expired.

ELIGIBILITY

To be eligible to the long-term disability benefit, an employee must be covered under the life insurance benefit.

ELIMINATION PERIOD

The elimination period is the period stipulated in the "Summary of Benefits" of the present policy.

REMISSION PERIOD PERMITTED

A period of one hundred and eighty (180) days immediately following the date a person ceases to be totally disabled.

BENEFIT AMOUNT

The benefit amount for each month of disability is stipulated in the "Summary of Benefits".

INDEXATION OF BENEFITS

When the disability benefit is indexed, the amount of benefit payable will be adjusted on the first day of January of each year following the first complete year of disability, excluding the elimination period, as per the indexation rate defined by the Quebec Pension Plan up to the maximum annual indexation rate indicated in the "Summary of Benefits".

EVIDENCE OF INSURABILITY

When the amount of monthly benefit exceeds the maximum amount of insurance without evidence of insurability stipulated in the "Summary of Benefits", the member is covered for the excess only if he submits proof satisfactory to the insurer. Subsequently, any increase in the amount of benefit will become effective only after the required evidence of insurability has been accepted by the insurer.

REDUCTION OF BENEFIT DUE TO INTEGRATION OF BENEFITS

Under the present article, the insurer pays a monthly disability benefit according to the lesser amount under paragraphs A) and B) that follow:

a) DIRECT INTEGRATION OF BENEFITS

The member is eligible only for disability benefits of the present benefit and those provided for by government plans.

The amount of disability benefits payable by the insurer is reduced by the amount of the initial basic benefits; without regard to subsequent increases due to indexation, payable under the following laws or plans, such as:

- the Quebec pension Plan or the Canada Pension Plan;
- the Occupational health and Safety Commission;

- the Automobile insurance Act in Quebec or Ontario;
- any other law providing income in case of disability.

However, this article only refers to the above-mentioned benefits whose payment started at the beginning or after the beginning of total disability.

If an member refuses or neglects to submit a request for benefits under the laws or plans mentioned above, when informed by the insurer that he could be eligible for such benefits, the insurer reserves the right to reduce from the benefits payable an estimate of benefits that could be provided by these laws or plans.

b) INDIRECT INTEGRATION OF BENEFITS

The member is eligible for additional disability benefits other than those of the preceding paragraph a).

If the member receives disability income that is greater than the maximum percentage of income permitted as specified in the "Summary of Benefits" and based on the member's income at the beginning of disability, the disability benefit is reduced so that the total amount of disability income does not exceed the maximum employment income at the beginning of disability. In calculating the maximum only the initial amounts of benefits will be considered without regard to subsequent increases due to indexation.

Other disability income amounts that are considered in the calculation mentioned in the preceding paragraph are:

- 1) any remuneration paid by an employer due to a salary continuation policy, holidays, sick days or any other benefits program established by the employer.
- 2) all annuities or benefits payable under the following laws or plans, such as:
 - the Quebec Pension Plan or the Canada Pension Plan;
 - the Occupational Health and Safety Commission;
 - the Automobile Insurance Act in the province of residence;
 - any other law providing income in case of disability.
- 3) any disability benefits payable under an insurance contract or a retirement plan.

MAXIMUM DISABILITY INCOME

For the purpose of this article, the maximum disability income is calculated by applying the percentage stipulated in the "Summary of Benefits":

- a) to the employee's gross income, if benefits payable by the insurer are taxable;
- b) the employee's net income, if benefits payable by the insurer are non taxable.

If an member refuses or neglects to submit a request for benefits with regards to such laws when eligible to such benefits, the insurer reserves the right to reduce from benefits payable an estimate of benefits that could be provided by these laws.

BENEFITS PAYMENT

Disability benefits are payable at the end of each month of disability, after the expiry of the elimination period.

For a period of disability that is less than one (1) month, the insurer pays one thirtieth (1/30th) of the monthly benefit for each day of total disability.

Benefits are payable for as long as the total disability period persists, without however, exceeding the maximal duration or the age limit as stipulated in the "Summary of Benefits".

REHABILITATION ASSISTANCE

If an member who has been totally disabled during at least the elimination period submits to a rehabilitation program approved by the insurer, he may retain the monthly disability benefits, in addition to any remuneration paid under the rehabilitation program. The rehabilitation status may be granted for a maximum period of twenty-four (24) months.

The monthly rehabilitation allowance is equal to the amount of the monthly benefits minus an amount equal to 50 % of the work income attained during the rehabilitation program.

The sum of income from the rehabilitation program and the monthly benefits may not, however, exceed one hundred per cent (100%) of the member's earned income at the beginning of disability; the benefits payable under this benefit will be reduced by any amount in excess of one hundred per cent (100%) of the member's earned income. The earned income is the employee's gross salary if the benefit is taxable or the net salary if the benefit is non-taxable.

The insurer may assist the member in any manner to encourage him to return to his regular occupation or any other remunerative occupation compatible with his state of health.

EXTENSION OF BENEFITS

Unless otherwise specifically mentioned for a particular benefit, the insurer pays the disability benefits provided in the present benefit for the entire disability period which began when the benefit was in force and for provided that disability persists, and the conditions of the contract are met. If the benefit is terminated, benefits will continue to be paid as if the benefit had remained in force, subject to the terms of the present benefit, as well as the laws in force.

DEDUCTION AT SOURCE

The insurer deducts each benefit payment the amounts imposed by the Income Tax Act.

EXCLUSIONS

No benefit is payable in the following cases:

- a) the member's participation in a criminal act or attempted criminal act;
- b) the member's active participation in a civil commotion, riot, insurrection or military operation during war, whether war is declared or not;
- c) the member's participation in an aerial flight, other than as a fare-paying passenger on a regular or chartered flight;

- d) a disability caused by a self-inflicted wound or mutilation, regardless of the member's state of mind;
- e) the fact of having suffered from body lesions while his ability to drive was impaired, because of diminished faculties due to the consumption of alcohol or drugs;
- f) the member's participation in land or water motor vehicle races, scuba diving, parachute jumping, free-fall or otherwise, bungee jumping, gliding or sail flights, or any other dangerous similar activity or sport;
- g) surgery not necessary for the member's health, for cosmetic or non-medically required care;
- h) during a period where an member stays more than fifteen (15) days outside of Canada;
- i) disability that occurs during a maternity leave provided for under provincial or federal law or an agreement with the employer;
- j) lumbago or back pain which diagnosis can only be made subjectively by the member's description of symptoms and cannot be supported by appropriate tests prescribed by a physician;
- k) period during which the member is not under the regular care of a specialist able to treat his illness, or if he does not receive proper therapy for his condition, or refuses such therapy;
- l) period during which the member is not under the care of a physician; the period of total disability may not start before the date of the first medical visit for the disability in question;
- m) disability that began before the effective date of the insurance;
- n) disability resulting from a work related accident or occupational illness unless otherwise stipulated in the "Summary of Benefits".

RESTRICTIONS

The amount of monthly benefits payable under the present benefit as well as disability benefits from all other sources cannot exceed the maximum percentage of the net income when benefits are non-taxable or the maximum gross income when benefits are taxable, as stipulated in the "Summary of Benefits".

When the member was not covered by an equivalent benefit and total disability begins within the twelve (12) month period following the effective date of the present benefit, no benefit is payable for an illness or an accident for which the member consulted a physician or other health professional, or received a medical treatment, or underwent an examination or diagnostic tests, or took medication, during the ninety (90) day period immediately preceding the effective date of the present benefit for an member.

TERMINATION OF BENEFITS

Benefits terminate on the first of the following dates:

- a) upon the member's death;
- b) the date the member ceases to be disabled;

- c) the date on which the member is unable to provide proof of his disability or refuses to provide such proof;
- d) the date on which the member refuses or neglects to submit to a medical examination as requested by the insurer;
- e) the date the member begins a remunerative occupation, unless he has the insurer's authorisation for rehabilitative employment, or the date on which he accomplishes one of the duties his regular occupation other than through a rehabilitation program;
- f) the date on which the member refuses without good reason totally or partially to participate in a rehabilitation program established and funded by the insurer to facilitate his return to the labour market and which the insurer's physicians and rehabilitation professionals deem reasonable and appropriate;
- g) the date on which the member receives a retirement income, other than the one he was receiving at the beginning of disability while he was actively at work.

TERMINATION OF INSURANCE

In addition to the reasons for the termination of the member's insurance benefit stipulated in the section entitled "General Provisions" of the present policy, the insurance for this benefit will terminate at the earliest of the following dates at midnight:

- a) the termination date or age limit stipulated in the "Summary of Benefits";
- b) the member's retirement date, if earlier.

HEALTH INSURANCE BENEFIT

This benefit includes hospitalization insurance and Medical and Paramedical Expenses Insurance.

PURPOSE

The purpose of coverage is to refund eligible expenses following hospitalization and medical and paramedical expenses incurred following an accident or illness by an insured while this benefit is in force.

ELIGIBILITY

Only persons covered by the governmental health insurance program of their province are eligible for the health insurance benefit.

HOSPITALIZATION

The purpose of hospitalization insurance is to refund an amount for each day that an insured person, due to illness or injury, spends in a hospital or a rehabilitation centre upon recommendation of a physician.

a) SHORT-TERM HOSPITALIZATION

The cost to stay in a hospital room as stipulated in the "Summary of Benefits" in a hospital for short-term care, less the fees that are refunded or refundable by a governmental insurance plan.

Eligible short-term care includes prevention, medical diagnosis and medical treatment for acute illnesses.

b) CONVALESCENCE AND PHYSICAL REHABILITATION

The cost to stay in a hospital room as stipulated in the "Summary of Benefits" in a physical rehabilitation centre or in a hospital, part of which is reserved for convalescence or physical rehabilitation care, less the fees that are refunded or refundable under a governmental insurance plan.

The insured person must be admitted within fourteen (14) days after leaving the hospital for which he was receiving short-term care or had been admitted for less than one (1) day for an operation requiring local anaesthesia. Eligible expenses are limited to a maximum period as stipulated in the "Summary of Benefits" for convalescence and physical rehabilitation combined.

DEFINITIONS OF INSTITUTIONS

a) HOSPITAL

Means a hospital center for short-term or long-term care as established by the laws in force, excluding part of such centre reserved for prolonged care.

b) REHABILITATION CENTRE FOR PHYSICAL DEFICIENCY

Means a centre offering physical rehabilitation services as established by the laws in force, excluding centres that are reserved for persons with a mental deficiency, or for youths or mothers with difficulties to adapt, or for alcoholics and drug abusers.

A hospital or rehabilitation centre for physical deficiency does not include a local centre for community services, a centre for youth and child protection, a lodging house or long-term care centre, a clinic, a hospital for the care of psychiatric illnesses or tuberculosis, a sanatorium, a home for the elderly, a rest or retirement home, a thermal station, a centre for AIDS victims or any other establishment whose main function is custodial care.

AMOUNT OF BENEFITS FOR HOSPITALIZATION

Eligible hospital or rehabilitation centre expenses are refunded at one hundred per cent (100%) without any deductible.

a) HOSPITALIZATION IN THE INSURED'S PROVINCE OF RESIDENCE

If the insured person is hospitalized in his province of residence, the insurer refunds, for each day in hospital, an amount equal to the cost of room and board charged by the hospital without, however, exceeding the cost of the type of room stipulated in the "Summary of Benefits" provided by the Quebec Hospitalization Act, including annual indexation.

The number of days in a hospital that is refundable in a period of twelve (12) consecutive months for a particular illness or accident is stipulated in the "Summary of Benefits".

b) HOSPITALIZATION OUTSIDE THE INSURED'S PROVINCE OF RESIDENCE

If the insured person is hospitalized outside his province of residence, the insurer refunds for each day in hospital, an amount equal to the cost for room and board requested by the hospital, without, however, exceeding the cost of a semi-private room, less any amount provided under the Quebec Hospitalization Act, including annual indexation.

The number of days in a hospital that is refundable in a period of twelve (12) consecutive months for a particular illness or accident, is stipulated in the "Summary of Benefits".

MEDICAL AND PARAMEDICAL EXPENSES

The purpose of medical and paramedical expenses insurance is to refund, in part, eligible expenses incurred for medical and paramedical treatments following an accidental injury, an illness or pregnancy.

For each insured person under the present benefit, the percentage of refund is applied on each amount of incurred expenses for treatment, visit or purchase of supplies as well as on each maximum amount per policy year for the medical and paramedical expenses enumerated in the article "Eligible medical and paramedical expenses" of this section.

BENEFIT AMOUNT

The benefit amount is derived by deducting the deductible from the eligible expenses and by multiplying the difference by the percentage of refund. The maximum amount of eligible benefits for medical and paramedical expenses are specified in the "Summary of Benefits".

ELIGIBLE MEDICAL AND PARAMEDICAL EXPENSES

The following expenses, excluding paramedical care, are covered on the condition that they are prescribed by a physician and are necessary for treatment of an illness or an accident and are normal and reasonable with current medical procedures. When a medical recommendation is required for paramedical care, a note is inscribed in the “*Summary of Benefits*”.

- a) If the “Summary of Benefits” stipulates “enlarged list”, only drugs obtained with the prescription of a physician or dentist are refundable.

If the “Summary of Benefits” stipulates “restrictive list”, only drugs that require the prescription of a physician are refundable.

If the “Summary of Benefits” stipulates “RAMQ list”, only the drugs published on the list of the Régie d’assurance maladie du Québec are refundable. Some of these drugs are however only refundable under the conditions and therapeutic indications determined by rules published by the RAMQ.

Also eligible are drugs prescribed by a physician where the therapeutic need is directly related to the following pathological conditions:

- cardiac problems;
- pulmonary problems;
- diabetes;
- arthritis;
- Parkinson's disease;
- epilepsy;
- cystic fibrosis;
- glaucoma.

In the event of a lay-off, a strike or a lock-out, the coverage for drug insurance is extended for a thirty (30) day period following the starting date of the lay-off, the strike or the lock-out. The premium corresponding to this extension period must be paid to the insurer.

An insured living in Quebec who has attained the age of sixty-five (65) may choose to be insured under the public plan provided for in the Loi de l’assurance médicaments du Québec rather than remaining insured under the present benefit. If this is the case, the insured is no longer eligible for benefits under the present contract and he may no longer be reinstated to the group insurance plan with regards to drug insurance.

- b) the purchase of one IUD per calendar year;
- c) the purchase of reactive sticks, syringes and needles for diabetics;
- d) the purchase of miscellaneous items necessary following colostomy, ileostomy or ureterostomy;
- e) in emergency situations, the cost of transportation to a hospital in a duly authorised ambulance, as well as transportation by railway or by air to the nearest hospital, if the insured person cannot be transported in any other manner;

- f) care by a licensed nurse at the insured person's home, upon presentation of a medical report, eligible up to a maximum amount and the period indicated in the "Summary of Benefits";
- g) the purchase of made-to-measure orthopaedic shoes, sold by a specialised orthopaedic laboratory. In any calendar year, these purchases are limited to the number of pairs and eligible maximum amount indicated in the "Summary of Benefits", as well as for a child less than or over sixteen (16) years of age, subject to the overall eligible maximum indicated in the "Summary of Benefits". These articles may also be prescribed by a podiatrist;
- h) the purchase of corrective items added to ordinary shoes, orthoses or plantar supports, eligible up to a maximum eligible amount and period indicated in the "Summary of Benefits". These items must be sold by a specialised orthopaedic laboratory and may also be prescribed by a podiatrist;
- i) the purchase of elastic stockings sold by a specialty house, up to the number and period indicated in the "Summary of Benefits";
- j) the purchase or repair of a hearing aid, up to the maximum eligible amount and period indicated in the "Summary of Benefits";
- k) the purchase of external mammary prosthesis necessary following mastectomy, in excess of the amount covered by a governmental plan, up to the maximum amount and period indicated in the "Summary of Benefits";
- l) the purchase of an initial capillary prosthesis necessary following chemotherapy, eligible up to the maximum amount and period indicated in the "Summary of Benefits";
- m) rental or purchase, whichever is deemed more economical by the insurer of a basic manual wheelchair, a manual hospital bed and crutches, when required for temporary therapeutic use. The insured must obtain the insurer's authorisation to purchase or rent any equipment. Failure to obtain authorisation from the insurer may result in the refusal of the claim;
- n) the initial purchase (not the replacement) or rental, not exceeding the initial cost of prosthesis (other than dental), as defined by the Régie de l'assurance maladie du Québec, eligible up to the maximum amount and period indicated in the "Summary of Benefits";
- o) blood transfusions or its derivatives, dressings;
- p) anaesthetic products;
- q) expenses for eye examination performed by an ophthalmologist or by a licensed optometrist for insured persons between the ages of eighteen (18) and sixty-four (64), eligible up to a maximum amount and period indicated in the "Summary of Benefits";
- r) when deemed necessary for prevention or diagnosis, the following expenses are refundable:
 - laboratory analysis, subjected to a maximum eligible amount of \$150 per calendar year;

- x-ray tests such as computer tomographies (scanners), ultrasounds, electrocardiograms, mammograms, x-rays (except for teeth and orthosis), subjected to a maximum eligible amount of \$300 per calendar year;
 - nuclear magnetic resonance imaging, subject to a maximum eligible amount of \$500 per calendar year;
- s)** the purchase or repair of an appliance to measure the rate of glucose in the blood of an insulin-dependent diabetic is payable upon presentation of a physician's complete report attesting to the insured's insulin dependency, eligible up to the maximum amount and period indicated in the "Summary of Benefits";
- t)** paramedical treatments; the fees for paramedical services given by:
- chiropractor;
 - psychologist, psychoanalyst, psychiatrist, social worker;
 - physiotherapist, ergotherapist, orthotherapist;
 - audiologist, orthophonist, osteopath, podiatrist, naturopath;
 - acupuncturist;
 - dietician;
 - massotherapist.

The maximum amount and number of visits per calendar year for each above-mentioned specialist or each grouping of specialists are indicated in the "Summary of Benefits";

In addition, eligible expenses per insured person are limited to one (1) visit per day per specialist. Specialists must be members of their professional association and provide services that fall within their specialty;

- u)** x-rays taken by a chiropractor for an insured person are limited per calendar year to the maximum amount indicated in the "Summary of Benefits";
- v)** nursing care services rendered at the insured's home required after a hospitalization or surgical intervention requiring local anaesthesia performed at the hospital. Expenses are refunded up to the eligible maximum amount and period indicated in the "Summary of Benefits". The nurse must be a member of the l'Ordre des infirmiers du Québec (OIIQ) or infirmier en pratique privée du Québec (IIPPQ);
- w)** the purchase or hernial bandages, corsets or orthopaedic bandages, splints, casts;
- x)** rental or purchase, whichever is deemed more economical by the insurer, of a breathing assistance apparatus and oxygen. The insured must obtain authorisation from the insurer before making any purchase or rental. Failure to obtain this authorisation may result in the insurer's refusal of the claim. The maximum eligible amount and period are indicated in the "Summary of Benefits";
- y)** rental or purchase, whichever is deemed more economical by the insurer, of a transcutaneous electric neurostimulator apparatus (tens). The insured must obtain authorisation from the insurer before making any purchase or

rental. Failure to obtain this authorisation may result in the insurer's refusal of the claim. The maximum eligible amount and period are indicated in the "Summary of Benefits";

- z)** fees for the substance used in medically required sclerosant injections administered by a physician. The maximum amount and period are indicated in the "Summary of Benefits".

DENTAL CARE AS A RESULT OF AN ACCIDENT

Expenses for dental care provided by a dental surgeon, outside a hospital when necessary following an accidental injury to natural, healthy and whole teeth, that occur while the person is insured and providing that treatment is given within twelve (12) months of the accident. Fees must be incurred in the province of residence and are eligible up to the maximum amount indicated in the "Summary of Benefits".

PROOF OF CLAIM

Eligible expenses are refundable upon presentation of original receipts.

To establish proof of claim, the insured must submit to the insurer original receipts from the suppliers providing treatments or products.

The insured must submit to a medical examination when the insurer is justified in requesting it considering the type of treatments that are required by the insured person's state of health. In the event of a medical examination, the physician is designated and paid by the insurer.

The insurer may also request, at the insured's expense, a report from the health professional that is treating the insured person. The insurer may request declarations from the person claiming benefits, as well as the use of the insurer's forms.

EXTENSION

Upon the member's death, the health insurance for insured dependants under the present benefit is extended without payment of premiums, up to the earliest of the following dates:

- a)** twenty-four (24) months after the member's death;
- b)** the date a dependant no longer meets the requirements mentioned in the definition of a dependant;
- c)** the termination date of the present benefit.

TREATMENTS OUTSIDE OF THE INSURED'S PROVINCE OF RESIDENCE

a) REQUIRED CONDITIONS

To be eligible, expenses for care outside the province of residence must meet the following conditions:

- 1)** In case of a medical consultation or hospitalization following an accident or sudden illness, the insured must communicate with the

medical assistance service, failure to do so may result in the refusal of the claim;

- 2) treatments are necessary following an emergency situation resulting from an accident or sudden illness occurring outside the insured's province of residence and the situation was not reasonably foreseeable at departure;
- 3) on the day of departure, the insured person must be less than seventy (70) years of age, nor be retired, nor be more than seven (7) months pregnant;
- 4) at departure, the anticipated stay outside of the insured's province of residence is less than ninety (90) days, and the insured must be covered by the government health plan of his province of residence. However, the stay may be prolonged provided that the reason is due to an illness or of an accident that occurred within the ninety (90) day period and due to justifiable medical reasons the return to his province of residence is impossible;
- 5) the expenses that are incurred due to a sudden illness or accident must occur within ninety (90) days following the departure date;
- 6) expenses are no longer admissible as of the date the patient is able to return to his province of residence by his own means or can be repatriated under medical supervision;
- 7) for an insured aged sixty-five (65) or over, treatments must not be related to a medical condition for which the insured person was hospitalized, has received or was prescribed a medical treatment or has consulted a physician in the ninety (90) days preceding the date of departure, unless proof satisfactory to the insurer is given that the condition affecting the insured person is stable. A change in medication, its posology or use is considered to be a medical treatment.

b) BENEFIT AMOUNT

Notwithstanding the percentage of refund of eligible expenses indicated in the "Summary of Benefits", eligible expenses outside the insured's province of residence for hospitalization, medical and surgical care including drugs that require a prescription from a physician, are refundable at one hundred per cent (100%).

c) THE MAXIMUM PAYABLE

The maximum amount of eligible expenses refunded by the insurer for outside the insured's province of residence is limited to one million dollars (\$1,000,000) during the insured's lifetime.

REDUCTION OF BENEFITS DUE TO COORDINATION OF BENEFITS

In an insured covered under another insurance contract for part or all of the expenses foreseen in the present contract, the benefits payable by the insurer will be adjusted so that the total amount of benefits under all contracts does not exceed one hundred per cent (100%) of eligible expenses under the present benefit.

In addition, the priority of payment of benefits will be determined in the following manner:

- a) if another contract does not contain the coordination of benefits clause, the benefits of this other contract are to be paid before benefits of the present contract;
- b) if another contract has the coordination of benefits clause, priority of payment will be given to the contract under which the person who is entitled to benefits:
 - 1) is not a dependant, or;
 - 2) is an member's dependant whose day and month of birth is first to occur in the calendar year.

If it is impossible to determine the priority of payment under the manner stipulated above, benefits under all contracts will be subjected to a proportional calculation based on the amounts that would have been paid under each contract, as if only one contract had existed.

EXCLUSIONS

No benefit is payable for losses resulting from the following causes or incidents:

- a) the insured person's participation in a criminal act or attempted criminal act;
- b) injury or illness resulting from the insured person's active participation in a civil commotion, riot, insurrection or military operation during war, whether war is declared or not;
- c) the insured person's participation in an aerial flight, other than as a fare-paying passenger on a regular or chartered flight;
- d) suicide or any self-inflicted wound or mutilation, regardless of the insured person's state of mind;
- e) the fact of having suffered from body lesions while driving a vehicle with diminished faculties due to the consumption of alcohol or drugs;
- f) the insured person's participation in land or water motor vehicle races, scuba diving, parachute jumping, free-fall or otherwise, bungee jumping, gliding or sail flights, or any other dangerous similar activity or sport;
- g) incurred expenses for surgery or an elective or non-urgent treatment, or when a trip outside the province of residence was undertaken with the intention of receiving a medical treatment or hospital services, regardless of whether the trip was recommended by a physician or not;
- h) incurred expenses for treatment not medically required, or for cosmetic purposes or treatments that exceeds usual care normally applied for therapeutic purposes;
- i) all expenses that are payable or refundable under any governmental insurance plan or normally would be, or private plan;

- j) all expenses in excess of those considered reasonable, taking into consideration the importance of the situation, the normal rates in the region and the procedure that is normally used;
 - k) all treatments or services that are provided free of charge or that would be free in the absence of insurance or that are not at the insured's expense;
 - l) expenses incurred for a health trip, a rest cure, diet purposes or weight-loss treatments;
 - m) treatments or services given by a member of the insured person's immediate family;
 - n) medical expenses resulting from illness or injury caused by employment or occupation for pay or profit, unless the member benefits from professional risk insurance coverage with regards to the present benefit;
 - o) expenses for varicose vein injections in the lower limbs, regardless of whether they are for medical purposes or not;
 - p) any drug that is available to the general public without a medical prescription.
- N.B.** Exclusions a) and b) do not apply to refundable drugs published on the list of the Régie d'assurance-maladie du Québec (RAMQ).

The following are not considered as drugs for the purpose of this benefit and are therefore not refundable:

- aa) milk, regardless of its nature, or milk substitutes;
- bb) proteins, dietary supplements, food, homeopathic or so called natural products;
- cc) products for aesthetic or cosmetic care;
- dd) products, hormones and injections for cellulites or obesity treatment, including anorexiant;
- ee) products or medication used for eliminating the use of tobacco;
- ff) mineral waters;
- gg) disinfectants, lubricating eye drops and solutions for contact lenses;
- hh) soaps, oils, shampoos and other hair products, emollients, creams and cough drops;
- ii) vitamins;
- jj) drugs administered for preventive measures. Under this exclusion, a drug used to stabilise or regulate a pathological state diagnosed by a physician is not considered as a preventive drug;
- kk) drugs or substances used in the treatment of infertility or impotence;
- ll) all substances used for insemination or contraceptive gels or foams;
- mm) anabolic steroids, growth hormones or experimentally administered drugs;

- nn)** all expenses arising from an illness or accident falling under the authority of the CSST or the Société de l'assurance automobile du Québec (SAAQ);
- oo)** drugs provided during hospitalization.

The insurer reserves the right to exclude or modify the premium on the date Health Canada approves any new drug having a significant effect on the cost of the benefit.

N.B. Notwithstanding the preceding, all medical expenses payable by the RAMQ list are also payable under this policy. Some of these expenses are however only covered under the therapeutic cases, conditions and indications determined by the rules published by the RAMQ.

TERMINATION OF INSURANCE

In addition to the reasons for the termination of the insured's insurance stipulated in the section entitled "General provisions" of the present policy, the insured's insurance for this benefit will terminate on the earliest of the following dates at midnight:

- a)** the termination date or age limit stipulated in the "Summary of Benefits";
- b)** the retirement date, if earlier;
- c)** for a dependant, on the date he no longer meets the definition of a dependant.

TRAVEL ASSISTANCE SERVICE AND TRIP CANCELLATION

TRAVEL ASSISTANCE SERVICE

PURPOSE

The purpose of this service is to offer an insured travel assistance service during a trip outside the province of residence and to refund the eligible expenses.

Hospital, medical or paramedical and drug expenses incurred outside the insured's province of residence are refundable under the terms of the health insurance benefit and not under the present service.

The insurer, in collaboration with the medical assistance service and its coordination centres, offers the services described hereafter which are complementary to those offered under the health insurance benefit providing that these charges are not excluded under the article entitled "Exclusions" of the health insurance benefit.

ELIGIBILITY

An insured covered under the health insurance benefit of the present policy is automatically eligible for Travel Assistance Service, provided that he is under seventy (70) years of age.

THE SERVICE

a) TELEPHONE SERVICE

Telephone access, toll free, to coordination centres, twenty-four (24) hours per day and seven (7) days per week, for the following multilingual assistance services, following an emergency while the insured person is travelling outside the province of residence.

b) MEDICAL ASSISTANCE

Following an accident or sudden illness, if the insured person must consult a physician or be hospitalized, he must immediately call the medical assistance service, which will make the necessary arrangements in order to provide the following services:

- for the state of Florida, direct the insured to an appropriate clinic or hospital, member of the Preferred Patient Care network;
- for all other destinations, direct the insured to an appropriate clinic or hospital and advance funds to the hospital, if necessary;
- confirm the medical insurance coverage so that the insured does not have to pay a substantial deposit;
- follow up on the medical file and communicate with the family physician;
- coordinate the insured's claim with the governmental health insurance plan of his province of residence and, if applicable, the automobile insurance plan of his province of residence.

c) MEDICAL TRANSFER

Following the recommendation and at the sole discretion of the physician designated by the medical assistance service, in consultation with a local attending physician signalling the necessity of transferring the insured to another hospital or treatment centre, or to repatriate the insured to his province of residence to receive treatment, the medical assistance service will make the necessary arrangements, and pay the cost, to transfer the insured, under proper medical supervision. Any repatriation refusal cancels all rights to benefits and a termination notice to the insured will be sufficient.

The decision as to the necessity of transferring or repatriating an insured is the exclusive medical decision of the designated physician appointed by the medical assistance service.

The decisions related to the means or dates of transfer of medical appliances, of medical supplies, of medical staff to be used for the transfer and the final destination of the insured, are also considered medical decisions exclusive to the physician appointed by the medical assistance service.

RESTRICTIONS

The insurer and the medical assistance service are not responsible for the availability or the quality of medical and hospital care administered, or the impossibility of obtaining such care.

ELIGIBLE EXPENSES

a) IN THE EVENT OF DEATH

In the event of death of an insured, the medical assistance service will be responsible for all the necessary formalities and will arrange for the transportation of the deceased to his province of residence. The refundable amount is limited to three thousand dollars (\$3,000), excluding the cost of embalming, coffin and funeral.

The cost of cremation or burial at the place of death is limited to one thousand five hundred dollars (\$1,500).

b) RETURN OF DEPENDANT CHILDREN

If an insured is hospitalized or dies leaving his dependant children who accompanied him without supervision, the necessary arrangements will be taken to organise supervision and settle their transport in economy class, accompanied when required, to their residence in Canada. If the children's travel tickets have not expired, only the additional cost of the return trip ticket will be refunded. If, on the other hand, the travel tickets have expired, necessary arrangements will be taken for the return trip by the most economical means. This cost is limited to two thousand dollars (\$2,000) for all children.

c) RETURN OF A TRAVELLING COMPANION

If an insured dies, or is hospitalized for one day or more, resulting in his travelling companion having to change his return flight, the necessary arrangements will be taken to organise and settle his transport in economy class for his return to his original destination in the insured's province of residence. If the travelling companion's travel ticket is not expired, only the additional cost of the return trip ticket will be refunded. If, on the other hand, the travel ticket is expired, necessary arrangements will be taken for the return trip by the most economical means. This cost is limited to one thousand five hundred dollars (\$1,500).

d) VISIT BY A FAMILY MEMBER

If an insured who travels alone dies, or is hospitalized for seven (7) or more consecutive days, the medical assistance service will make the necessary travel arrangements according to the most economical return trip, to have a family member visit the insured at the hospital where he is staying or to identify the deceased prior to transport. These costs are limited to one thousand five hundred dollars (\$1,500), and to one visitor only.

e) RETURN OF A VEHICLE

If an insured travelling with his personal vehicle is unable to use his vehicle due to sickness or accident, the medical assistance service will organise and settle the return of the vehicle to the insured's residence. These costs are limited to seven hundred and fifty dollars (\$750).

f) SUBSISTENCE ALLOWANCE

If, following the insured's hospitalization for a period of more than twenty-four (24) hours, or following his death, costs for room and meals are incurred by the insured person or his travelling companions, because of a change in departure, or due to a visiting family member, these costs are reimbursed up to one hundred and fifty (\$150) per day and a total maximum of one thousand two hundred (\$1,200) for all persons covered.

g) LEGAL ASSISTANCE OR BAIL

When necessary, the medical assistance service will intervene to facilitate the organisation and depositing of funds for bail raised amongst family members or friends of the insured. The medical assistance service will assist any insured person with legal counsel when involved in a highway accident or guilty of offences to the highway code or any other legal infractions excluding criminal acts. However, the insured is responsible for choosing his lawyer, and the legal fees.

Health professionals or legal advisors recommended or designated by the medical assistance service are neither their employees nor their agents. Consequently, neither the medical assistance service nor the insurer may be held responsible for any negligence or omissions committed by these professionals or advisors.

BENEFIT REDUCTION DUE TO COORDINATION OF BENEFITS

If an insured is entitled to similar benefits under any other insurance contract, the benefits payable will be limited to the insurer's proportional share of the total eligible incurred expenses.

INSURED'S OBLIGATION

If, following an accident or sudden illness, the insured must contact the medical assistance service or one of its coordination centres as soon as possible. Failure to do so may result in claims being denied.

RESTRICTIONS

- a) The medical assistance service reserves the right to interrupt, shorten or restrict travel assistance services in any part of the world, in the event of rebellion, riot, military insurrection, war, work conflict or strike, nuclear accident, natural disaster, or in the event when the country's authorities forbid the medical assistance service to offer services. However, the medical assistance service will do everything that is possible to provide services under such circumstances.
- b) In the absence of medical contraindication, the insurer may require repatriation of any insured person or his transfer to other medical facilities. Refusal of repatriation by the insured person ends the insurance and notice or termination to the insured will be sufficient.
- c) No fees will be paid nor any assistance provided to an insured by the insurer or the medical assistance service when expenses are incurred as the result of a trip in his province of residence.

PROOF OF CLAIM

Eligible expenses are refundable upon presentation of original receipts.

To establish proof of claim, the insured must submit to the insurer original notes or bills from the suppliers of care or products.

In the event where the medical assistance service settles different accounts, they will submit to the insurer medical bills paid for the insured.

The insured must submit to a medical examination by a physician of the insurer's choice and at the insurer's expense, when the request is justified with regards to the nature of treatments required for the insured's state of health.

The insurer may also request, at the insured's expense, a report from the health professional treating the insured person. The insurer may require declarations from the insured presenting a claim and require the use of company forms.

TRIP CANCELLATION

TRIP CANCELLATION INSURANCE BENEFIT

a) REQUIRED CONDITIONS

To be eligible, the fees for the trip cancellation must meet the following conditions:

- 1) They are paid in advance by the insured while this benefit is in force;
- 2) At the time to finalise the arrangements for travel, the insured is not aware of the event that could reasonably lead to the cancellation or interruption of the planned trip;
- 3) The present benefit is in force at the time of the planned trip period;

b) BENEFIT AMOUNT

The insurer reimburses one hundred percent (100%) of the eligible fees up to five thousand dollars (\$5,000) per insured per trip.

c) SPECIFIC DEFINITIONS TO THE TRIP CANCELLATION INSURANCE

In the present policy, unless one of the benefits, a change, an amendment or the Summary of Benefits stipulates otherwise, we hereby define:

1) ACTIVITY OF A COMMERCIAL NATURE

Meeting, congress, convention, exhibition, show or seminar, of a professional or commercial nature, such activity must be public, under the responsibility of an official organisation and in compliance with the laws, regulations and policies in effect in the region in which the activity is scheduled to be held, and which is the only reason for the planned trip.

2) BUSINESS ASSOCIATE

The person with whom the insured is associated within a company of 4 co-shareholders or less, or for profit-sharing society of 4 associates or less.

3) TRAVELING COMPANION

The person with whom the insured shares the room or apartment at the destination or whose expenses were paid with those of the insured.

4) TRAVEL EXPENSES PAID IN ADVANCE

Amount paid by the insured for the purchase of a package deal, a ticket from a public carrier or for the rental of a motorised vehicle from an accredited agency. The following amounts are also eligible:

- Amount paid relating to reservations for trip arrangements usually included in a package deal;
- Amount paid relating to registration fees for an activity of a commercial nature.

5) HOST AT DESTINATION

The person whose main residence must serve as the place of accommodations for the insured in accordance with a prior agreement.

d) ELIGIBLE CAUSES OF CANCELLATION OR INTERRUPTION

The trip must be cancelled or interrupted for one of the following causes:

- 1) An illness or accident preventing the insured or close family member, his traveling companion or his business associate from performing his usual activities and which is reasonably serious to justify the cancellation or interruption of the trip;
- 2) The death of the insured, of a close family member, of his traveling companion or of his business associate. The funeral must take place during the planned period of the trip or within the 14 days preceding it;
- 3) The death or emergency hospitalisation of the host at destination;
- 4) The notification of the insured or of his traveling companion to report for jury duty or their subpoena to appear as a witness in a trial to be heard during the period of the trip. The person convened must undertake the necessary steps to obtain a postponement the case to be heard. A summons to appear is not considered eligible for cancellation of the trip when the person concerned is the party prosecuted or intent to take proceedings;
- 5) The hijacking of the airplane in which the insured is traveling;
- 6) The putting of the insured into quarantine, except if such quarantine ends more than 7 days prior to the planned date of departure;
- 7) A loss making uninhabitable the main residence of the insured or the host at destination, providing that the residence must be uninhabitable 7 days or less prior to the planned date of departure or that the loss occurs during the trip;
- 8) The transferring of the insured for the same employer, 175 or more kilometres from his present domicile, within 30 days preceding the planned departure date;
- 9) A situation in the country where the insured is traveling that prompts the Canadian government to issue a recommendation not to travel to that country. This recommendation shall be in force for the period of travel and have been issued after the insured has finalised arrangements for the trip;
- 10) A loss occurring at the place of business or on the physical premises where an activity of a commercial nature is scheduled to be held and thereby making impossible the holding of the activity such that a written notice cancelling the activity is issued by the official organisation in charge of organising it;
- 11) The cancellation of a business meeting or an activity of a commercial nature following the death or hospitalisation of the person with whom

- the insured took prior arrangements for the meeting or the activity of a commercial nature. A written proof of those arrangements is necessary;
- 12) A departure missed due to a delay in the means of transportation used to get to the departure point or the departure point for a connection after the scheduled departure. The means of transportation used should include an arrival at least 3 hours before the departure. The cause for the delay must be mechanical difficulties (except for a private automobile), by a traffic accident or by the emergency closing of a road. Each of the last two causes must be backed up by a police report;
 - 13) The atmospheric conditions delaying the departure of the public carrier used by the insured, at the scheduled point of departure, at least 30% (48 hours minimum) of the planned duration of the trip or preventing the insured from making a planned connection with another carrier insofar as this latter carrier be delayed for at least 30% (48 hours minimum) of the planned duration of the trip.

e) ELIGIBLE EXPENSES

1) IN THE EVENT OF CANCELLATION PRIOR TO DEPARTURE

- a) The non-refundable portion of the planned trip expenses paid in advance;
- b) The additional expenses incurred by the insured who decides to travel alone in the event where his traveling companion must cancel his trip for one of the reasons provided by this benefit. The fees are refundable up to the amount of the penalty for cancellation applicable to the insured at the time when his traveling companion must make the cancellation;
- c) The non-refundable portion of the travel fees paid in advance, up to 70% of the said fees, if the departure of the insured is delayed due to atmospheric conditions and that he decides not to make the trip.

2) IN THE EVENT OF A MISSED DEPARTURE OR TRIP INTERRUPTION

The additional cost the most economical required by a public carrier (train, bus or air line) for a single ticket, with the fixed schedule, by most direct route, up to the planned destination.

The insured's departure must be missed due to a delay in the means of transportation as described in section 9.17 d) 13-.

The trip must be temporarily interrupted due to an illness or an accident sustained by the insured or his traveling companion, as described in section 9.17 d) 1-.

3) IF THE EVENT OF AN ADVANCED OR DELAYED RETURN

- a)** The additional cost the most economical required by a public carrier (train, bus or air line) for a single ticket, with the fixed schedule, by most direct route, up to the destination initially planned. These expenses must be agreed to in advance with the insurer;
- b)** The unused and non-refundable portion of the land part of travel fees paid in advance.

If the insured's return is delayed for more than 7 days following an illness or accident sustained by the insured or his traveling companion, incurred expenses are covered insofar as the person involved has been admitted to a hospital centre as an in-patient for more than 48 hours within the said 7 day period.

f) REDUCTION OF BENEFITS DUE TO COORDINATION OF BENEFITS

If an insured covered under another insurance contract for part or all of the expenses foreseen in the present contract, the benefits payable by the insurer will be adjusted so that the total amount of benefits under all contracts does not exceed one hundred percent (100%) of eligible expenses under the present benefit.

In addition, the priority of payment of benefits will be determined in the following manner:

- a)** if another contract does not contain the coordination of benefits clause, the benefits of this other contract are to be paid before benefits of the present contract;
- b)** If another contract has the coordination of benefits clause, priority of payment will be given to the contract under which the person who is entitled to benefits:
 - 1)** is not a dependant, or;
 - 2)** is a member's dependant whose day and month of birth is first to occur in the calendar.

If it is impossible to determine the priority of payment under the manner stipulated above, benefits under all contracts will be subject to a proportional calculation based on the amounts that would have been paid under each contract, as if only one contract had existed.

g) DEADLINE FOR REQUESTING CANCELLATION

In the event of cancellation prior to the departure, the trip must be cancelled with the travel agency or the carrier within a maximum delay of 48 hours, or if it is a holiday, the next business day. The insurer must be notified at the same time.

The insurer's liability is limited to the cancellation fees stipulated in the travel contract 48 hours after the date of the cause of cancellation, or on the first business day if it is a holiday.

However, this limitation does not apply if the insured and his spouse show, to the satisfaction of the insurer that they were in the total and absolute inability to act. In that case, the trip must be cancelled as soon as one of them is able to do so. The insurer's liability is then limited to the cancellation fees stipulated in the travel contract on that date.

h) SPECIFIC EXCLUSIONS APPLYING TO THE TRAVEL CANCELLATION INSURANCE BENEFIT

No benefit is payable for losses resulting from the following causes or incidents:

- 1) the insured or traveling companion's participation in a criminal act or attempted criminal act;
- 2) injury or illness resulting from the active participation of the insured or his traveling companion to a public confrontation, in a riot, insurrection or military operation, whether war is declared or not;
- 3) suicide or any injury or damage that the insured has inflicted, whether sane or insane;
- 4) the fact of having suffered from body lesions while driving a vehicle with diminished faculties due to the consumption of alcohol or drugs;
- 5) the insured's participation in a sport for consideration, in land or water motor vehicle races, scuba diving, parachute jumping, free-fall or otherwise, bungee jumping, gliding or sail flights, or any other dangerous similar sport or activity, ;
- 6) the trip is undertaken with the intention of receiving medical treatment or hospitalisation services, whether the trip has been recommended or not by a physician;
- 7) the trip has been undertaken for purposes of visiting a person who is ill or has had an accident and the cancellation or interruption of the trip results from the death or deterioration of the medical condition of such person;
- 8) all the fees that are payable or refundable under any governmental insurance plan or normally would be, or private plan;
- 9) all treatments or services that are provided free of charge or that would be free in the absence of insurance or that are not at the insured's expense;
- 10) at the time of finalising the trip arrangements, the insured is aware of an event that could reasonably cause the trip's cancellation or interruption;
- 11) declared or undeclared war or act of war, in Canada or in a foreign country, if the Canadian government recommends not staying in the country. This exclusion does not apply to the insured present in a foreign country at the time where war or an act of war is declared and that the Canadian government then recommends leaving the country.

The insured must however make the necessary arrangements in order to leave the country in the best delay;

- 12) the insured's abusive absorption of medication, drugs or alcohol;
- 13) pregnancy, miscarriage, childbirth or related complications when these expenses are incurred within twelve weeks of the expected date of birth.

i) PROOF OF CLAIM

The insured must submit to the insurer the required proof in the 90 days following the event. It is the insured's responsibility to assume all expenses incurred for proof satisfactory to the insurer. The following required documents are then necessary:

- 1) The unused transportation tickets;
- 2) The official receipts for the cost of additional transportations;
- 3) The receipts for the travel arrangements. The receipts must include the contracts that were officially issued through the travel agency or an accredited company, and must indicate the amounts not refunded in the event of cancellation. A written proof of the benefits request or cancellation and the travel agency or carrier's response must be submitted to the insurer;
- 4) The official documents stating the cause of cancellation. If the cancellation is due to medical reasons, the insured must provide a medical certificate from the attending physician practicing in the region where the accident or illness occurred. The medical certificate must indicate the complete diagnosis and specify the exact reasons why the trip had to be cancelled, delayed or interrupted;
- 5) A police report when the means of transportation used by the insured is delayed due to a traffic accident or the emergency closing of a road;
- 6) the official report issued by the concerned authority relating to the weather conditions;
- 7) The written notice attesting the cancellation of an activity of a commercial nature or a business reunion issued by the official organization indicating the precise reasons that justify the event's cancellation.;
- 8) The insurer can require statements from the insured, or any other report allowing the benefits request justification.

LEGAL ADVISOR

THE SERVICE

A service providing the member or his/her dependants with legal information with a simple phone call.

UV Insurance covers the telephone consultation fees given for the service of “Legal Advisor” on the aspects of law concerning:

Family and People’s Rights
(e.g.: divorce motives)

Consumer Rights
(e.g.: debts and loans)

Residential Lease
(e.g.: renewal)

Wills and Estate
(e.g.: settling of an estate)

Real Estate Rights
(e.g.: worker’s compensation board appeals)

Real Estate Rights
(e.g.: appeal for hidden defects, flaws)

Business law
(e.g.: patent, copyright and trademark)

Youth Protection
(e.g.: abused children)

The service is offered from 9:00 am to 8:00 pm Monday to Friday and 9:00 am to 5:00 pm Saturday, except on public holidays, using the following telephone numbers:

(514) 871-3263 1-800-550-3263

This service is available on an information basis only. It is not to be construed as a replacement of the usual legal advisor.

OPTIONAL LIFE INSURANCE BENEFIT FOR THE INSURED INCLUDING ACCIDENTAL DEATH OR DISMEMBERMENT BENEFIT

PURPOSE

The purpose of this benefit is to pay a death benefit upon death of an insured, when death occurs when the present life insurance benefit is in force.

SPECIFIC DEFINITIONS TO THE OPTIONAL LIFE INSURANCE BENEFIT FOR THE INSURED INCLUDING ACCIDENTAL DEATH OR DISMEMBERMENT BENEFIT

In the present policy, unless one of the benefits, a change, an amendment or the Summary of Benefits stipulates otherwise, we hereby define:

INSURED

A member or his spouse.

ELIGIBILITY

An insured is eligible for insurance under the present benefit, provided that he is under sixty-five (65) years of age and if he is already covered under the basic life insurance benefit.

To be insured, an eligible employee or his spouse must first submit a written request on the forms provided by the insurer.

AMOUNT OF INSURANCE

The amount of insurance for the present benefit is indicated hereinafter and, if applicable, according to the option selected by the member on the optional life insurance form:

MEMBER

- According to the number of \$1 000 units chosen by the member;
- Minimum amount: \$10 000;
- Maximum amount: \$1 000 000 including the life insurance benefit basic amount.

SPOUSE

- According to the number of \$1 000 units chosen by the member;
- Minimum amount: \$5 000;
- Maximum amount: \$100 000 including the life insurance benefit basic amount.

EVIDENCE OF INSURABILITY

All optional life insurance amounts become effective once the insurer has approved the evidence of insurability provided by the member or his spouse.

MAXIMUM AGE

The insurance for the present benefit cannot extend beyond the insured's sixty-fifth (65th) birthday.

SUICIDE

Should death occur within the twenty-four (24) month period following the beginning or the increase of the optional life insurance, and if death is by means of suicide, whether the insured is sane or not, the amount of optional life insurance or the increased amount is not payable, and the insurer's only responsibility is to refund the premiums.

FALSE DECLARATION

If the insurer issues an optional life insurance certificate with non-smoker rates, following the insured's declaration that he has not smoked during the preceding twelve (12) month period, and it is later proven that this declaration is false, the optional life insurance certificate becomes null and void, and the insurer's responsibility is limited to the refund of paid premiums, should death occur.

AGE ERROR

If the insured's declared age is found to be incorrect after the insured's death, the amount of insurance is adjusted in proportion to the premium received to the one that corresponds to the insured's true age, without, however, exceeding the amount of insurance that the insured would have been entitled to for his true age.

PREMIUM

The monthly insurance premium for the present benefit is established according to the gender, age group, and smoker or non-smoker status and is applicable to each thousand dollars (\$1,000) of insurance. The insured's age is the one attained on his birthday which is the closest to the date of the last contract renewal.

DEFINITION OF NON-SMOKER

A non-smoker is a person who has not used tobacco or other products containing nicotine during the twelve (12) months preceding the signature of the application for insurance or the review of his status, and in addition, this person has not consumed any illegal drugs during this same period. The insurer reserves the right to require a signed declaration with regards to his non-smoker status at each renewal.

ACCIDENTAL DEATH OR DISMEMBERMENT BENEFIT INCLUDED WITH THE OPTIONAL LIFE INSURANCE BENEFIT FOR THE INSURED

The benefit amount of the accidental death or dismemberment is the same amount as the optional life insurance benefit for the insured. Conditions and restrictions applicable to the present benefit are those indicated in the Section entitled "Accidental death or dismemberment benefit included with optional life insurance benefit for the insured" of the present contract.

MONTHLY COST PER \$1 000 UNITS :

Attained age	Male		Female	
	Non-smoker	Smoker	Non-smoker	Smoker
Less than 30	\$0,147	\$0,177	\$0,090	\$0,104
30 to 34	\$0,160	\$0,213	\$0,102	\$0,132
35 to 39	\$0,162	\$0,238	\$0,118	\$0,176
40 to 44	\$0,182	\$0,309	\$0,146	\$0,255
45 to 49	\$0,237	\$0,471	\$0,176	\$0,347
50 to 54	\$0,343	\$0,793	\$0,235	\$0,502
55 to 59	\$0,526	\$1,331	\$0,344	\$0,746
60 to 64	\$0,856	\$2,179	\$0,547	\$1,127

ACCIDENTAL DEATH OR DISMEMBERMENT BENEFIT INCLUDED WITH OPTIONAL LIFE INSURANCE BENEFIT FOR THE INSURED

PURPOSE

The purpose of coverage is to pay the insured an indemnity when he incurs a loss as described in the article Eligible losses of the present benefit, and this loss is by accidental means and occurs while the optional life insurance benefit for the insured is in force.

SPECIFIC DEFINITIONS TO THE ACCIDENTAL DEATH OR DISMEMBERMENT BENEFIT INCLUDED WITH OPTIONAL LIFE INSURANCE BENEFIT FOR THE INSURED

In the present policy, unless one of the benefits, a change, an amendment or the Summary of Benefits stipulates otherwise, we hereby define:

INSURED

A member or his spouse.

AMOUNT OF INDEMNITY

The amount of indemnity is equal to the product (a x b):

- a) the amount of insurance in force for the optional life insurance benefit for the insured including accidental death or dismemberment benefit;
- b) the relative value of the loss according to the table of losses, hereinafter.

ELIGIBLE LOSSES

Eligible losses are the ones listed in the table below; they must be the result of an accident and the loss must occur within three hundred and sixty-five (365) days of the accident.

TABLE OF LOSSES AND PERCENTAGE OF INDEMNITY	
LOSSES	PERCENTAGES
Quadriplegia, hemiplegia or paraplegia	200%
Life	100%
Two hands or two feet	100%
One eye and one hand or one foot	100%
Two eyes	100%
One hand and one foot	100%
Speech and hearing in both ears	100%
One arm or one leg	75%
One hand or one foot or one eye	66,67%
Speech	66,67%
Hearing in both ears	66,67%
Four fingers of the same hand	33,33%
The thumb and index of the same hand	33,33%
All the toes of the same foot	33,33%
Hearing in one ear	12,50%

Loss of an eye means total and permanent loss of sight of the eye.

Loss of speech must be total and permanent.

Loss of one hand or one foot means the amputation at the wrist or ankle joint or above, or the loss of its use.

Loss of one arm or one leg means the amputation at the elbow joint or knee joint or above, or the loss of its use.

Loss of hearing means total and permanent loss of hearing.

Loss of one finger means amputation at the joint between the finger and the hand or above, or the loss of its use.

Loss of one toe means amputation at the joint between the toe and the foot or the loss of its use.

Loss of use of a limb means total and permanent loss of each and all of the functions of the limb.

RESTRICTIONS

If the insured suffers more than one loss from the same accident, only one indemnity is paid, being indemnity for the most severe loss suffered.

In the case of quadriplegia, hemiplegia or paraplegia if the insured dies within ninety (90) days of the accident, the benefit payable is limited to one hundred per cent (100%) of the amount of insurance.

EXPOSURE AND DISAPPEARANCE

If, following an accident, the insured is inevitably exposed to natural elements causing a loss which would normally give rise to an indemnity; such loss will be covered under the provisions of the present benefit.

If the insured is not found within the year following his disappearance, due to a wreck or destruction of the means of transportation in which he was travelling at the time of the accident, loss of life due to bodily injury will be presumed after a period of three hundred and sixty-five (365) days following the date of the accident.

EXCLUSIONS

No indemnity will be payable if the loss is the result:

- a) of the insured's participation in a criminal act or attempted criminal act;
- b) of the insured's active participation in a civil commotion, riot, insurrection or military operation during war, whether war is declared or not;
- c) of the insured's participation in an aerial flight, other than as a fare-paying passenger on a regular chartered flight;
- d) of suicide or self-inflicted wound or mutilation, regardless of the insured's state of mind;

- e)** of death or having suffered from body lesions while his ability to drive is impaired according to the law, because of diminished faculties due to the consumption of alcohol or drugs;
- f)** of the insured's participation in land or water motor vehicle races, scuba diving, parachute jumping, free-fall or otherwise, bungee jumping, gliding or sail flights, or any other dangerous similar activity or sport;
- g)** of intoxication by or while under the influence of alcohol or drugs;
- h)** of an injury that does not show any visible trauma or external wounds, except for drowning or internal lesions discovered by autopsy;
- i)** of a physical or mental infirmity, or any kind of illness;
- j)** of poisoning or infection, except for an infection resulting from a wound or accidental cut;
- k)** of inhalation of toxic gas, except when inhalation is the result of an accident related to the insured's employment;
- l)** of service with the military, naval or air forces or with any other auxiliary or armed forces of any country, whether war is declared or not;
- m)** of a medical or dental treatment, surgery or anaesthesia.

Group Insurance Plan

OLYMEL ST-DAMASE ET SYNDICAT TUAC - LOCAL 1991-P

Group: 4160

Issued for class:

888 - EMPLOYEES NON-PHIL COVERAGE (CLASS 1)

Issued:

Dec 7, 2022

Negotiated through:

**AZUR SERVICES CONSEIL
1540 BOULEVARD MARIE-VICTORIN
LONGUEUIL QC
J4G 1A4
Tel: (450) 640-1900
Fax: (450) 640-1901**

This explanatory brochure constitutes a useful and important guide.

This document contains texts briefly describing group insurance benefits of your plan. However, these texts do not confer any contractual rights and do not alter in any manner benefits of the plan. In all instances, the provisions and stipulations of the policy issued to the contract owner shall prevail.

We urge you to read it carefully and to save it for future reference whenever required.

Filing of claim

You can submit your claims by Internet on our secured site or by mail.

You can access our *online services* on our secured site at www.uvinsurance.ca under the **My Universe Login - Group Insurance - Member** section.

To send your claims by mail, you must include your original receipts and a completed form available from your group insurance plan administrator or online at www.uvinsurance.ca under the **Group Insurance - Learn more - Forms** section.



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www.uvinsurance.ca

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SUMMARY OF BENEFITS

CONTRACT NO.: 4160, CLASS 888 - EMPLOYEES NON-PHIL COVERAGE (CLASS 1)

LIFE INSURANCE BENEFIT FOR THE MEMBER

Effective date: Nov 1, 2022

INSURABLE AMOUNT:

The insurable amount is a fixed amount of \$ 40 000.

Maximum amount without proof: \$ 40 000

Maximum amount with proofs: \$ 40 000

Reduction of 50 % at the member's 65th birthday, for a maximum amount of: \$ 20 000

Reduction of 100 % at the member's 70th birthday.

Reduction of 100 % at retirement.

WAIVER OF PREMIUMS:

Waiver of premiums in the event of disability of the member up to age 65, after a waiting period of 6 months.

SUMMARY OF BENEFITS

CONTRACT NO.: 4160, CLASS 888 - EMPLOYEES NON-PHIL COVERAGE (CLASS 1)

LIFE INSURANCE BENEFIT FOR DEPENDANTS

Effective date: Nov 1, 2022

INSURABLE AMOUNT:

	SPOUSE	CHILD(REN)*	CHILD(REN)**	CHILD(REN)***
Family coverage:	\$ 10 000	\$ 10 000	\$ 10 000	\$ 10 000

* Per child aged 24 hours to 14 days

** Per child aged 15 days to 6 months

*** Per child over 6 months

TERMINATION:

The maximum age for a dependent child is 21 years, or 26 years if a full time student.

Termination of benefit at age 70 for the member.

Termination of benefit upon retirement of the member.

WAIVER OF PREMIUMS:

Waiver of premiums in the event of disability of the member up to age 65, after a waiting period of 6 months.

SUMMARY OF BENEFITS

CONTRACT NO.: 4160, CLASS 888 - EMPLOYEES NON-PHIL COVERAGE (CLASS 1)

SHORT-TERM DISABILITY BENEFIT

Effective date: Nov 1, 2022

INSURABLE AMOUNT:

Weekly insurable amount: 66.670 % of the salary rounded to the next dollar.

Maximum insurable amount: \$ 610

Taxation of the insurable amount: Taxable

The maximum of disability income: 100 % of the gross salary

WAITING PERIOD:

For an accident: 0 day

For an illness: 5 business days

For hospitalisation: 0 day

BENEFIT:

The maximum duration of benefits: 26 weeks

Frequency of cheques: Every 7 days, payable on a 5-day week basis.

Termination of benefit at: Age 65 for the member

WAIVER OF PREMIUMS:

Waiver of premiums in the event of disability of the member up to age 65, after a waiting period of 6 months.

SUMMARY OF BENEFITS

CONTRACT NO.: 4160, CLASS 888 - EMPLOYEES NON-PHIL COVERAGE (CLASS 1)

LONG-TERM DISABILITY INSURANCE BENEFIT

Effective date: Nov 1, 2022

INSURABLE AMOUNT:

Monthly insurable amount: 75.000 % of the salary rounded to the next dollar.

Maximum insurable amount without proof: \$ 2 000

Maximum insurable amount with proof: \$ 2 000

Taxation of the insurable amount: Taxable

Maximum percentage of disability income: 75 % of the gross salary

WAITING PERIOD:

For an accident: 182 days

For an illness: 189 days

For hospitalisation: 182 days

BENEFIT:

The maximum duration of benefits: Age 65 for the member

Frequency of cheques: 1 per month

The definition of own occupation is: The inability to accomplish own occupation for 3 years.

Termination of benefit at: Age 65 for the member

WAIVER OF PREMIUMS:

Waiver of premiums in the event of disability of the member up to age 65, after a waiting period of 6 months.

SUMMARY OF BENEFITS

CONTRACT NO.: 4160, CLASS 888 - EMPLOYEES NON-PHIL COVERAGE (CLASS 1)

HEALTH INSURANCE BENEFIT

Effective date: Nov 1, 2022

TOTAL AMOUNT PAYABLE:

The total amount payable for health insurance has no limit.

DEDUCTIBLE:

Individual coverage: \$ 25*

Family coverage: \$ 25*

Combined deductible: Yes, with drug insurance

**The deductible is applicable by calendar year.*

ELIGIBLE FEES:

Description	Refund	-----Per Period-----			Maximum	Type	Deduc- tible	Max Age
		Frequency	No.	Visit				
HOSPITALISATION:								
PARAMEDICAL EXPENSES:								
AUDIOLOGIST	90%	Calendar Year	11	\$40		(E)	Yes	99
CHIROPRACTOR	90%	Calendar Year	11	\$40		(E)	Yes	99
X-RAY (CHIROPRACTOR)	90%	Calendar Year		\$25	\$100	(E)	Yes	99
MASSOTHERAPIST [1]	90%	Calendar Year	11	\$40		(E)	Yes	99
NATUROPATH	90%	Calendar Year	11	\$40		(E)	Yes	99
NATUROTHERAPIST	90%	Calendar Year	11	\$40		(E)	Yes	99
ORTHOPHONIST	90%	Calendar Year	11	\$40		(E)	Yes	99
ORTHOTHERAPIST [1]	90%	Calendar Year	11	\$40		(E)	Yes	99
OSTEOPATH	90%	Calendar Year	11	\$40		(E)	Yes	99
PHYSIOTHERAPIST [2]	90%	Calendar Year	11	\$40		(E)	Yes	99
PODIATRIST	90%	Calendar Year	11	\$40		(E)	Yes	99
PSYCHOANALYST [3]	90%	Calendar Year	11	\$40		(E)	Yes	99
PSYCHOLOGIST [3]	90%	Calendar Year	11	\$40		(E)	Yes	99
READAPTATION THERAP. [2]	90%	Calendar Year	11	\$40		(E)	Yes	99
SOCIAL WORKER [3]	90%	Calendar Year	11	\$40		(E)	Yes	99

Maximum amounts are combined for overall fees for each whole group.

These groups are: [1], [2], [3] and [4]

Type (E) = maximum eligible amount, Type (P) = maximum payable amount

[R] = medical recommendation required for these paramedical expenses

SUMMARY OF BENEFITS

CONTRACT NO.: 4160, CLASS 888 - EMPLOYEES NON-PHIL COVERAGE (CLASS 1)

HEALTH INSURANCE BENEFIT

ELIGIBLE FEES (CONTINUED):

DESCRIPTION	Refund	-----Per Period-----			Maximum	Type	Deduc- tible	Max Age
		Frequency	No.	Visit				
OTHER FEES:								
COLOSTOMY AND AL.	90%	See contract			Unlimited	(E)	Yes	99
AMBULANCE	90%	See contract			Unlimited	(E)	Yes	99
LAB TEST/DIAGNOSIS	90%	Calendar Year			\$1 000	(E)	Yes	99
ANESTHETIC	90%	See contract			Unlimited	(E)	Yes	99
HEARING AID	90%	48 months			\$600	(E)	Yes	99
RESP. APPRAR./OXYGEN	90%	Lifetime			\$10 000	(E)	Yes	99
BANDAGE / SPLINT	90%	See contract			Unlimited	(E)	Yes	99
OTHER PROSTHESIS	90%	See contract			\$5 000	(E)	Yes	99
DYN. ORTHOSIS / CORS.	90%	See contract			Unlimited	(E)	Yes	99
ELASTIC STOCKINGS	90%	Calendar Year	3		Unlimited	(E)	Yes	99
ORTHOPEDIC SHOES#1 [4]	75%	12 months	2		\$300	(E)	Yes	16
ORTHOPEDIC SHOES#2 [4]	75%	12 months	1		\$300	(E)	Yes	99
DENTAL ACCIDENT	90%	See contract			\$5 000	(E)	Yes	99
FOOT ORTHOSIS	90%	12 months			\$495	(E)	Yes	99
EYE EXAM	90%	24 months			\$75	(E)	Yes	65
MEDICAL SUPPLIES	90%	See contract			Unlimited	(E)	Yes	99
GLUCOMETER	90%	36 months			\$300	(E)	Yes	99
NURSE	90%	12 months		\$300	\$10 000	(E)	Yes	99
REGISTERED NURSE	90%	12 months			\$200	(E)	Yes	99
SCLER. INJEC. DRUGS	90%	Calendar Year		\$20		(E)	Yes	99
RENTAL (CHAIR/BED)	90%	See contract			Unlimited	(E)	Yes	99
CAPILLARY PROSTHESIS	90%	Lifetime	1		\$300	(E)	Yes	99
MAMMARY PROSTHESIS	90%	24 months			\$1 000	(E)	Yes	99
X-RAY	90%	Calendar Year			\$1 000	(P)	Yes	99
MAG. RESONANCE (MRI)	100%	Calendar Year			\$1 000	(P)	Yes	99
I.U.D.	90%	Calendar Year		1		(E)	Yes	99
TENS	90%	60 months			\$1 000	(E)	Yes	99
TRANSFUSION	90%	See contract			Unlimited	(E)	Yes	99

Maximum amounts are combined for overall fees for each whole group.

These groups are: [1], [2], [3] and [4]

Type (E) = maximum eligible amount, Type (P) = maximum payable amount

SUMMARY OF BENEFITS

CONTRACT NO.: 4160, CLASS 888 - EMPLOYEES NON-PHIL COVERAGE (CLASS 1)

HEALTH INSURANCE BENEFIT

TERMINATION:

The maximum age for a dependent child is 21 years, or 26 years if a full time student.

WAIVER OF PREMIUMS:

Waiver of premiums in the event of disability of the member up to age 65, after a waiting period of 6 months. The waiver of premium terminates on the earliest of the following dates: The date this benefit terminates or the date this policy terminates.

REMARK(S) FOR HEALTH INSURANCE BENEFIT:

OTHER PARAMEDICAL EXPENSES INCLUDED :

- KINESITHERAPIST COMBINED WITH MASSOTHERAPIST AND ORTHOTHERAPIST.
- NATUROPATH COMBINED WITH NATUROTHERAPIST.
- CHIROPODIST COMBINED WITH PODIATRIST.
- PSYCHOEDUCATOR COMBINED WITH PSYCHOANALYST AND SOCIAL WORKER.

OTHER ELEGIBLE FEES :

- REPLACEMENT MASK COMBINED WITH RESP.APPRAR/OXYGEN.
- DEEP SHOES: MAXIMUM PAYABLE AMOUNT OF \$ 100.00 PER CALENDAR YEAR.
- INSULIN PUMP : MAXIMUM PAYABLE AMOUNT OF \$ 7 500.00 PER 60 MONTH-PERIOD.
- SUPPLIES FOR THE INSULIN PUMP : MAXIMUM PAYABLE AMOUNT OF \$ 10 000.00 PER 60 MONTH-PERIOD.
- RX CHIROPDIST, RX PODIATRIST, RX NATUROPATH AND RX OSTEOPATH COMBINED WITH X-RAY.
- LABORATORY ANALYSIS: MAXIMUM PAYABLE AMOUNT OF \$ 1000.00 PER CALENDAR YEAR
- POST-MASTECTOMY BRASSIERES SOLD BY A SPECIALIZED LABORATORY: MAXIMUM LIFETIME PAYABLE AMOUNT OF \$ 200.00.
- CONTACT LENSES OR INTRAOCULAR LENSES FOLLOWING A CATARACT SURGERY: MAXIMUM LIFETIME PAYABLE AMOUNT OF \$ 1000.00.
- THERAPEUTIC DEVICES: MAXIMUM LIFETIME PAYABLE AMOUNT OF \$ 10 000.00.
- TOMODENSITOMETRY: MAXIMUM PAYABLE AMOUNT OF \$ 1000.00 PER CALENDAR YEAR.
- ELECTROCARDIOGRAM: MAXIMUM PAYABLE AMOUNT OF \$ 1000.00 PER CALENDAR YEAR.
- ECHOGRAPHY: MAXIMUM PAYABLE AMOUNT OF \$ 300.00 PER CALENDAR YEAR.
- EXPENSES OF SURGERY NECESSARY TO THE REPAIR OF AN ESTHETIC DAMAGE ASCRIBABLE WITH AN ACCIDENT WHICH HAS OCCURRED WHEREAS THIS INSURANCE IS IN FORCE, WITH CONDITION WHICH THE SERVICES WERE DONE IN THE 36 MONTHS OF THE DATE OF ACCIDENT: MAXIMUM PAYABLE AMOUNT OF 5000.00\$ BY ACCIDENT.
- SCREENING TESTS DURING PREGNANCY ARE COVERED UNDER LABORATORY ANALYSIS.

SUMMARY OF BENEFITS

CONTRACT NO.: 4160, CLASS 888 - EMPLOYEES NON-PHIL COVERAGE (CLASS 1)

DRUG INSURANCE BENEFIT

Effective date: August 1, 2022

DEDUCTIBLE:

Individual coverage: \$ 25*

Family coverage: \$ 25*

Combined deductible: Yes, with health insurance

**The deductible is applicable by calendar year.*

REIMBURSEMENT:

For drugs prescribed in the province of residence according to the RESTRICTIVE drugs list.

Eligible innovator drugs: 90 %**

Eligible generic drugs: 90 %**

Eligible brand drugs: 90 %**

Drug card: Direct payment

*** After satisfying the deductible*

EMPLOYEE'S CONTRIBUTION:

Each year, the maximum an insured contributes for drug fees with respect to the deductible and the percentage of reimbursement is equal to the most recent amount determined by the "Régie de l'assurance maladie du Québec". This maximum applies to the total amount of drug fees incurred by the insured and their insured dependants. The maximum contribution does not apply to the drug cost that the member has to pay outside Quebec and to members residing outside Quebec.

TERMINATION:

The maximum age for a dependent child is 21 years, or 26 years if a full time student.

WAIVER OF PREMIUMS:

Waiver of premiums in the event of disability of the member up to age 65, after a waiting period of 6 months. The waiver of premium terminates on the earliest of the following dates: The date this benefit terminates or the date this policy terminates.

GENERAL PROVISIONS

DEFINITIONS

In the present policy, unless one of the benefits, a modification, an amendment or the "Summary of Benefits" stipulates otherwise, we hereby define:

a) ACCIDENT

A corporal blow diagnosed by a physician, arising directly and independently of all other causes, from the sudden, violent and unforeseeable action of an external cause.

b) MEMBER

An eligible and insured employee under this contract.

c) 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.

d) INSURED

A member or one of his dependants.

e) SPOUSE

A person with whom the insured is living. The union must be a marriage duly recognised by Quebec legislation or the common-law state of a single, widowed or divorced person having resided permanently for more than one year with a person who is also single, widowed or divorced, who is publicly presented as a spouse. The stated delay is not applicable if a child is born of the union. The dissolution of a marriage by divorce as well as legal separation results in the loss of the marital status. The same loss of marital status results in the event of any de facto separation of more than three (3) months, in the case of a non-legally contracted union.

The spouse is the one designated by the insured. Only one person may be insured as a spouse at any given time.

f) ELIMINATION PERIOD

A continuous period beginning at the start of a total disability during which no disability benefit is payable under this benefit.

g) DRUGS

Controlled or limited usage drugs including medication or narcotics as defined in the Food and Drugs Act and Narcotic Control Act.

h) EMPLOYEE

A person residing in Canada who works for an employer or duly registered member of the policyowner.

i) EMPLOYER

The policyowner or a subsidiary associated or affiliated company whose name appears in the "Summary of Benefits".

j) CHILD

Any single child of the insured or of his spouse, including any legally adopted child, residing in Canada and who meets one of the following conditions:

- is under twenty-one (21) years of age, or;
- is under twenty-six (26) years of age and duly registered as a full time student at a recognised teaching institution, or;
- is totally disabled and became totally disabled while one of the two (2) preceding conditions existed, and resides with the member.

With regards to life insurance for dependants, the infant must be at least twenty-four (24) hours of age.

k) IMMEDIATE FAMILY

The insured, his spouse, his children, his father, his mother, his grandparents, his brothers, his sisters and his grand-children at least 18 years of age.

l) DEDUCTIBLE

The deductible is the part of eligible expenses that must be paid by the insured in each calendar year before a benefit is payable. If applicable, the deductible amount is specified in the "Summary of Benefits".

If the present contract replaces another, the fees disbursed between January 1st and the effective date of the contract will be applied toward the deductible.

In the event where there is no previous insurer, for the first year of insurance, the deductible is proportional to the number of months between the effective date and the end of the calendar year, unless otherwise agreed differently between the insurer and the policyowner.

m) TOTAL DISABILITY

For the elimination period stipulated in the "Summary of Benefits" and the twenty-four (24) months that follow, the inability of a person, due to illness or an accidental injury, to perform all the duties of his regular occupation; subsequently, the inability to perform any remunerative occupation that could reasonably be performed when taking into consideration the education, training or experience of that person, regardless of the availability of employment in the region of the member's place of residence.

n) ILLNESS

A deterioration of health or disorder of the organism diagnosed by a physician specialised in the treatment of the illness. Pregnancy is not considered to be an illness; only major complications due to pregnancy are considered to be a deterioration of health.

o) PHYSICIAN

Any legally authorised person who practices medicine in his field of specialty. The physician must not be the insured, or a member of his immediate family.

p) REGULAR OCCUPATION

All the functions, as a whole, that a person performs relating to his occupation.

q) TOTAL DISABILITY PERIOD

A continuous period of total disability or successive periods of total disability resulting from the same cause or from related causes and separated by one or several recurrence periods shorter than the recurrence period allowed under the said benefit. A new period of total disability begins when the insured returns to work on a full-time basis at full salary for at least one day and the disability is the result of a cause completely independent of the first disability.

r) RECURRENCE

A period immediately following the date a person ceases to be totally disabled.

s) DEPENDANT

The member's spouse or child taken individually in accordance with the definitions of spouse or child in the present contract. It is noted that the following persons are not to be considered as the member's dependants:

- 1) a child who is not depending on the member for financial support or who has a full-time job;
- 2) a child with a spouse.

t) REIMBURSEMENT PERCENTAGE

The percentage of admissible fees that can be reimbursed after deducting the deductible, as specified in the "Summary of Benefits".

u) POLICYOWNER

A corporate body or physical person stipulated in the face page of this policy or in the "Summary of Benefits". The policyowner is the owner of the contract. The policyowner may or may not be the employer.

v) RETIREMENT

Date on which a member ceases to work for reason of retirement or early retirement.

w) PROFESSIONAL RISK

Any risk related to a job, occupation, trade or profession.

x) GROSS EARNED INCOME

The regular gross earned income excluding bonuses, payments for overtime, fees, allowances for lodging and meals, isolation payments and any lump sum occasional payments which are not part of the regular remuneration.

For the members whose income derives totally or partially from commissions or performance bonuses, salary means the average percentage of the employee's pay, paid by the employer, including commissions indicated on the employee's T4 and T4A income tax forms during the two (2) preceding years. In the event where the employee has not completed two years of continued service with the same employer, but at least one year, an income average will be established based on the full duration of service. However, if the employee has been employed for less than one year, salary means the average percentage of the employee's pay as is declared by the employer.

However, for the short-term disability benefit, income represents the insurable remuneration as established by the Canadian employment insurance legislation if the plan is duly registered with the Human Resources and Social Development Canada (HRDC).

y) NET INCOME

For a salaried employee, net income is earned income less provincial and federal income taxes, contributions to unemployment insurance, Quebec Pension Plan and Canada Pension Plan deducted from the salary.

EMPLOYEE ELIGIBILITY

An employee becomes eligible for insurance:

- a) on the effective date of the contract if he meets the eligibility provisions stipulated in the "Summary of Benefits", or;
- b) after the effective date, from the date he meets the eligibility provisions stipulated in the "Summary of Benefits".

Seasonal employees or part-time employees (i.e. those working less than nine (9) months per year) and partial part-time employees (i.e. those who work less than twenty (20) hours per week) are eligible only if designated in the "Summary of Benefits".

DEPENDANT ELIGIBILITY

An employee's dependants become eligible for insurance on the later of the following dates:

- a) the date when the employee becomes eligible, or;
- b) the date when they become dependants as per the definition of a dependant stipulated in the present contract.

APPLICATION FOR INSURANCE

To be insured under this contract, an eligible employee must submit a written request by completing an application form provided by the insurer.

To insure his dependants, an employee must list them on his application form. For subsequent coverage, the employee must advise the policyowner, who must then complete the required form and forward it to the insurer without further delay.

EFFECTIVE DATE OF INSURANCE FOR THE EMPLOYEE

An employee's insurance becomes effective:

- a) on his date of eligibility, if the insurer has received the request for insurance on or before this date, or;
- b) on the date the insurer receives the request for insurance, if this date is within the thirty (30) day period following his eligibility date, or;

- c) on the date the insurer accepts the evidence of insurability that the employee must provide at his expense and which is satisfactory to the insurer, if the form requesting the insurance is received more than thirty (30) days after the eligibility date.

Notwithstanding the foregoing, any insurance that is subject to evidence of insurability becomes effective only on the date of acceptance of such proof by the insurer.

If the day on which the insurance becomes effective is a working day and the employee is not at work on that day for reasons other than a scheduled vacation period, his insurance becomes effective the day he returns to work full-time and is able to accomplish all the duties of his regular occupation.

If the day on which the insurance becomes effective is not a working day, the insurance becomes effective:

- a) on that date, provided the employee was actually at work on the last previous working day, otherwise;
- b) the day he returns to work full-time and is able to accomplish all the duties of his regular occupation.

EFFECTIVE DATE OF INSURANCE FOR A DEPENDANT

The insurance for a dependant becomes effective:

- a) on the date of eligibility of a dependant if the insurer has received the written request on or before that date; or
- b) on the date the insurer receives the request for insurance, if this date is within the thirty (30) day period following the dependant eligibility date; or
- c) on the date the insurer accepts the evidence of insurability that the employee must provide at his expense and which is satisfactory to the insurer, if the form requesting the insurance is received more than thirty (30) days after the dependant's eligibility date.

Any new dependant child of the member whose other dependants are already insured becomes rightfully and immediately insured. The name and date of birth of the new child must however be communicated to the insurer by means of a written notice for the processing of future claims.

However, with the exception of any newborn, if a dependant is hospitalised on the effective date of his own life, such insurance becomes effective only on the day after leaving the hospital.

CLAIMS

a) FILING A CLAIM

Any claim for benefits under this contract must be filed with the insurer within thirty (30) days thereafter.

b) PROOF OF CLAIM

The insured must submit to the insurer the required proof according to the benefit in the ninety (90) days following the event. It is the insured's

responsibility to assume all expenses incurred for proof satisfactory to the insurer.

c) ADDITIONAL DELAY

Failure in filing a claim or submitting proof within the specified period will not invalidate a claim under the contract if proven that it was impossible for the insured to file the claim on time, and the claim was filed or the proof was submitted within twelve (12) months following the date of the event giving rise to the claim.

d) PAYMENT

The insurer must pay claims within thirty (30) days following the date of receipt of all required proof.

All amounts become payable to the member, if living. Otherwise, the amounts are payable to the designated beneficiary.

e) BENEFICIARY

Providing it is not contrary to law and where no irrevocable beneficiary designation has been made, an insured may, by giving a written notice to the insurer, designate or revoke any beneficiary.

The insurer assumes no responsibility for the validity of any beneficiary designation. If no beneficiary designation has been made, all amounts payable at death are issued to the member's estate.

RULES OF MINIMAL PARTICIPATION OF ELIGIBLE EMPLOYEES

A minimum of two (2) members at all times is required to maintain this contract in force.

Any employee that satisfies the eligibility provisions stipulated in the summary of benefits and who subscribes to the insurance plan must remain insured under the provisions of the policy.

In addition, for each member and for each benefit, the policyowner must pay at least the proportion on the premium indicated in the "Summary of Benefits".

An "insurance premium", for the purpose of this article, excludes the premium for any additional insurance benefit.

TERMINATION OF AN MEMBER'S INSURANCE

A member's insurance under the present contract or under one of its benefits or services terminates at midnight on the earliest of the following dates:

- a)** the date of cancellation of the present contract or of the relevant benefit;
- b)** the date the member ceases to be an employee or ceases to be in a class of employees' eligible for insurance;
- c)** the date the insurer receives a written notice from the policyowner requesting termination of an member's insurance, or any subsequent date mentioned in the notice;
- d)** the date on which the insured attains the maximum age for the relevant benefit for any such insurance;

- e) the due date of any premium, if on that date the member's premium is not paid, unless a request for waiver of premiums due to disability has been made and accepted;
- f) the date of the member's death, subject to the payment of benefits that are due.

TERMINATION OF DEPENDANT INSURANCE

A dependant's insurance under the present contract or under one of its benefits or services terminates at midnight on the earliest of the following dates:

- a) the date of cancellation of the present contract or of the implied benefits;
- b) the date the member ceases to be an employee or ceases to be in a class of employees' eligible for insurance;
- c) the date the insurance for the member ceases;
- d) the date a dependant no longer meets requirements mentioned in the definition of dependant;
- e) the due date of any premium, if on that date the dependant's premium is not paid, unless a request for waiver of premiums in the event of disability has been made and accepted;
- f) the date of the dependant's death subject to the payment of benefits that is due.

ERROR AND FALSE DECLARATION

A false declaration of age does not lead to the annulment of the insurance. In this situation, the true date of birth, established to the insurer's satisfaction, serves as the basis of premium calculation and an equitable adjustment of premiums and insured amount, if necessary, will be made.

The insurer is justified in requesting that the life insurance be null and void when the insured's age at issue was outside the age limits set by the insurer's rates. The insurer must act within three (3) years of the issue of the insured's certificate, providing it does so while the insured is living and within sixty (60) days of becoming aware of the error.

An error concerning the insured's age cannot prolong any amount of insurance beyond the date these amounts would have terminated, taking into account the insured's actual age.

INCONTESTABILITY

In the absence of fraud, a false declaration or a withholding of information may not be invoked as sufficient reason to terminate or reduce the insurance if it has been in force for more than two (2) years. However, this rule does not apply to disability insurance if said disability started during the first two (2) years of insurance.

INFORMATION TO MEMBERS

The insurer provides the policyowner with a written summary the insured's rights and obligations under the present contract, as well as a certificate of proof of coverage for insured employees.

The policyowner must forward this information to the member. Its purpose is to advise the member of his rights and obligations. In the event of litigation, only the contract may be invoked.

The member may consult the contract at the policyowner's business address and make a copy at his own expense.

LAWS THAT GOVERN THIS CONTRACT

For the purpose of this policy, reference to a law signifies the effective law in force at that particular time, or if repealed, the new law that replaces it or any law of the same nature with the same end result.

FILE ACCESS

In order to maintain the confidential nature of personal information on the insured, the insurer agrees to the following:

To create an individual insurance file that contains information on the insured relating to the application, as well as any information relating to the claim.

Access to the file is restricted solely to the insurer's employees, legal advisors or representatives responsible for the underwriting, investigations and evidence of insurability.

The insured's file is kept by the Union Life, Mutual Insurance Company.

The insured has the right to be informed of the personal information in of this file and if applicable, may have the file corrected by making a written request to the insurer. All requests are to be sent to the access information officer.

WAIVER OF PREMIUMS BENEFIT

PURPOSE

Waiver of premiums applies to each benefit indicated in the "Summary of Benefits". The purpose is to continue coverage of the insurance benefits in force at the beginning of disability. Disability must begin before the insured's sixtieth (60th) birthday in order for him to be eligible for waiver of premiums. Total disability must be as described in the definition of the "General Provisions" section of the present policy.

ELIMINATION PERIOD

The elimination period is the period that commences at the beginning of a total disability period and for which no disability payment is payable under this benefit.

The elimination period is stipulated in the "Summary of Benefits". Premiums are waived starting from the 1st day of the month following or coinciding with the date on which the elimination period is completed.

REMISSION PERIOD PERMITTED

A period less than one hundred and eighty (180) days immediately following the date a person who was totally disabled ceases to be.

PREMIUMS TO BE WAIVED

The premiums to be waived are those for insured benefits under the present contract at the beginning of disability as stipulated in the "Summary of Benefits". A retroactive refund of premiums will not exceed six (6) months from the date of approval of the claim for waiver by the insurer.

PROOF OF DISABILITY

To prove his disability or its continuance, the member must submit to the insurer a medical certificate by using the appropriate forms provided by the insurer. The insurer may, at its own expense, and as often as deemed necessary, have the insured undergo a medical examination by a physician chosen by the insurer, if it judges that the proof submitted by the member is unsatisfactory.

TERMINATION OF WAIVER OF PREMIUMS

In addition to the reasons of termination of insurance for the member in the section entitled "General Provisions" of the present policy, the waiver of premiums for an insured ceases when he is no longer disabled or when he cannot provide proof of his total disability or refuses to submit such proof.

In addition, waiver of premiums cease at midnight on the earliest of the following dates:

- the termination date or age limit stipulated in the "Summary of Benefits";
- his retirement date, if earlier.

EXCLUSIONS

The insurance provided by the present waiver of premiums benefit does not apply and the insurer assumes no responsibility if disability is the result:

- a)** of the insured's participation in a criminal act or an attempted criminal act, or;
- b)** of the insured's active participation in a civil commotion, riot, insurrection or military operation during war, whether war is declared or not, or;
- c)** of the insured's participation in an aerial flight other than as a fare paying passenger on a regular or chartered flight, or;
- d)** of an attempted suicide or self-inflicted wound or mutilation, regardless of the insured's state of mind, or;
- e)** of the fact of having suffered body lesions while driving a vehicle with diminished faculties due to alcohol or drug consumption (criminal act), or;
- f)** of the insured's participation in land or water motor vehicle races, scuba diving, parachute jumping, free-fall or otherwise, bungee jumping, gliding or sail flights, or any other dangerous similar activities or sports, or;
- g)** of intoxication by or while under the influence of alcohol or drugs, or;
- h)** of lumbago or back pain whose diagnosis can only be made subjectively by the insured's description of symptoms and cannot be supported by appropriate tests prescribed by a physician, or;
- i)** of disability that began prior to the effective date of insurance.

LIFE INSURANCE BENEFIT FOR THE MEMBER

PURPOSE

The purpose is to pay a death benefit when the member's death occurs while this insurance benefit is in force.

BENEFIT AMOUNT

The benefit amount is equal to the amount specified in the "Summary of Benefits" and is subject, if applicable, to reduction due to the member's age.

EXTENSION

Upon receipt and acceptance of required documents establishing to the satisfaction of the insurer, that an member was totally disabled while covered under the present contract and that the member:

- a) remained totally disabled up to the date of his death and died from the same condition as his disability, and;
- b) died before his sixty-fifth (65th) birthday and before the end of a six (6) month period calculated from the date he stopped working due to his disability, and;
- c) was not covered by another insurer under an insurance contract with a similar benefit.

The insurer pays the insurance amount to which the member was entitled as stipulated in the present contract without however, exceeding the amount that was in force on his life on the date he left his employment.

ANTICIPATED DEATH BENEFIT

Provided that the present benefit is in force in accordance with the provisions foreseen for the "Waiver of premiums" benefit of the present contract and a member's life expectancy is not more than twelve (12) months, he has the right to an anticipated death benefit payment. The amount is the lesser of twenty-five thousand dollars (\$25,000) or fifty per cent (50%) of the amount of life insurance in force.

The written request to the insurer must include satisfactory proof that the member's life expectancy does not exceed twelve (12) months as of the date requested.

Upon the member's death, the amount payable to the beneficiary by the insurer is reduced by the amount paid to the insured under the present right, increased by interest accrued since the date of the payment of this benefit at an annual rate of ten per cent (10%).

EVIDENCE OF INSURABILITY

When the amount of insurance exceeds the maximum amount of insurance without evidence of insurability stipulated in the "Summary of Benefits", the member is covered for the excess only if he submits proof satisfactory to the insurer. Subsequently, any increase in the amount of insurance will become effective only after the required evidence of insurability has been accepted by the insurer.

CONVERSION PRIVILEGE

If, before the member attains age sixty-five (65) the insurance on his life terminates due to the termination of his employment or the loss of a membership in an insured group, the member may convert all or part of the insurance amount lost into an individual life policy, without having to prove his insurability. The amount of insurance converted for the same insured cannot exceed the amount of benefit of the present benefit at the date of conversion, subject to the higher of a minimum of five thousand dollars (\$5,000) or twenty-five per cent 25% of the member's insurance amount, and a maximum of two hundred thousand dollars (\$200,000) or the difference between the amount of insurance lost under the present contract and the amount of insurance provided for by another contract under which the member became eligible at the time of exercising his conversion privilege.

In addition, upon termination of the present contract, on the condition that the member was covered for at least five (5) years and the contract was not replaced by another under which he became eligible, the member may convert, totally or partially the insurance volume lost to an individual permanent life insurance without evidence of insurability.

To convert, the member must make a written request to the insurer on the form provided by the insurer, and pay the insurer the amount of premium for the proposed contract, within thirty-one (31) days as of the termination of the insurance.

If the member dies during the thirty-one (31) day conversion privilege period, the insurer will pay the maximum amount of life insurance the insured could have been converted.

The member can subscribe to any one of the following individual insurance contracts:

- 1) a one (1) year term insurance, convertible at the end of the year to a term insurance to age sixty-five (65) or a whole life insurance contract;
- 2) a term insurance to age sixty-five (65);
- 3) a whole life insurance.

No additional benefit may be added to this insurance unless anticipated for specifically elsewhere in this contract.

The premium rate for the individual insurance contract is the rate in use by the insurer according to the amount converted, the plan chosen, and the member's gender and age at the time of conversion. If the member is already subjected to an increased premium or exclusion under the present benefit, the insurer will increase the premium or reinstate the exclusion for the individual insurance in a similar way. Any premium mode typically offered by the insurer may be selected. In the first year of conversion, insurance premiums may be paid quarterly. The individual contract

will become effective thirty-one (31) days after the termination of the insurance with regards to the present contract.

A decreased amount due to age or a change of category of the member does not give the member the right to convert his insurance.

The member who has used his conversion privilege is no longer eligible for insurance under the present contract, unless satisfactory evidence of insurability accepted by the insurer. The conversion privilege of the present contract, once exercised, is no longer available.

TERMINATION OF THE MEMBER'S INSURANCE

In addition to the reasons for the termination of the member's insurance stipulated in the section entitled "General Provisions" of the present policy, the insurance for this benefit will terminate at the earliest of the following dates at midnight:

- the termination date or age limit stipulated in the "Summary of Benefits";
- the member's retirement date, if earlier.

LIFE INSURANCE BENEFIT FOR DEPENDANTS

PURPOSE

the purpose is to pay a death benefit upon death of a member's dependant, if death occurs while this insurance benefit is in force.

AMOUNT OF BENEFIT

The amount of the benefit payable upon death of the spouse or a dependant child is specified in the "Summary of Benefits".

EXTENSION

If upon the member's death dependants are insured under this benefit, the dependants' life insurance is extended without payment of premiums up to the earliest of the following dates:

- a) twenty-four (24) months after the member's death;
- b) the termination date of the life insurance benefit for dependants had the member been living;
- c) the termination date of the present benefit.

TERMINATION OF INSURANCE

In addition to the reasons for the termination of the dependants' insurance benefit stipulated in the section entitled "General Provisions" of the present policy, the insurance for this benefit will terminate at the earliest of the following dates at midnight:

- the termination date or age limit stipulated in the "Summary of Benefits";
- the member's retirement date, if earlier;
- when the spouse or child no longer meets the definition of dependant.

SHORT-TERM DISABILITY BENEFIT

PURPOSE

The purpose of coverage is to temporarily replace and in part the employment income loss for a member during a period of total disability starting after the effective date of this benefit.

EXCLUSIVITY OF BENEFIT

Once the long-term disability benefits have started, a return to the short-term disability benefits is not possible for the same or related causes, until the total disability period giving rise to the claim has terminated.

ELIGIBILITY

To be eligible for the short-term disability benefit, an employee must be covered under the life insurance benefit.

ELIMINATION PERIOD

The elimination period for the present benefit corresponds to the number of days indicated in the "Summary of Benefits", separately for total disability resulting from an illness, an accident or a hospitalization.

The elimination period in the event of an illness applies for any total disability period beginning more than thirty (30) days after the date of the accident causing the disability.

The elimination period in the event of hospitalization begins at the date of hospitalization. In addition, the elimination period for hospitalization applies on the condition that the date of hospitalization precedes the date the elimination period for an illness ends.

In the present article, hospitalization means occupying a hospital room for a minimum period of eighteen (18) consecutive hours, or to have been admitted to the hospital for less than one day for surgery requiring anaesthesia.

REMISSION PERIOD PERMITTED

A period less than fifteen (15) days.

MAXIMUM ELIGIBLE WEEKLY INCOME

When the maximum eligible weekly income is as defined by the Canada employment insurance act, this expression is designated by M.E.W.I. in the "Summary of Benefits".

BENEFIT AMOUNT

The amount of disability benefits is payable according to the frequency indicated in the "Summary of Benefits".

BENEFIT PAYMENTS

Benefits become payable after the elimination period.

The amount of disability benefit is divided, if applicable, by one-fifth (1/5) of the amount provided for a complete week, for each working day of a normal work week, or by one-seventh (1/7) for each day of absence during the week as specified in the "Summary of Benefits".

Benefits are payable for provided that total disability persists without exceeding the maximum number of weeks specified in the "Summary of Benefits".

In addition, notwithstanding the maximum age specified in the "Summary of Benefits" which indicates the end of payment of benefits, it is stipulated that the said payment continues, with proof of disability satisfactory to the insurer, until the member has received at least fifteen (15) weeks of benefits in total including benefits paid before the maximum age. However, benefits end as soon as the member is able to resume work or as soon as he elects retirement, whichever period is shorter.

No disability period may start after the maximum age as specified in the "Summary of Benefits".

REHABILITATION

The insurer may assist the member in any manner to encourage him to return to his regular occupation or any other remunerative occupation compatible with his state of health.

In the case of a rehabilitation program accepted by the insurer, if a gradual return to work is appropriate considering the state of health, the amount of the payable benefit will be adjusted, taking into account the period worked.

REDUCTION OF BENEFIT DUE TO INTEGRATION OF BENEFITS

Under the present article, the insurer pays a weekly disability benefit according to the lesser of the amounts calculated under paragraphs A) or B) that follow:

a) DIRECT INTEGRATION OF BENEFITS

The member is only eligible for disability benefits of the present benefit and those provided for by government plans.

The amount of disability benefits payable by the insurer is reduced by the amount of initial basic benefits; without regard to subsequent increases due to indexation, payable under the following laws or plans, such as:

- 1)** the Quebec Pension Plan or the Canada Pension Plan;
- 2)** the Occupational Health and Safety Commission;
- 3)** the Automobile Insurance Act in Quebec or Ontario.

However, this article only refers to the above-mentioned benefits whose payment started at the beginning or after the beginning of total disability.

If an member refuses or neglects to submit a request for benefits under the laws or plans mentioned above, when informed by the insurer that he could be eligible for such benefits, the insurer reserves the right to reduce from

the benefits payable an estimate of benefits that could be provided by these laws or plans.

b) INDIRECT INTEGRATION OF BENEFITS

The member is eligible for additional disability benefits and those foreseen in the preceding paragraph a).

If the member receives disability income that is greater than the maximum percentage of income permitted, as specified in the "Summary of Benefits" and based on the member's income at the beginning of disability, the disability benefit is reduced so that the total amount of disability income does not exceed the maximum employment income at the beginning of disability. In calculating the maximum, only initial amounts of benefits will be considered without regard to subsequent increases due to indexation.

Other income amounts that are considered in the calculation mentioned in the preceding paragraph are:

- 1) Any remuneration paid by an employer due to a salary continuation policy, holidays, sick days or any other benefits program established by the employer;
- 2) all annuities or disability benefits payable under the following laws:
 - the Quebec Pension Plan or the Canada Pension Plan;
 - the Occupational Health and Safety Commission;
 - the Automobile Insurance Act in the province of residence.
- 3) any disability benefits payable under a group insurance contract or a retirement plan from the employer.

At all times, the total disability income payable under the present benefit and the other above-mentioned sources, cannot exceed the maximum amount equal to one hundred per cent (100%) of the member's net income at the beginning of his disability. (100% of the gross income if the benefit payable is taxable).

If a member refuses or neglects to submit a request for benefits under the laws mentioned above, when informed by the insurer that he could be eligible for such benefits, the insurer reserves the right to reduce from the benefits payable an estimate of benefits that could be provided by these laws.

EXCLUSIONS

No benefit is payable in the following cases:

- a) the member's participation in a criminal act or attempted criminal act;
- b) the member's active participation in a civil commotion, riot, insurrection or military operation during war, whether war is declared or not;
- c) self-inflicted wound or mutilation, regardless of the member's state of mind;
- d) the fact of having suffered from body lesions while his ability to drive was impaired, because of diminished faculties due to the consumption of alcohol or drugs;

- e) surgery not necessary for the member's health, for cosmetic or non-medically required care;
- f) during a period where an member stays more than 15 days outside of Canada;
- g) during a maternity leave provided for under provincial or federal law or of an agreement with the employer;
- h) period during which the member is not under the regular care of a specialist able to treat his illness, or if he does not receive proper therapy for his condition, or refuses such therapy;
- i) period during which the member is not under the care of a physician; the period of total disability may not start before the date of the first medical visit for the disability in question;
- j) disability that began before the effective date of insurance;
- k) disability as a result of a work related accident or occupational illness, unless otherwise stipulated in the "Summary of Benefits".

PROOF OF DISABILITY

To prove his disability and its continuance, the member must submit to the insurer a medical certificate using the insurer's forms.

The insurer may have the member undergo a medical examination by a physician of the insurer's choice and at the insurer's expense, as often as it judges necessary, if the proof submitted is not satisfactory to the insurer.

EXTENSION OF BENEFITS

Unless otherwise specifically mentioned for a particular benefit, the insurer pays the disability benefits provided in the present benefit for the entire disability period which began when the benefit was in force, and for provided that disability persists, and the conditions of the contract are met. If the benefit is terminated, benefits will continue to be paid as if the benefit had remained in force subject to the terms of the present benefit, as well as the laws in force.

DEDUCTION AT SOURCE

The insurer deducts from each benefit payment the amounts imposed by the Tax Act.

TERMINATION OF BENEFITS

Benefits terminate on the first of the following dates:

- a) the date of the member's death;
- b) the date on which the member ceases to be disabled;
- c) the date on which the member is unable to provide proof of his disability or refuses to provide such proof;

- d)** the date on which the member refuses or neglects to submit to a medical examination as requested by the insurer;
- e)** the date the member begins a remunerative occupation, unless he has the insurer's authorisation for rehabilitative employment, or the date on which he accomplishes one of the duties of his regular occupation other than through a rehabilitation program;
- f)** the date on which the member refuses without good reason totally or partially to participate in a rehabilitation program established and funded by the insurer to facilitate his return to the labour market and which the insurer's physicians and rehabilitation professionals deem reasonable and appropriate;
- g)** the date on which the member receives a retirement income, other than the one he was receiving at the beginning of disability while he was actively at work.

TERMINATION OF INSURANCE

In addition to the reasons for the termination of the member's insurance benefit stipulated in the section entitled "General Provisions" of the present policy, the insurance for this benefit will terminate at the earliest of the following dates at midnight:

- a)** the termination date or age limit stipulated in the "Summary of Benefits";
- b)** the member's retirement date, if earlier.

LONG-TERM DISABILITY BENEFIT

PURPOSE

The purpose of coverage is to replace in part the employment income loss incurred by an member during a period of total disability starting after the effective date of this benefit.

EXCLUSIVITY OF BENEFIT

No long-term disability benefits are payable until short-term disability benefits have expired.

ELIGIBILITY

To be eligible to the long-term disability benefit, an employee must be covered under the life insurance benefit.

ELIMINATION PERIOD

The elimination period is the period stipulated in the "Summary of Benefits" of the present policy.

REMISSION PERIOD PERMITTED

A period of one hundred and eighty (180) days immediately following the date a person ceases to be totally disabled.

BENEFIT AMOUNT

The benefit amount for each month of disability is stipulated in the "Summary of Benefits".

INDEXATION OF BENEFITS

When the disability benefit is indexed, the amount of benefit payable will be adjusted on the first day of January of each year following the first complete year of disability, excluding the elimination period, as per the indexation rate defined by the Quebec Pension Plan up to the maximum annual indexation rate indicated in the "Summary of Benefits".

EVIDENCE OF INSURABILITY

When the amount of monthly benefit exceeds the maximum amount of insurance without evidence of insurability stipulated in the "Summary of Benefits", the member is covered for the excess only if he submits proof satisfactory to the insurer. Subsequently, any increase in the amount of benefit will become effective only after the required evidence of insurability has been accepted by the insurer.

REDUCTION OF BENEFIT DUE TO INTEGRATION OF BENEFITS

Under the present article, the insurer pays a monthly disability benefit according to the lesser amount under paragraphs A) and B) that follow:

a) DIRECT INTEGRATION OF BENEFITS

The member is eligible only for disability benefits of the present benefit and those provided for by government plans.

The amount of disability benefits payable by the insurer is reduced by the amount of the initial basic benefits; without regard to subsequent increases due to indexation, payable under the following laws or plans, such as:

- the Quebec pension Plan or the Canada Pension Plan;
- the Occupational health and Safety Commission;

- the Automobile insurance Act in Quebec or Ontario;
- any other law providing income in case of disability.

However, this article only refers to the above-mentioned benefits whose payment started at the beginning or after the beginning of total disability.

If an member refuses or neglects to submit a request for benefits under the laws or plans mentioned above, when informed by the insurer that he could be eligible for such benefits, the insurer reserves the right to reduce from the benefits payable an estimate of benefits that could be provided by these laws or plans.

b) INDIRECT INTEGRATION OF BENEFITS

The member is eligible for additional disability benefits other than those of the preceding paragraph a).

If the member receives disability income that is greater than the maximum percentage of income permitted as specified in the "Summary of Benefits" and based on the member's income at the beginning of disability, the disability benefit is reduced so that the total amount of disability income does not exceed the maximum employment income at the beginning of disability. In calculating the maximum only the initial amounts of benefits will be considered without regard to subsequent increases due to indexation.

Other disability income amounts that are considered in the calculation mentioned in the preceding paragraph are:

- 1) any remuneration paid by an employer due to a salary continuation policy, holidays, sick days or any other benefits program established by the employer.
- 2) all annuities or benefits payable under the following laws or plans, such as:
 - the Quebec Pension Plan or the Canada Pension Plan;
 - the Occupational Health and Safety Commission;
 - the Automobile Insurance Act in the province of residence;
 - any other law providing income in case of disability.
- 3) any disability benefits payable under an insurance contract or a retirement plan.

MAXIMUM DISABILITY INCOME

For the purpose of this article, the maximum disability income is calculated by applying the percentage stipulated in the "Summary of Benefits":

- a) to the employee's gross income, if benefits payable by the insurer are taxable;
- b) the employee's net income, if benefits payable by the insurer are non taxable.

If an member refuses or neglects to submit a request for benefits with regards to such laws when eligible to such benefits, the insurer reserves the right to reduce from benefits payable an estimate of benefits that could be provided by these laws.

BENEFITS PAYMENT

Disability benefits are payable at the end of each month of disability, after the expiry of the elimination period.

For a period of disability that is less than one (1) month, the insurer pays one thirtieth (1/30th) of the monthly benefit for each day of total disability.

Benefits are payable for as long as the total disability period persists, without however, exceeding the maximal duration or the age limit as stipulated in the "Summary of Benefits".

REHABILITATION ASSISTANCE

If an member who has been totally disabled during at least the elimination period submits to a rehabilitation program approved by the insurer, he may retain the monthly disability benefits, in addition to any remuneration paid under the rehabilitation program. The rehabilitation status may be granted for a maximum period of twenty-four (24) months.

The monthly rehabilitation allowance is equal to the amount of the monthly benefits minus an amount equal to 50 % of the work income attained during the rehabilitation program.

The sum of income from the rehabilitation program and the monthly benefits may not, however, exceed one hundred per cent (100%) of the member's earned income at the beginning of disability; the benefits payable under this benefit will be reduced by any amount in excess of one hundred per cent (100%) of the member's earned income. The earned income is the employee's gross salary if the benefit is taxable or the net salary if the benefit is non-taxable.

The insurer may assist the member in any manner to encourage him to return to his regular occupation or any other remunerative occupation compatible with his state of health.

EXTENSION OF BENEFITS

Unless otherwise specifically mentioned for a particular benefit, the insurer pays the disability benefits provided in the present benefit for the entire disability period which began when the benefit was in force and for provided that disability persists, and the conditions of the contract are met. If the benefit is terminated, benefits will continue to be paid as if the benefit had remained in force, subject to the terms of the present benefit, as well as the laws in force.

DEDUCTION AT SOURCE

The insurer deducts each benefit payment the amounts imposed by the Income Tax Act.

EXCLUSIONS

No benefit is payable in the following cases:

- a) the member's participation in a criminal act or attempted criminal act;
- b) the member's active participation in a civil commotion, riot, insurrection or military operation during war, whether war is declared or not;
- c) the member's participation in an aerial flight, other than as a fare-paying passenger on a regular or chartered flight;

- d) a disability caused by a self-inflicted wound or mutilation, regardless of the member's state of mind;
- e) the fact of having suffered from body lesions while his ability to drive was impaired, because of diminished faculties due to the consumption of alcohol or drugs;
- f) the member's participation in land or water motor vehicle races, scuba diving, parachute jumping, free-fall or otherwise, bungee jumping, gliding or sail flights, or any other dangerous similar activity or sport;
- g) surgery not necessary for the member's health, for cosmetic or non-medically required care;
- h) during a period where an member stays more than fifteen (15) days outside of Canada;
- i) disability that occurs during a maternity leave provided for under provincial or federal law or an agreement with the employer;
- j) lumbago or back pain which diagnosis can only be made subjectively by the member's description of symptoms and cannot be supported by appropriate tests prescribed by a physician;
- k) period during which the member is not under the regular care of a specialist able to treat his illness, or if he does not receive proper therapy for his condition, or refuses such therapy;
- l) period during which the member is not under the care of a physician; the period of total disability may not start before the date of the first medical visit for the disability in question;
- m) disability that began before the effective date of the insurance;
- n) disability resulting from a work related accident or occupational illness unless otherwise stipulated in the "Summary of Benefits".

RESTRICTIONS

The amount of monthly benefits payable under the present benefit as well as disability benefits from all other sources cannot exceed the maximum percentage of the net income when benefits are non-taxable or the maximum gross income when benefits are taxable, as stipulated in the "Summary of Benefits".

When the member was not covered by an equivalent benefit and total disability begins within the twelve (12) month period following the effective date of the present benefit, no benefit is payable for an illness or an accident for which the member consulted a physician or other health professional, or received a medical treatment, or underwent an examination or diagnostic tests, or took medication, during the ninety (90) day period immediately preceding the effective date of the present benefit for an member.

TERMINATION OF BENEFITS

Benefits terminate on the first of the following dates:

- a) upon the member's death;
- b) the date the member ceases to be disabled;

- c) the date on which the member is unable to provide proof of his disability or refuses to provide such proof;
- d) the date on which the member refuses or neglects to submit to a medical examination as requested by the insurer;
- e) the date the member begins a remunerative occupation, unless he has the insurer's authorisation for rehabilitative employment, or the date on which he accomplishes one of the duties his regular occupation other than through a rehabilitation program;
- f) the date on which the member refuses without good reason totally or partially to participate in a rehabilitation program established and funded by the insurer to facilitate his return to the labour market and which the insurer's physicians and rehabilitation professionals deem reasonable and appropriate;
- g) the date on which the member receives a retirement income, other than the one he was receiving at the beginning of disability while he was actively at work.

TERMINATION OF INSURANCE

In addition to the reasons for the termination of the member's insurance benefit stipulated in the section entitled "General Provisions" of the present policy, the insurance for this benefit will terminate at the earliest of the following dates at midnight:

- a) the termination date or age limit stipulated in the "Summary of Benefits";
- b) the member's retirement date, if earlier.

HEALTH INSURANCE BENEFIT

This benefit includes Medical and Paramedical Expenses Insurance.

PURPOSE

The purpose of coverage is to refund eligible expenses following medical and paramedical expenses incurred following an accident or illness by an insured while this benefit is in force.

ELIGIBILITY

From the day that the employee not covered by the governmental health insurance program of their province satisfies to the eligibility conditions stated in the summary of benefits.

HOSPITALIZATION

This benefit is not available for persons not covered by the health insurance plan of the insured's province of residence.

MEDICAL AND PARAMEDICAL EXPENSES

The purpose of medical and paramedical expenses insurance is to refund, in part, eligible expenses incurred for medical and paramedical treatments following an accidental injury, an illness or pregnancy.

For each insured person under the present benefit, the percentage of refund is applied on each amount of incurred expenses for treatment, visit or purchase of supplies as well as on each maximum amount per policy year for the medical and paramedical expenses enumerated in the article "Eligible medical and paramedical expenses" of this section.

BENEFIT AMOUNT

The benefit amount is derived by deducting the deductible from the eligible expenses and by multiplying the difference by the percentage of refund. The maximum amount of eligible benefits for medical and paramedical expenses are specified in the "Summary of Benefits".

ELIGIBLE MEDICAL AND PARAMEDICAL EXPENSES

The following expenses, excluding paramedical care, are covered on the condition that they are prescribed by a physician and are necessary for treatment of an illness or an accident and are normal and reasonable with current medical procedures. When a medical recommendation is required for paramedical care, a note is inscribed in the "Summary of Benefits".

- a) If the “Summary of Benefits” stipulates “enlarged list”, only drugs obtained with the prescription of a physician or dentist are refundable.

If the “Summary of Benefits” stipulates “restrictive list”, only drugs that require the prescription of a physician are refundable.

If the “Summary of Benefits” stipulates “RAMQ list”, only the drugs published on the list of the Régie d’assurance maladie du Québec are refundable. Some of these drugs are however only refundable under the conditions and therapeutic indications determined by rules published by the RAMQ.

Also eligible are drugs prescribed by a physician where the therapeutic need is directly related to the following pathological conditions:

- cardiac problems;
- pulmonary problems;
- diabetes;
- arthritis;
- Parkinson’s disease;
- epilepsy;
- cystic fibrosis;
- glaucoma.

In the event of a lay-off, a strike or a lock-out, the coverage for drug insurance is extended for a thirty (30) day period following the starting date of the lay-off, the strike or the lock-out. The premium corresponding to this extension period must be paid to the insurer.

An insured living in Quebec who has attained the age of sixty-five (65) may choose to be insured under the public plan provided for in the Loi de l’assurance médicaments du Québec rather than remaining insured under the present benefit. If this is the case, the insured is no longer eligible for benefits under the present contract and he may no longer be reinstated to the group insurance plan with regards to drug insurance.

- b) the purchase of one IUD per calendar year;
- c) the purchase of reactive sticks, syringes and needles for diabetics;
- d) the purchase of miscellaneous items necessary following colostomy, ileostomy or ureterostomy;
- e) in emergency situations, the cost of transportation to a hospital in a duly authorised ambulance, as well as transportation by railway or by air to the nearest hospital, if the insured person cannot be transported in any other manner;
- f) care by a licensed nurse at the insured person’s home, upon presentation of a medical report, eligible up to a maximum amount and the period indicated in the “Summary of Benefits”;
- g) the purchase of made-to-measure orthopaedic shoes, sold by a specialised orthopaedic laboratory. In any calendar year, these purchases are limited to the number of pairs and eligible maximum amount indicated in the “Summary of Benefits”, as well as for a child less than or over sixteen (16)

years of age, subject to the overall eligible maximum indicated in the “Summary of Benefits”. These articles may also be prescribed by a podiatrist;

- h)** the purchase of corrective items added to ordinary shoes, orthoses or plantar supports, eligible up to a maximum eligible amount and period indicated in the “Summary of Benefits”. These items must be sold by a specialised orthopaedic laboratory and may also be prescribed by a podiatrist;
- i)** the purchase of elastic stockings sold by a specialty house, up to the number and period indicated in the “Summary of Benefits”;
- j)** the purchase or repair of a hearing aid, up to the maximum eligible amount and period indicated in the “Summary of Benefits”;
- k)** the purchase of external mammary prosthesis necessary following mastectomy, in excess of the amount covered by a governmental plan, up to the maximum amount and period indicated in the “Summary of Benefits”;
- l)** the purchase of an initial capillary prosthesis necessary following chemotherapy, eligible up to the maximum amount and period indicated in the “Summary of Benefits”;
- m)** rental or purchase, whichever is deemed more economical by the insurer of a basic manual wheelchair, a manual hospital bed and crutches, when required for temporary therapeutic use. The insured must obtain the insurer’s authorisation to purchase or rent any equipment. Failure to obtain authorisation from the insurer may result in the refusal of the claim;
- n)** the initial purchase (not the replacement) or rental, not exceeding the initial cost of prosthesis (other than dental), as defined by the Régie de l’assurance maladie du Québec, eligible up to the maximum amount and period indicated in the “Summary of Benefits”;
- o)** blood transfusions or its derivatives, dressings;
- p)** anaesthetic products;
- q)** expenses for eye examination performed by an ophthalmologist or by a licensed optometrist for insured persons between the ages of eighteen (18) and sixty-four (64), eligible up to a maximum amount and period indicated in the “Summary of Benefits”;
- r)** when deemed necessary for prevention or diagnosis, the following expenses are refundable:

 - laboratory analysis, subjected to a maximum eligible amount of \$150 per calendar year;
 - x-ray tests such as computer tomographies (scanners), ultrasounds, electrocardiograms, mammograms, x-rays (except for teeth and orthosis), subjected to a maximum eligible amount of \$300 per calendar year;
 - nuclear magnetic resonance imaging, subject to a maximum eligible amount of \$500 per calendar year;

- s) the purchase or repair of an appliance to measure the rate of glucose in the blood of an insulin-dependent diabetic is payable upon presentation of a physician's complete report attesting to the insured's insulin dependency, eligible up to the maximum amount and period indicated in the "Summary of Benefits";
- t) paramedical treatments; the fees for paramedical services given by:
 - chiropractor;
 - psychologist, psychoanalyst, psychiatrist, social worker;
 - physiotherapist, ergotherapist, orthotherapist;
 - audiologist, orthophonist, osteopath, podiatrist, naturopath;
 - acupuncturist;
 - dietician;
 - massotherapist.

The maximum amount and number of visits per calendar year for each above-mentioned specialist or each grouping of specialists are indicated in the "Summary of Benefits";

In addition, eligible expenses per insured person are limited to one (1) visit per day per specialist. Specialists must be members of their professional association and provide services that fall within their specialty;

- u) x-rays taken by a chiropractor for an insured person are limited per calendar year to the maximum amount indicated in the "Summary of Benefits";
- v) nursing care services rendered at the insured's home required after a hospitalization or surgical intervention requiring local anaesthesia performed at the hospital. Expenses are refunded up to the eligible maximum amount and period indicated in the "Summary of Benefits". The nurse must be a member of the l'Ordre des infirmiers du Québec (OIIQ) or infirmier en pratique privée du Québec (IIPPQ).
- w) the purchase or hernial bandages, corsets or orthopaedic bandages, splints, casts;
- x) rental or purchase, whichever is deemed more economical by the insurer, of a breathing assistance apparatus and oxygen. The insured must obtain authorisation from the insurer before making any purchase or rental. Failure to obtain this authorisation may result in the insurer's refusal of the claim. The maximum eligible amount and period are indicated in the "Summary of Benefits";
- y) rental or purchase, whichever is deemed more economical by the insurer, of a transcutaneous electric neurostimulator apparatus (tens). The insured must obtain authorisation from the insurer before making any purchase or rental. Failure to obtain this authorisation may result in the insurer's refusal of the claim. The maximum eligible amount and period are indicated in the "Summary of Benefits";
- z) fees for the substance used in medically required sclerosant injections administered by a physician. The maximum amount and period are indicated in the "Summary of Benefits".

DENTAL CARE AS A RESULT OF AN ACCIDENT

Expenses for dental care provided by a dental surgeon, outside a hospital when necessary following an accidental injury to natural, healthy and whole teeth, that occur while the person is insured and providing that treatment is given within twelve (12) months of the accident. Fees must be incurred in the province of residence and are eligible up to the maximum amount indicated in the "Summary of Benefits".

PROOF OF CLAIM

Eligible expenses are refundable upon presentation of original receipts.

To establish proof of claim, the insured must submit to the insurer original receipts from the suppliers providing treatments or products.

The insured must submit to a medical examination when the insurer is justified in requesting it considering the type of treatments that are required by the insured person's state of health. In the event of a medical examination, the physician is designated and paid by the insurer.

The insurer may also request, at the insured's expense, a report from the health professional that is treating the insured person. The insurer may request declarations from the person claiming benefits, as well as the use of the insurer's forms.

EXTENSION

Upon the member's death, the health insurance for insured dependants under the present benefit is extended without payment of premiums, up to the earliest of the following dates:

- a) twenty-four (24) months after the member's death;
- b) the date a dependant no longer meets the requirements mentioned in the definition of a dependant;
- c) the termination date of the present benefit.

TREATMENTS OUTSIDE OF THE INSURED'S PROVINCE OF RESIDENCE

This benefit is not available for persons not covered by the health insurance plan of the insured's province of residence.

REDUCTION OF BENEFITS DUE TO COORDINATION OF BENEFITS

In an insured covered under another insurance contract for part or all of the expenses foreseen in the present contract, the benefits payable by the insurer will be adjusted so that the total amount of benefits under all contracts does not exceed one hundred per cent (100%) of eligible expenses under the present benefit.

In addition, the priority of payment of benefits will be determined in the following manner:

- a) if another contract does not contain the coordination of benefits clause, the benefits of this other contract are to be paid before benefits of the present contract;

- b) if another contract has the coordination of benefits clause, priority of payment will be given to the contract under which the person who is entitled to benefits:
 - 1) is not a dependant, or;
 - 2) is an member's dependant whose day and month of birth is first to occur in the calendar year.

If it is impossible to determine the priority of payment under the manner stipulated above, benefits under all contracts will be subjected to a proportional calculation based on the amounts that would have been paid under each contract, as if only one contract had existed.

EXCLUSIONS

No benefit is payable for losses resulting from the following causes or incidents:

- a) the insured person's participation in a criminal act or attempted criminal act;
- b) injury or illness resulting from the insured person's active participation in a civil commotion, riot, insurrection or military operation during war, whether war is declared or not;
- c) the insured person's participation in an aerial flight, other than as a fare-paying passenger on a regular or chartered flight;
- d) suicide or any self-inflicted wound or mutilation, regardless of the insured person's state of mind;
- e) the fact of having suffered from body lesions while driving a vehicle with diminished faculties due to the consumption of alcohol or drugs;
- f) the insured person's participation in land or water motor vehicle races, scuba diving, parachute jumping, free-fall or otherwise, bungee jumping, gliding or sail flights, or any other dangerous similar activity or sport;
- g) incurred expenses for surgery or an elective or non-urgent treatment, or when a trip outside the province of residence was undertaken with the intention of receiving a medical treatment or hospital services, regardless of whether the trip was recommended by a physician or not;
- h) incurred expenses for treatment not medically required, or for cosmetic purposes or treatments that exceeds usual care normally applied for therapeutic purposes;
- i) all expenses that are payable or refundable under any governmental insurance plan or normally would be, or private plan;
- j) all expenses in excess of those considered reasonable, taking into consideration the importance of the situation, the normal rates in the region and the procedure that is normally used;
- k) all treatments or services that are provided free of charge or that would be free in the absence of insurance or that are not at the insured's expense;

- l)** expenses incurred for a health trip, a rest cure, diet purposes or weight-loss treatments;
- m)** treatments or services given by a member of the insured person's immediate family;
- n)** medical expenses resulting from illness or injury caused by employment or occupation for pay or profit, unless the member benefits from professional risk insurance coverage with regards to the present benefit;
- o)** expenses for varicose vein injections in the lower limbs, regardless of whether they are for medical purposes or not;
- p)** any drug that is available to the general public without a medical prescription.

N.B. Exclusions aa) and ab) do not apply to refundable drugs published on the list of the Régie d'assurance-maladie du Québec (RAMQ).

The following are not considered as drugs for the purpose of this benefit and are therefore not refundable:

- aa)** milk, regardless of its nature, or milk substitutes;
- bb)** proteins, dietary supplements, food, homeopathic or so called natural products;
- cc)** products for aesthetic or cosmetic care;
- dd)** products, hormones and injections for cellulites or obesity treatment, including anorexiant;
- ee)** products or medication used for eliminating the use of tobacco;
- ff)** mineral waters;
- gg)** disinfectants, lubricating eye drops and solutions for contact lenses;
- hh)** soaps, oils, shampoos and other hair products, emollients, creams and cough drops;
- ii)** vitamins;
- jj)** drugs administered for preventive measures. Under this exclusion, a drug used to stabilise or regulate a pathological state diagnosed by a physician is not considered as a preventive drug;
- kk)** drugs or substances used in the treatment of infertility or impotence;
- ll)** all substances used for insemination or or contraceptive gels or foams;
- mm)** anabolic steroids, growth hormones or experimentally administered drugs;
- nn)** all expenses arising from an illness or accident falling under the authority of the CSST or the Société de l'assurance automobile du Québec (SAAQ);

oo) drugs provided during hospitalization.

The insurer reserves the right to exclude or modify the premium on the date Health Canada approves any new drug having a significant effect on the cost of the benefit.

N.B. Notwithstanding the preceding, all medical expenses payable by the RAMQ list are also payable under this policy. Some of these expenses are however only covered under the therapeutic cases, conditions and indications determined by the rules published by the RAMQ.

TERMINATION OF INSURANCE

In addition to the reasons for the termination of the insured's insurance stipulated in the section entitled "General provisions" of the present policy, the insured's insurance for this benefit will terminate on the earliest of the following dates at midnight:

- a)** the termination date or age limit stipulated in the "Summary of Benefits";
- b)** the retirement date, if earlier;
- c)** for a dependant, on the date he no longer meets the definition of a dependant.

LEGAL ADVISOR

THE SERVICE

A service providing the member or his/her dependants with legal information with a simple phone call.

UV Insurance covers the telephone consultation fees given for the service of “Legal Advisor” on the aspects of law concerning:

Family and People’s Rights
(e.g.: divorce motives)

Consumer Rights
(e.g.: debts and loans)

Residential Lease
(e.g.: renewal)

Wills and Estate
(e.g.: settling of an estate)

Real Estate Rights
(e.g.: worker’s compensation board appeals)

Real Estate Rights
(e.g.: appeal for hidden defects, flaws)

Business law
(e.g.: patent, copyright and trademark)

Youth Protection
(e.g.: abused children)

The service is offered from 9:00 am to 8:00 pm Monday to Friday and 9:00 am to 5:00 pm Saturday, except on public holidays, using the following telephone numbers:

(514) 871-3263 1-800-550-3263

This service is available on an information basis only. It is not to be construed as a replacement of the usual legal advisor.

OPTIONAL LIFE INSURANCE BENEFIT FOR THE INSURED INCLUDING ACCIDENTAL DEATH OR DISMEMBERMENT BENEFIT

PURPOSE

The purpose of this benefit is to pay a death benefit upon death of an insured, when death occurs when the present life insurance benefit is in force.

SPECIFIC DEFINITIONS TO THE OPTIONAL LIFE INSURANCE BENEFIT FOR THE INSURED INCLUDING ACCIDENTAL DEATH OR DISMEMBERMENT BENEFIT

In the present policy, unless one of the benefits, a change, an amendment or the Summary of Benefits stipulates otherwise, we hereby define:

INSURED

A member or his spouse.

ELIGIBILITY

An insured is eligible for insurance under the present benefit, provided that he is under sixty-five (65) years of age and if he is already covered under the basic life insurance benefit.

To be insured, an eligible employee or his spouse must first submit a written request on the forms provided by the insurer.

AMOUNT OF INSURANCE

The amount of insurance for the present benefit is indicated hereinafter and, if applicable, according to the option selected by the member on the optional life insurance form:

MEMBER

- According to the number of \$1 000 units chosen by the member;
- Minimum amount: \$10 000;
- Maximum amount: \$1 000 000 including the life insurance benefit basic amount.

SPOUSE

- According to the number of \$1 000 units chosen by the member;
- Minimum amount: \$5 000;
- Maximum amount: \$100 000 including the life insurance benefit basic amount.

EVIDENCE OF INSURABILITY

All optional life insurance amounts become effective once the insurer has approved the evidence of insurability provided by the member or his spouse.

MAXIMUM AGE

The insurance for the present benefit cannot extend beyond the insured's sixty-fifth (65th) birthday.

SUICIDE

Should death occur within the twenty-four (24) month period following the beginning or the increase of the optional life insurance, and if death is by means of suicide, whether the insured is sane or not, the amount of optional life insurance or the increased amount is not payable, and the insurer's only responsibility is to refund the premiums.

FALSE DECLARATION

If the insurer issues an optional life insurance certificate with non-smoker rates, following the insured's declaration that he has not smoked during the preceding twelve (12) month period, and it is later proven that this declaration is false, the optional life insurance certificate becomes null and void, and the insurer's responsibility is limited to the refund of paid premiums, should death occur.

AGE ERROR

If the insured's declared age is found to be incorrect after the insured's death, the amount of insurance is adjusted in proportion to the premium received to the one that corresponds to the insured's true age, without, however, exceeding the amount of insurance that the insured would have been entitled to for his true age.

PREMIUM

The monthly insurance premium for the present benefit is established according to the gender, age group, and smoker or non-smoker status and is applicable to each thousand dollars (\$1,000) of insurance. The insured's age is the one attained on his birthday which is the closest to the date of the last contract renewal.

DEFINITION OF NON-SMOKER

A non-smoker is a person who has not used tobacco or other products containing nicotine during the twelve (12) months preceding the signature of the application for insurance or the review of his status, and in addition, this person has not consumed any illegal drugs during this same period. The insurer reserves the right to require a signed declaration with regards to his non-smoker status at each renewal.

ACCIDENTAL DEATH OR DISMEMBERMENT BENEFIT INCLUDED WITH THE OPTIONAL LIFE INSURANCE BENEFIT FOR THE INSURED

The benefit amount of the accidental death or dismemberment is the same amount as the optional life insurance benefit for the insured. Conditions and restrictions applicable to the present benefit are those indicated in the Section entitled "Accidental death or dismemberment benefit included with optional life insurance benefit for the insured" of the present contract.

MONTHLY COST PER \$1 000 UNITS :

Attained age	Male		Female	
	Non-smoker	Smoker	Non-smoker	Smoker
Less than 30	\$0,147	\$0,177	\$0,090	\$0,104
30 to 34	\$0,160	\$0,213	\$0,102	\$0,132
35 to 39	\$0,162	\$0,238	\$0,118	\$0,176
40 to 44	\$0,182	\$0,309	\$0,146	\$0,255
45 to 49	\$0,237	\$0,471	\$0,176	\$0,347
50 to 54	\$0,343	\$0,793	\$0,235	\$0,502
55 to 59	\$0,526	\$1,331	\$0,344	\$0,746
60 to 64	\$0,856	\$2,179	\$0,547	\$1,127

ACCIDENTAL DEATH OR DISMEMBERMENT BENEFIT INCLUDED WITH OPTIONAL LIFE INSURANCE BENEFIT FOR THE INSURED

PURPOSE

The purpose of coverage is to pay the insured an indemnity when he incurs a loss as described in the article Eligible losses of the present benefit, and this loss is by accidental means and occurs while the optional life insurance benefit for the insured is in force.

SPECIFIC DEFINITIONS TO THE ACCIDENTAL DEATH OR DISMEMBERMENT BENEFIT INCLUDED WITH OPTIONAL LIFE INSURANCE BENEFIT FOR THE INSURED

In the present policy, unless one of the benefits, a change, an amendment or the Summary of Benefits stipulates otherwise, we hereby define:

INSURED

A member or his spouse.

AMOUNT OF INDEMNITY

The amount of indemnity is equal to the product (a x b):

- a) the amount of insurance in force for the optional life insurance benefit for the insured including accidental death or dismemberment benefit;
- b) the relative value of the loss according to the table of losses, hereinafter.

ELIGIBLE LOSSES

Eligible losses are the ones listed in the table below; they must be the result of an accident and the loss must occur within three hundred and sixty-five (365) days of the accident.

TABLE OF LOSSES AND PERCENTAGE OF INDEMNITY	
LOSSES	PERCENTAGES
Quadriplegia, hemiplegia or paraplegia	200%
Life	100%
Two hands or two feet	100%
One eye and one hand or one foot	100%
Two eyes	100%
One hand and one foot	100%
Speech and hearing in both ears	100%
One arm or one leg	75%
One hand or one foot or one eye	66,67%
Speech	66,67%
Hearing in both ears	66,67%
Four fingers of the same hand	33,33%
The thumb and index of the same hand	33,33%
All the toes of the same foot	33,33%
Hearing in one ear	12,50%

Loss of an eye means total and permanent loss of sight of the eye.

Loss of speech must be total and permanent.

Loss of one hand or one foot means the amputation at the wrist or ankle joint or above, or the loss of its use.

Loss of one arm or one leg means the amputation at the elbow joint or knee joint or above, or the loss of its use.

Loss of hearing means total and permanent loss of hearing.

Loss of one finger means amputation at the joint between the finger and the hand or above, or the loss of its use.

Loss of one toe means amputation at the joint between the toe and the foot or the loss of its use.

Loss of use of a limb means total and permanent loss of each and all of the functions of the limb.

RESTRICTIONS

If the insured suffers more than one loss from the same accident, only one indemnity is paid, being indemnity for the most severe loss suffered.

In the case of quadriplegia, hemiplegia or paraplegia if the insured dies within ninety (90) days of the accident, the benefit payable is limited to one hundred per cent (100%) of the amount of insurance.

EXPOSURE AND DISAPPEARANCE

If, following an accident, the insured is inevitably exposed to natural elements causing a loss which would normally give rise to an indemnity; such loss will be covered under the provisions of the present benefit.

If the insured is not found within the year following his disappearance, due to a wreck or destruction of the means of transportation in which he was travelling at the time of the accident, loss of life due to bodily injury will be presumed after a period of three hundred and sixty-five (365) days following the date of the accident.

EXCLUSIONS

No indemnity will be payable if the loss is the result:

- a) of the insured's participation in a criminal act or attempted criminal act;
- b) of the insured's active participation in a civil commotion, riot, insurrection or military operation during war, whether war is declared or not;
- c) of the insured's participation in an aerial flight, other than as a fare-paying passenger on a regular chartered flight;
- d) of suicide or self-inflicted wound or mutilation, regardless of the insured's state of mind;

- e)** of death or having suffered from body lesions while his ability to drive is impaired according to the law, because of diminished faculties due to the consumption of alcohol or drugs;
- f)** of the insured's participation in land or water motor vehicle races, scuba diving, parachute jumping, free-fall or otherwise, bungee jumping, gliding or sail flights, or any other dangerous similar activity or sport;
- g)** of intoxication by or while under the influence of alcohol or drugs;
- h)** of an injury that does not show any visible trauma or external wounds, except for drowning or internal lesions discovered by autopsy;
- i)** of a physical or mental infirmity, or any kind of illness;
- j)** of poisoning or infection, except for an infection resulting from a wound or accidental cut;
- k)** of inhalation of toxic gas, except when inhalation is the result of an accident related to the insured's employment;
- l)** of service with the military, naval or air forces or with any other auxiliary or armed forces of any country, whether war is declared or not;
- m)** of a medical or dental treatment, surgery or anaesthesia.