

**CENTRAL ONTARIO STANDARD BRED
ASSOCIATION**

(CLASSES 7, 8 & 9)

CENTRAL ONTARIO STANDARDBRED ASSOCIATION

GROUP POLICY NUMBER: G28227

Class 7 - Grooms who are under age 50

Class 8 - Grooms who are age 50 or over but under age 65

Class 9 - Grooms who are age 65 or older

This Booklet provides you with a brief outline of the benefits for which you and, if applicable, your dependents are eligible. This booklet does not confer or create any contractual or other rights.

The exact terms of the benefits are described in the Group Policy G28227 issued by Industrial Alliance Insurance and Financial Services Inc. All rights with respect to the benefits will be governed solely by the Group Policy and in the event of a discrepancy between the Booklet and the Group Policy, the terms of the Group Policy will apply.

The policyholder reserves the right to amend or suspend any coverages, including coverages for retirees, that are provided under the group policy as well as terminate the group policy in its entirety at any time with respect to active employees (including those that may be absent due to a disability) as well as retired employees after their retirement.

In addition, the policyholder reserves the right to change the contribution requirements for the coverages, including coverages for retirees, provided under the group policy at any time with respect to active employees (including those that may be absent due to a disability) as well as retired employees after their retirement.

All matters and questions which you may have regarding your benefits should be handled by your Association, or, if applicable, the plan administrator who has been appointed by your Association.

Submission of Claims

Please forward all claim submissions to MDM Insurance Services Inc. at the following address for authorization:

MDM Insurance Services Inc.
Attention: Angela Moreau
P.O. Box 970
Guelph, Ontario N1H 6N1
Tel: (800) 838-1531

General Claim Inquiries

Industrial Alliance Insurance and Financial Services Inc.
Tel: 1-877-422-6487

Group Insurance Program

Arranged By:

The Leslie Group Ltd.

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SUMMARY OF BENEFITS

This section provides a summary of the benefits for which you and, if applicable, your dependents, are eligible to be covered for. A more detailed description of the benefits follows this section.

LIFE INSURANCE BENEFIT

Basic Life Insurance

<u>Classification</u>	<u>Amount of Basic Life Insurance</u>
All Members	\$20,000

Reductions and Termination

Your Basic Life Insurance will reduce to 50% at age 65 and terminate at age 70.

SUMMARY OF BENEFITS

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT

Basic Accidental Death and Dismemberment Insurance

<u>Classification</u>	<u>Amount of Basic Principal Sum</u>
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All Members	\$30,000
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Reductions and Termination

Your Basic Principal Sum will reduce to 50% at age 65 and terminate at age 70.

SUMMARY OF BENEFITS

LIFE INSURANCE BENEFIT FOR DEPENDENTS

<u>Classification</u>	<u>Amount of Dependent Life Insurance</u>
All Members	
Spouse:	\$5,000
Each child:	*\$2,500

*Dependent Life Insurance shall not be applicable to a child who is under 24 hours of age.

Termination

All amounts of Dependent Life Insurance on your spouse and children will terminate on the earlier of:

- (1) your 70th birthday, and
- (2) the date your spouse is no longer a dependent, with respect to the spouse,
or
- (3) the date the child is no longer a dependent, with respect to a child.

SUMMARY OF BENEFITS

SUPPLEMENTARY HEALTH INSURANCE BENEFIT FOR MEMBERS AND DEPENDENTS

Covered Expenses

- Nursing Care
- Convalescent Home Care
- Substance Abuse Treatment Facility
- Ambulance, Laboratory and Out-Patient Charges
- Prescription Drugs (Drug Card Plan)
- Paramedical Care
- Appliances
- Physician's Services
- Accidental Dental Care

Cash Deductible

- | | |
|--|---|
| - Chiropractic Services
(applicable only to an
insured person who resides
in Ontario) | \$10 per visit for the first 15 visits in a
calendar year and Nil thereafter during
such calendar year. |
| - All Other Covered Expenses | Not subject to a Cash Deductible |

Benefit Percentage

- | | |
|------------------------------|------|
| - Prescription Drugs | |
| - Fertility Drugs | 50% |
| - All other Drugs | 80%* |
| - All Other Covered Expenses | 80% |

*If an insured person should order his prescription drugs from Costco Wholesale Canada Ltd., the Benefit Percentage shall be 90% with respect to such drugs.

The Benefit Percentage means that part of the Covered Expense that the Insurer pays after the Cash Deductible has been satisfied.

SUMMARY OF BENEFITS

Covered Expense Maximums

- Nursing Care	\$10,000 in any continuous period of 12 months.
- Convalescent Home Care	\$20 per day.
- Substance Abuse Treatment Facility	Semi-private room rate.
- Prescription Drugs	Dispensing fee maximum of \$8.00 for each prescription item or refill of a prescription item.
- Paramedical Care	Physiotherapists: \$1,000 in any calendar year. All other practitioners: \$350 in any calendar year. The maximum is applied separately to each practitioner. (If the services of the practitioner are covered under the Provincial Medicare Act, no benefit is payable until the annual maximum under the Act is satisfied.)
- Accidental Dental Care	\$3,000 per lifetime.

Additional maximums are applicable to the Covered Expenses provided under this Benefit. You should refer to the Benefit description for these maximums.

Lifetime Maximum Benefit

\$5,000,000 in respect of each insured person while the member is under age 65. When the member attains age 65, the lifetime maximum shall reduce to \$50,000 in respect of each insured person, less any claims incurred by the insured person prior to the member attaining age 65.

SUMMARY OF BENEFITS

DENTAL EXPENSE BENEFIT FOR MEMBERS AND DEPENDENTS

(This Benefit will not be applicable to you and to your dependents until you have completed at least one month of continuous membership, provided you are insured under this Policy for all other Benefits.)

Covered Expenses

Part A Services

- Diagnostic
- Preventive
- Restorative
- Minor Surgical
- Other (includes denture rebasing and relining)

Part B Services

- Endodontic Services
- Periodontic Services
- Oral Surgery

Part C Services

- Prosthodontic Services - Removable

Cash Deductible

- | | |
|------------------------|----------------------------------|
| - All Covered Expenses | Not subject to a Cash Deductible |
|------------------------|----------------------------------|

Benefit Percentage

Part A Services	80%
Part B Services	80%
Part C Services	50%

SUMMARY OF BENEFITS

The Benefit Percentage means that part of the Covered Expense that the Insurer pays after the Cash Deductible has been satisfied.

Schedule of Fees

Current Provincial Fee Schedule for General Dental Practitioners less one year.

Covered Expense Maximums

Part A, B and C Services (combined)	\$1,500 in any calendar year per insured person, while the member is under age 65. When the member attains age 65, the maximum shall be \$1,500 in any calendar year, subject to a lifetime maximum of \$10,000 per insured person, less any claims incurred by the insured person prior to the member attaining age 65.
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Benefits for some dental procedures are limited. You should refer to the Benefit description for these limits.

LIFE INSURANCE BENEFIT FOR MEMBERS

Benefit

In the event of your death FROM ANY CAUSE, the amount of Life Insurance for which you are eligible will be paid to your beneficiary.

You name your own beneficiary and should you desire to change beneficiaries at any time you may do so (subject to any applicable law) by completing the necessary form which may be obtained from your Association.

Waiver of Premium Benefit

If you become disabled prior to age 65 and your disability lasts for a continuous period of 6 months, your Life Insurance will be continued without payment of further premiums while you remain disabled. The coverage being continued will terminate on your 65th birthday.

The amount of Life Insurance for which premium payments are being waived will be the amount of Life Insurance you were insured for on the date your total disability commenced.

This Benefit will be subject to proof of initial and continuing disability as set out in the Group Policy.

As used in this Benefit, “totally disabled” means your complete incapacity due to a medically determinable mental or physical impairment to perform substantially all of the essential duties of any occupation or employment for which you are reasonably qualified by education, training or experience.

Conversion Privilege

If your Life Insurance should terminate on or prior to your 65th birthday, you will, in specific circumstances, have a conversion privilege with respect to such insurance. The conversion privilege, if any, will be as set out in the Group Policy.

NOTE: The total amount of Life Insurance that you can convert during the lifetime of the Group Policy will be \$200,000.

LIFE INSURANCE BENEFIT FOR DEPENDENTS

Benefit

In the event of the death of one of your dependents FROM ANY CAUSE, the amount of Life Insurance for which they are insured will be paid to you.

Conversion Privilege

If the Dependent Life Insurance on your dependent should cease on or prior to the earlier of (1) your 65th birthday and (2) your dependent's 65th birthday, you or your dependent, in specific circumstances, may have a conversion privilege with respect to such Dependent Life Insurance. The conversion privilege will be as set out in the Group Policy.

Waiver of Premium Benefit

When the premiums for your Life Insurance are waived because of your total disability, the premiums in respect of your dependent's Life Insurance will also be waived subject to the following:

- (1) there will be no increase in the amount of insurance on the life of the dependent during the period premiums are being waived, and
- (2) the insurance on the life of the dependent will not be continued beyond the time it would otherwise terminate as provided for under the terms of the Group Policy.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT FOR MEMBERS

Definitions

As used throughout this Benefit:

“Principal Sum” shall mean the amount of Basic Principal Sum which applies to you on the date of the accident.

“Loss” shall mean:

- (1) with regard to the hand or foot, complete severance through or above the wrist or ankle joint, but below the elbow or knee joint;
- (2) with regard to an arm or a leg, complete severance through or above the elbow or knee joint;
- (3) with regard to the thumb, complete loss of one entire phalanx of the thumb;
- (4) with regard to a finger, complete loss of two entire phalanges of the finger;
- (5) with regard to a toe, the complete loss of one entire phalanx of the big toe and all phalanges of the other toes;
- (6) with regard to an eye, the irrecoverable loss of the entire sight thereof;
- (7) with regard to speech, the complete and irrecoverable loss of the ability to utter intelligible sounds; and
- (8) with regard to hearing, the complete and irrecoverable loss of hearing.

“Loss of Use” shall mean the total and irrecoverable loss of use provided the loss is continuous for 12 consecutive months and such loss of use is determined to be permanent at the end of such period.

Benefit

If you suffer any of the losses listed in the Schedule of Amounts of Insurance (see below) as a direct result of an accident which occurred while you were covered under this Benefit, the Insurer will pay the amount of insurance specified for the loss in the Schedule provided the loss occurred within 365 days after the date on which the accident occurred. The amount payable will be subject to any limitations and exclusions included in this Benefit.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT FOR MEMBERS

Schedule of Amounts of Insurance

Principal Sum for “Loss” of: Life; Both hands; Both feet; Sight of both eyes; One hand and one foot; One hand and sight of one eye; One foot and sight of one eye; Speech and hearing in both ears.

Two times the Principal Sum for: Quadriplegia (total paralysis of both upper and both lower limbs), paraplegia (total paralysis of both lower limbs), hemiplegia (total paralysis of both the upper and lower limbs of one side of the body).

Principal Sum for “Loss of Use” of: Both hands; Both feet.

Three-quarters of the Principal Sum for “Loss” of: One arm; One leg.

Three-quarters of the Principal Sum for “Loss of Use” of: One arm; One leg.

Two-thirds of the Principal Sum for “Loss” of: One hand; One foot; Sight of one eye; Speech; Hearing in both ears.

Two-thirds of the Principal Sum for “Loss of Use” of: One hand; One foot.

One-third of the Principal Sum for “Loss” of: Thumb and index finger of one hand; Four fingers on one hand; All toes on one foot.

One-quarter of the Principal Sum for “Loss” of: Hearing in one ear.

Exposure and Disappearance

If due to an accident you are unavoidably exposed to the elements and as a result of such exposure suffer a loss for which a benefit is otherwise payable hereunder, such loss will be covered under the terms of this provision.

If your body is not found within one year of an accident which results in the disappearance, sinking or wrecking of the conveyance in which you were riding at the time of the accident and such accident occurs under circumstances as would otherwise be covered hereunder, it will be presumed that you suffered an

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT FOR MEMBERS

accidental loss of life at the time of such disappearance, sinking or wrecking, unless there is evidence to the contrary.

Rehabilitation

If you should sustain a loss for which a benefit is payable under this provision, and such loss requires you to undergo a rehabilitation program in order to be qualified to engage in a special occupation for which you would not have engaged except for such loss the Insurer will pay the reasonable and necessary expenses incurred for such program, provided the Insurer has approved the rehabilitation program in advance. Payment by the Insurer for the total of all expenses incurred shall not exceed \$10,000, nor shall payment be made for any expenses incurred more than 3 years after the date of the accident or for any expenses for room, board, or other ordinary living, travelling or clothing expenses. If a rehabilitation benefit is provided under any other provision included in the Group Policy, it will only be payable under one of the provisions.

Occupational Training

If you suffer an accidental loss of life for which a benefit is payable under this provision, the Insurer will pay the reasonable and necessary expenses incurred by your spouse if he or she engages in an occupational training program in order to become specifically qualified for active employment in an occupation for which he or she would not otherwise have sufficient qualifications provided the Insurer approves such program in advance. Payment by the Insurer for the total of all expenses incurred shall not exceed \$10,000 nor shall payment be made for any expenses incurred more than 3 years after the date of the accident or for any expenses for room, board or other ordinary living, travelling or clothing expenses. If the spouse should receive a benefit hereunder, he or she will not be eligible to receive a benefit under the Education benefit.

Education

If you suffer an accidental loss of life for which a benefit is payable under this provision, the Insurer will pay the reasonable and necessary expenses incurred as a result of your dependent's continuation of their education as a full-time student at an educational institute which is beyond the high school level provided that the dependent was enrolled as a full-time student at such institute at the time of

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT FOR MEMBERS

your death or if the dependent is in high school at the time of your death, he or she enrolls as a full-time student at an educational institute which is beyond the high school level within 365 days of the date of your death. Payments will be made by the Insurer each year, for up to 4 successive years, that the dependent provides proof that he or she is a full-time student at an educational institute which is beyond the high school level. The amount of each payment shall not exceed \$5,000. If the spouse should receive a benefit hereunder, he or she will not be eligible to receive a benefit under the Occupational Training benefit.

Family Transportation and Accommodation

Should you be hospitalized more than 150 kilometers from your normal place of residence due to a loss for which a benefit is payable under this provision and you are under the regular care and attendance of a physician, the Insurer may pay the expenses for accommodation and transportation incurred by your immediate family members in visiting you. The expenses will only be reimbursed if (i) the Insurer deems the expenses to be reasonable and necessary, (ii) the expenses are a direct result of the visit, (iii) the transportation was by the most direct route to the hospital and (iv) the visit itself was deemed by the attending physician to be beneficial to your health. Payment by the Insurer for the total of all expenses incurred shall not exceed \$2,000.

If transportation is provided by a vehicle other than one operated under a license for the conveyance of passengers for hire, the reimbursement of transportation expenses will be limited to a maximum of \$0.20 per kilometer.

As used above, "immediate family" shall mean a person who is at least 18 years of age and who is your spouse, son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law.

If a family transportation and accommodation benefit is provided under any other provision included in the Group Policy, it will only be payable under one of the provisions.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT FOR MEMBERS

Repatriation

Should you accidentally die while outside of your province of residence and a benefit is payable for such loss under this provision, the Insurer will reimburse the actual expenses, up to a maximum of \$10,000, which are incurred for the preparation of your body for transportation and the actual transportation of the body to its first resting place (e.g. funeral home) in proximity to your normal place of residence. The reimbursement of the expenses will be made to the individual who incurred the expenses.

If a repatriation benefit is provided under any other provision included in the Group Policy, it will only be payable under one of the provisions.

Home Alteration and Vehicle Modification

If you should suffer a loss for which a benefit is payable under this provision and such loss results in you requiring a wheelchair to be ambulatory, the Insurer will pay the one time costs associated with

- (1) alterations to your principal residence, which have been recommended, in writing, by a recognized organization providing support to wheelchair users and which have been made by an individual experienced in such alterations, so as to make the residence wheelchair accessible and habitable, and
- (2) modifications to a motor vehicle used by you which have been made by an individual experienced in such modifications and which have been approved by the appropriate Provincial licensing authorities, so as to make the vehicle accessible and/or drivable by you.

Payment by the Insurer for the costs associated with the home alterations and vehicle modifications shall not exceed \$10,000 in total, nor shall payment be made for any expenses which are deemed by the Insurer to be unreasonable or unnecessary or which are incurred more than 365 days after the date of the accident which caused your loss.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT FOR MEMBERS

Seat Belt

If you should sustain a loss for which a benefit is payable under this provision and such loss occurred while you were driving or riding in a motor vehicle and while you were wearing a seat belt the Insurer will pay an additional benefit equal to 10% of your Principal Sum provided

- (1) the motor vehicle was being used in a prudent manner at the time of the accident,
- (2) the operator of the motor vehicle had a valid driver's license for the type of motor vehicle being used, and
- (3) proof, satisfactory to the Insurer, that you were wearing a seat belt at the time of the accident is submitted to the Insurer at time of claim.

As used above, "motor vehicle" means a private passenger motor vehicle.

Day Care

If you should suffer an accidental loss of life for which a benefit is payable under this provision, the Insurer will pay the reasonable and necessary expenses incurred as a result of your dependent child's enrollment in a legally licensed Day Care Centre, provided the child was enrolled in the Day Care Centre at the time of your death or is enrolled in the Day Care Centre within 365 days of your death. Payments will be made by the Insurer each year that the child is enrolled in a legally licensed Day Care Centre, for up to four successive years or until the dependent child's twelfth birthday, if earlier. Proof that the dependent child is enrolled in the legally licensed Day Care Centre will be required by the Insurer before payments will be made. The amount of each payment shall not exceed \$5,000.

Limitations

- (1) The total amount payable for all losses resulting from any one accident shall not exceed your Principal Sum, except with respect to hemiplegia, quadriplegia and paraplegia.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT FOR MEMBERS

- (2) If as a result of any one accident, you should suffer more than one of the losses shown in the Schedule of Amounts of Insurance with respect to any one limb, payment will be made only for the one loss for which the largest amount is applicable.

Aggregate Limit of Indemnity

The Insurer's aggregate limit of indemnity for all losses resulting from any one aircraft accident for which coverage under this provision is provided is \$5,000,000. In the event this limit is insufficient to pay the full amount of indemnity for each individual involved in the accident, the amount payable for each individual shall be in the proportion that the limit of indemnity for any one such accident bears to the total amount of benefit that would have been payable except for such limit of indemnity.

Exclusions

No benefit will be payable for any loss that resulted either directly or indirectly from, or was in any manner or degree associated with, or occasioned by, any one or more of:

- (1) Suicide, while sane or insane, or intentionally self-inflicted injury.
- (2) War or any act of war, whether declared or undeclared.
- (3) Participation in any riot or civil strife.
- (4) Committing or attempting to commit a criminal offense or provoking an assault.
- (5) Travel or flight in any vehicle or device for aerial navigation except:
 - (a) riding as a passenger and not as a pilot, operator or member of the crew, in or on any aircraft having a current and valid certificate of air worthiness and piloted by a person who holds a current and valid pilot's license of a rating authorizing such person to pilot the aircraft, or

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE BENEFIT FOR MEMBERS

- (b) riding as a passenger and not as a pilot, operator or member of the crew, in or on any aircraft operated by the Canadian Armed Forces or by a similar military service of any duly constituted governmental authority of any other recognized country.

Boarding or alighting from the aircraft will be deemed to be part of the flight. However, this provision will not cover any loss sustained while and in consequence of riding as a passenger, pilot, operator or member of the crew in or on any aircraft owned, operated, chartered or leased by the Policyholder.

SUPPLEMENTARY HEALTH INSURANCE BENEFIT FOR MEMBERS AND DEPENDENTS

Benefit

The Insurer will reimburse you for all covered expenses which are incurred by you or your insured dependents in an amount equal to the Benefit Percentage as outlined under the Summary of Benefits. Such amount will be subject to the Cash Deductible, any dollar maximums shown in the Summary of Benefits, and the limitations and exclusions included in this Benefit. The covered expenses apply separately to each insured person.

Covered Expenses

A charge made for any of the following services and supplies shall be considered to be a covered expense provided:

- (1) The charge is deemed to be reasonable and customary by the Insurer. If the charge is in excess of what is deemed reasonable and customary, it will only be covered up to the level which has been deemed reasonable and customary.
- (2) The charge is incurred after the person became insured under this Benefit.
- (3) The services or supplies are deemed by the Insurer to be medically necessary.
- (4) Coverage of the services or supplies is not prohibited under the Provincial Hospital or Provincial Medicare Act of your province of residence.

Nursing Care

Private duty nursing when (i) certified in writing by the attending physician as medically necessary and (ii) performed in the patient's home by a registered graduate nurse or registered nursing assistant, provided the nurse is not a relative of yours and does not have the same legal residence as you. All private duty nursing care must be pre-approved by the Insurer.

SUPPLEMENTARY HEALTH INSURANCE BENEFIT FOR MEMBERS AND DEPENDENTS

Convalescent Home Care

Room and board charges made by a convalescent home which is licensed by the appropriate licensing authority, to the extent that the charges are not covered by any other plans and do not include any part of a charge exceeding the limit stated under the Summary of Benefits, for a maximum of 180 days during any one continuous period of confinement provided the confinement:

- (1) occurs within 48 hours following a hospital stay of at least 3 consecutive days,
- (2) is for the same cause or causes as the preceding hospital stay,
- (3) has been recommended and approved, in writing, by a legally licensed physician, and
- (4) is primarily for rehabilitation or convalescent care and not primarily for custodial care.

"Continuous period of confinement" as used above, shall include all periods of confinement in a convalescent home which are due to the same or related cause or causes except periods of confinement separated by more than (i) 30 consecutive days, with respect to you and (ii) 180 consecutive days with respect to your dependent, during which you or your dependent was not so confined.

Substance Abuse Treatment Facility

Room and board charges made by a substance abuse treatment facility which is licensed by the appropriate licensing authority, to the extent that the charges are not covered by any other plans and do not include any part of a charge exceeding the limit stated under the Summary of Benefits, subject to a cumulative lifetime maximum of 60 days of confinement, provided:

- (1) The facility is located in your province of residence.
- (2) Confinement in the facility is the result of the insured person's involvement in a substance abuse rehabilitation program and is not primarily for custodial care.

SUPPLEMENTARY HEALTH INSURANCE BENEFIT FOR MEMBERS AND DEPENDENTS

- (3) A benefit with respect to the confinement is payable under the Provincial Hospital Act and/or Provincial Medicare Act of your province of residence. The insured person must confirm that a benefit is payable, in writing, with the administrators of such Acts prior to the confinement occurring.
- (4) The insured person has received approval for the confinement from the Insurer prior to the confinement occurring.

Ambulance, Laboratory and Out-Patient Charges

- (1) Use of professional ambulance service (including, where necessary, use of air ambulance and scheduled common carrier), to transport the insured person in a medical emergency to the nearest hospital equipped to provide the required treatment.
- (2) X-ray examinations and other diagnostic laboratory services.
- (3) Out-patient charges.

Prescription Drugs

- (1) The following items are covered when prescribed by a legally licensed physician, surgeon or dentist:
 - (a) Prescribed drugs which bear a valid Drug Identification Number (DIN) and are listed as prescription-requiring in the federal or provincial drug schedule.

Smoking cessation drugs, limited to a lifetime maximum of \$500 per insured person.
Fertility drugs, limited to a lifetime maximum of \$3,000 per insured person.
 - (b) Prescribed drugs which bear a valid Drug Identification Number (DIN) and which by convention require a prescription.

SUPPLEMENTARY HEALTH INSURANCE BENEFIT FOR MEMBERS AND DEPENDENTS

- (c) Extemporaneous preparations or compounds provided one of the ingredients is eligible for coverage.
 - (d) Insulin supplies, such as needles, syringes, lancets and diagnostic testing materials.
- (2) The quantity of drugs which may be dispensed for any one prescription will be limited to that amount sufficient for up to a 34-day period, except in the case of drugs for long term therapy (maintenance drugs) for which up to a 100 day supply is allowable.

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

If the drug is a brand name product which has a generic equivalent, the amount payable will be based on the lowest priced interchangeable product. However, if the healthcare provider who prescribed the drug has included the notation "Do not product select", "No Sub." or "No Substitution", the amount payable will be based on the cost of the eligible drug prescribed.

- (3) Items not covered, whether prescribed or not, include:
- (a) Over-The-Counter (OTC) drugs.
 - (b) Alcohol, alcohol swabs, disinfectants, cotton or bandages.
 - (c) Vitamins, other than injectable vitamins, minerals, dietary supplements, infant formulas or injectable Total Parenteral Nutrition (TPN) solutions.
 - (d) Diaphragms, condoms, contraceptive jellies/sponges/foams/suppositories, Intrauterine Devices (IUDs), contraceptive implants or appliances normally used for contraception.
 - (e) Proprietary drugs bearing a General Product (G.P.) number.
 - (f) Homeopathic preparations.

SUPPLEMENTARY HEALTH INSURANCE BENEFIT FOR MEMBERS AND DEPENDENTS

- (g) Prescriptions dispensed by a physician, dentist, clinic or by any non-accredited hospital pharmacy or for treatment as an outpatient in a hospital, including emergency status and investigational status drugs.
- (h) Preventative immunization vaccines and toxoids.
- (i) All allergy extracts, compounded by a lab, which do not bear a Drug Identification Number (DIN).
- (j) Habit breaking drugs for, but not limited to, obesity, drugs and alcohol, but not including drugs for smoking cessation.
- (k) Drugs considered lifestyle drugs such as, but not limited to, drugs for the treatment of erectile dysfunction, but not including drugs for the treatment of infertility.

Paramedical Care

Services performed by a licensed Chiropracist⁽¹⁾ or Podiatrist, Chiropractor, Masseur, Naturopath, Osteopath, Speech Therapist, Physiotherapist, Psychologist, or Acupuncturist, excluding any charges in excess of the limits stated in the Summary of Benefits.

⁽¹⁾in Ontario and Saskatchewan only

Appliances

The Insurer will rent or purchase at its option the following:

splints excluding dental splints,
apnea monitors for respiratory dysrhythmias,
canes and walkers,
crutches,
casts,
burn garments,
sleeves for lymphoedema following mastectomy,
support hose (calendar year maximum of four pair per insured person),
braces with rigid support,
orthopedic shoes which have been custom made, customized or custom molded for the Insured and which were recommended, in writing, by a legally licensed physician, up to a calendar year maximum of one pair per insured person,

SUPPLEMENTARY HEALTH INSURANCE BENEFIT FOR MEMBERS AND DEPENDENTS

stock item orthopedic shoes, up to a calendar year maximum of \$100 per insured person,
artificial eyes (repairs and replacements covered up to a calendar year maximum of \$1,000 per insured person),
artificial limbs and prostheses other than myoelectric and electric prostheses (repairs and replacements covered up to a calendar year maximum of \$2,000 per insured person),
wigs required as a result of chemotherapy or bodily injury (lifetime maximum of \$500 per insured person),
back supports,
stump socks,
shoulder harnesses,
head halter,
traction apparatus,
cervical collar,
colostomy and ileostomy apparatus and supplies,
catheters,
external breast prosthesis (two per insured person in any calendar year),
surgical bras (two per insured person in any calendar year),
diabetic monitoring and administration equipment (lifetime maximum of \$1,000 per insured person),
non-electric wheelchairs (lifetime maximum of \$2,000 per insured person) or electric wheelchairs where medically necessary (lifetime maximum of \$4,000 per insured person).
hospital beds,
bed rail,
trapeze bar,
transcutaneous nerve stimulator (lifetime maximum of \$2,000 per insured person),
intermittent positive pressure breathing machine,
aerosol equipment, mist tents and nebulizers for cystic fibrosis, acute emphysema, chronic obstructive bronchitis or chronic asthma,
oxygen tent and oxygen supplies,
sphygmomanometers (lifetime maximum of \$200 per insured person).
Foot orthoses which have been specifically designed and constructed for the Insured and which were recommended, in writing, by a physician or legally licensed surgeon, up to a calendar year maximum of \$100 per insured person.

SUPPLEMENTARY HEALTH INSURANCE BENEFIT FOR MEMBERS AND DEPENDENTS

Hearing aids obtained on a written prescription of a physician licensed as a otolaryngologist (excluding charges for batteries) up to \$500 per insured person in any 5 consecutive calendar years.

Physician's Services

- (1) Charges made by a legally licensed physician or surgeon in your province of residence, in excess of the current tariff of the relevant Medical Association, where not prohibited by any government legislation or regulations.
- (2) Charges made by a legally licensed physician or surgeon in respect of services performed outside of your province of residence but excluding any benefit payable under the provincial government plan and where not prohibited by any government legislation or regulations.

Accidental Dental Coverage

Charges by a legally licensed dentist for treatment necessitated by a traumatic injury to sound natural teeth or the surrounding tissues provided:

- (1) The damage is not due to an object or food placed wittingly or unwittingly in the mouth.
- (2) The injury occurs while the insured person is insured under this Benefit.
- (3) The charges are incurred within twelve months of the injury. However, if the charges are to be incurred more than 60 days after such injury, a treatment plan must be submitted to the Insurer within 60 days of the injury.
- (4) The treatment is the least expensive that will provide a professionally adequate result.
- (5) No payment will be made by the Insurer for any part of the charge which exceeds the amount shown for the treatment in the Current Provincial Fee Schedule for general practitioners in your province of residence.

SUPPLEMENTARY HEALTH INSURANCE BENEFIT FOR MEMBERS AND DEPENDENTS

The total amount payable under this covered expense during the lifetime of the insured person (whether or not the insured person is continuously insured) including any amount payable for charges incurred following discontinuance of the insured person's insurance under this Benefit shall not exceed the limit stated in the Summary of Benefits.

Extension of Benefits

If you or your insured dependent is disabled on the date your or their insurance is discontinued under this Benefit, benefits will be available during the continuance of such disability but only while this Benefit remains in force and only with respect to the charges for covered expenses which arise as a result of the disability, provided such charges are incurred within three months of the date of the discontinuance.

As used above “disabled” and “disability” mean that an insured person, due to injury, disease or pregnancy is confined to hospital or is receiving treatment by a legally licensed physician or surgeon.

Survivor Benefit

If you die while insured under this Benefit and prior to any continuance of insurance as provided under the Extension of Benefits section, insurance under this Benefit will be continued with respect to your dependents who were insured under this Benefit on the date of your death, without payment of premiums. The insurance will terminate on the earliest of:

- (1) 2 years following the date of your death, and
- (2) the date the dependent no longer qualifies as a dependent, and
- (3) the date of termination of this Benefit with respect to active members.

Coordination of Benefits

The Group Policy includes a Coordination of Benefits provision. This provision operates in the event that you and/or your insured dependents are covered under this policy as a member and as a dependent or as a dependent of more than one

SUPPLEMENTARY HEALTH INSURANCE BENEFIT FOR MEMBERS AND DEPENDENTS

member, or under another Group Plan, or individual insurance plan, or any government legislated automobile insurance plan including the Quebec Automobile Insurance Plan, and ensures that payments made by all plans do not exceed the actual expenses incurred.

Exclusions

"Covered Expenses" shall not include any charge:

- (1) For any services or benefits which are "insured services or benefits" under any government legislation or regulation and to the extent that insurance for such service is prohibited by law.
- (2) For or in connection with general health examinations.
- (3) For or in connection with the treatment of pre-existing dental disease or orthodontic malocclusion in order to facilitate treatment for a traumatic injury to sound natural teeth or the surrounding tissues.
- (4) For or in connection with a surgical procedure or treatment performed for primarily cosmetic reasons, or for hospital confinement for such procedure or treatment.
- (5) For or in connection with any services or supplies which are for the sole purpose of facilitating the insured person's participation in sports or recreational activities and not for other daily living activities.
- (6) For services or treatments due to insurrection or war, declared or undeclared, whether or not the insured person is actually participating in such insurrection or war.
- (7) Which occurs as a result of participation in a riot or civil commotion.
- (8) Which results from the commission of or attempted commission of a criminal offense or the provoking of an assault.

SUPPLEMENTARY HEALTH INSURANCE BENEFIT FOR MEMBERS AND DEPENDENTS

- (9) Which results from an intentionally self-inflicted injury while sane or insane.
- (10) For services for which the insured person is not required to make payment or where payment is received as a result of legal action or settlement.
- (11) For any drugs, medicines, medical testing, surgical procedures and appliances considered by the Insurer to be experimental and not recognized by the Canadian Medical Association as an established standard treatment for the condition.
- (12) For private duty nursing where:
 - (a) services are performed by a registered graduate nurse unless such qualified individual is required to administer intravenous medication or narcotics and to continuously monitor the vital signs of the patient;
 - (b) services are performed by a registered nursing assistant when the care could be administered by a less qualified individual;
 - (c) no record of the nurse's daily duties are submitted as part of the proof of claim.
- (13) For any orthotic appliance which was not specifically designed and constructed for the insured person and which was not recommended, in writing, by a legally licensed physician or surgeon.
- (14) For any fees charged in respect of services performed by a legally licensed physician or surgeon in your province of residence which are not included in the current tariff of the provincial government plan.
- (15) For any services received or performed outside of Canada.
- (16) For which the insured person may apply and receive indemnity or compensation under any Worker's Compensation Act.

SUPPLEMENTARY HEALTH INSURANCE BENEFIT FOR MEMBERS AND DEPENDENTS

- (17) For any care or treatment which was provided by a healthcare provider who, or a service provider that:
- (a) has been charged with professional misconduct or improper practices; or
 - (b) is under investigation by an official body resulting from a law or regulation; or
 - (c) is under investigation by the insurer in regards to his professional conduct or practice; or
 - (d) is a member of a profession that is not regulated by an officially recognized federal or provincial regulatory body in the jurisdiction where the services were provided and, in the reasonable opinion of the insurer, does not meet the industry standards relevant to his profession.

Conversion Privilege

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

- a) his employment; or
- b) his group membership,

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

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

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

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

DENTAL EXPENSE BENEFIT FOR MEMBERS AND DEPENDENTS

Benefit

The Insurer will reimburse you for all covered expenses which are incurred by you or your insured dependents. Payment will be made up to the amount set for General Practitioners in the Provincial Association Schedule of Fees subject to the Benefit Percentage, Cash Deductible and any dollar maximums shown in the Summary of Benefits and the limitations and exclusions included in this Benefit.

Alternative Courses of Treatment

When there are two or more courses of treatment available with respect to a dental condition, the amount payable under this Benefit will be limited to the least expensive treatment which will produce a professionally adequate result.

Pre-Determination of Benefits

When a course of treatment is expected to exceed \$1,000 or when an alternative course of treatment is available, you may want to submit a treatment plan, prepared by the dentist, for review prior to the treatment commencing. This will enable the Insurer to determine for you what level of coverage will be provided under this Benefit with respect to the proposed treatment, thus avoiding any potential misunderstandings.

Covered Expenses

A charge made for any of the following services shall be considered to be a covered expense provided:

- (1) The charge was incurred after the person became insured under this Benefit.
- (2) The services for which the charge was incurred are deemed by the Insurer to be necessary.
- (3) The services for which the charge was incurred were performed by a legally licensed dentist.

DENTAL EXPENSE BENEFIT FOR MEMBERS AND DEPENDENTS

- (4) Coverage of the services for which the charge was incurred is not prohibited by law.

PART A SERVICES

(1) Diagnostic

- (a) Clinical oral examinations
 - complete oral examinations – limited to one in any 2 calendar years
 - recall examinations – limited to 2 in any calendar year
 - all other limited and specific examinations – limited to 2 in total in any calendar year
- (b) X-rays
 - complete series – limited to one in any 2 calendar years
 - bitewings – limited to 6 films in any calendar year
 - panoramic – limited to one in any 3 calendar years
- (c) Histological, cytological and pulp vitality tests and analyses
- (d) Treatment planning and consultation with the dentist – limited to 2 units in any calendar year

(2) Preventive Services

- (a) Polishing of teeth – limited to 2 units in any calendar year
- (b) Scaling of teeth – limited to 2 units in any calendar year*
* If Periodontal Services are covered under this Benefit, any additional units of scaling will be combined with root planing.
- (c) Topical application of fluoride – limited to twice in any calendar year
- (d) Oral hygiene instruction – limited to once per lifetime
- (e) Application of fissure sealants for children under 18 years of age

DENTAL EXPENSE BENEFIT FOR MEMBERS AND DEPENDENTS

- (f) Space maintainers for children under 18 years of age – maintenance limited to twice in any calendar year
 - (g) Finishing restorations provided the restorations are at least 2 years of age
 - (h) Interproximal diskling of teeth – limited to 2 units in any calendar year
 - (i) Recontouring of teeth for functional reasons – limited to 2 units in any calendar year
- (3) Minor Restorative Services** – only covered if necessitated by decay or traumatic injury to the teeth
- (a) Caries, trauma and pain control
 - (b) Amalgam, prefabricated (for children under 18 years of age), tooth coloured composite and gold foil restorations
 - (c) Retentive pins
- (4) Minor Surgical**
- (a) Removal of teeth and residual roots
 - (b) Control of hemorrhages
- (5) Additional Services**
- (a) Anesthesia – local, general, deep and conscious sedation
 - (b) Special professional visits (home, office and institutional visits) – limited to \$250 in total during any calendar year
 - (c) Therapeutic injections

DENTAL EXPENSE BENEFIT FOR MEMBERS AND DEPENDENTS

- (d) Repairs or additions to dentures – limited to twice in any calendar year
- (e) Relining or rebasing of dentures – limited to once in any 2 years
- (f) Repairs to porcelain/ceramic inlays, onlays and crowns
- (g) Recontouring of existing crowns

PART B SERVICES

- (1) **Endodontic Services** (includes pulpotomy/pulpectomy, root canal therapy, apexification and periapical services) – a claim for services on a tooth within 3 months of a previous claim on the same tooth will be reduced by the amount of the previous benefit paid
- (2) **Periodontic Services** (includes non-surgical, surgical and adjunctive services)
 - occlusal adjustment/equilibration – limited to 2 units in any calendar year
 - root planing – limited to 8 units in any calendar year*
* Will be combined with any units of scaling which are in excess of the limit stated under the Preventive Section.
 - periodontal appliances (includes impression, insertion and adjustment) – limited to one in any 4 years
 - repair, maintenance and adjustments of periodontal appliances – limited to 2 units in any calendar year
- (3) **Oral Surgery**
 - (a) Transplantation or repositioning of tooth – limited to a maximum of \$150
 - (b) Remodelling and recontouring of oral tissues (includes alveoloplasty, gingivoplasty, stomatoplasty and vestibuloplasty)

DENTAL EXPENSE BENEFIT FOR MEMBERS AND DEPENDENTS

- (c) Surgical excision provided not in conjunction with tooth removal
 - excision of benign or malignant tumors – if over 1 cm. in diameter will be limited to a maximum of \$150
 - enucleation of cysts/granulomas – if over 1cm. in diameter will be limited to a maximum of \$150
 - marsupialization of cyst – if over 1cm. in diameter will be limited to a maximum of \$150
 - excision of cyst – if over 1cm. in diameter will be limited to a maximum of \$150

- (d) Surgical incisions
 - removal of foreign bodies – limited to a maximum of \$150

- (e) Treatment of fractures (includes treatment of mandibular, maxillary and alveolar fractures)
 - mandibular or maxillary fractures (includes wiring) – if open reduction will be limited to a maximum of \$750

 - alveolar fractures - repairs and lacerations - if over 6 cm. will be limited to \$750

- (f) Frenectomy/ frenoplasty

- (g) Antral surgery

PART C SERVICES

(1) Prosthodontic Services – Removable

- (a) Complete and partial dentures (includes overdentures)
 - precision, semi-precision and stress breaker attachments – limited to a maximum of \$550 plus lab fees
 - denture adjustments – limited to twice in any calendar year but not within 3 months of the insertion of the denture unless performed by a dentist other than the dentist who provided the dentures

DENTAL EXPENSE BENEFIT FOR MEMBERS AND DEPENDENTS

- prophylaxis and polishing of dentures – limited to once every 2 years

Part C Services: Exclusions and Limitations

Covered expenses will not include any charges incurred directly for or as a result of the following:

- (1) The replacement of an existing appliance (removable partial or complete dentures) which has been lost or stolen.
- (2) The replacement of an existing appliance (removable partial or complete dentures) unless (i) necessitated by the extraction of one or more additional natural teeth while insured under this Benefit*, (ii) the existing appliance is at least 4 years old and cannot be repaired, or (iii) the existing appliance is temporary and is replaced with a permanent bridge or a permanent denture.

If the replacement appliance is of a different type, the maximum amount payable will be limited to the current coverage of the type of appliance being replaced.

*The stipulation that the extraction of one or more natural teeth occur **while insured under this Benefit** will only apply to those insured persons whose coverage became effective on or after October 1, 2009.

- (3) The initial installation of an appliance (removable, partial or complete dentures), unless the appliance is required to replace one or more natural teeth extracted while insured under this Benefit*.

*The stipulation that the extraction of one or more natural teeth occur **while insured under this Benefit**, will only apply to those insured persons whose coverage became effective on or after October 1, 2009.

Coordination of Benefits

The Group Policy includes a Coordination of Benefits provision. This provision operates in the event that you and/or your insured dependents are covered under

DENTAL EXPENSE BENEFIT FOR MEMBERS AND DEPENDENTS

the policy as a member and as a dependent or as a dependent of more than one member, or under another Group Plan, or individual insurance plan, or any government legislated automobile insurance plan and ensures that payments made by all plans do not exceed the actual expenses incurred.

Survivor Benefit

If you die while insured under this Benefit and prior to any continuation of insurance that may be provided, the insurance under this Benefit will be continued with respect to your dependents who are insured under this Benefit on the date of your death, without payment of premiums. The insurance will terminate on the earliest of

- (1) 2 years following the date of your death, and
- (2) the date the dependent no longer qualifies as a dependent, and
- (3) the date of termination of this Benefit with respect to active members.

Limitations

If the date your dependent's insurance commenced is more than 31 days after the date your dependent became eligible, covered expenses will be limited to \$200 for the first 12 months of coverage, during which time full premiums must be paid.

Exclusions

The determination of "Covered Expenses" shall not include any charge:

- (1) For services or treatments due to insurrection or war, declared or undeclared, whether or not the insured person is actually participating in such insurrection or war.
- (2) For services or treatments due to participation in any riot or civil commotion.

DENTAL EXPENSE BENEFIT FOR MEMBERS AND DEPENDENTS

- (3) For services or treatments due to the commission of or attempted commission of a criminal offense or provoking an assault.
- (4) For services or treatments due to an intentionally self-inflicted injury, while sane or insane
- (5) For services or an examination performed by a dentist solely for the use of a third party.
- (6) For recent duplication of services by the same or a different dentist.
- (7) For a broken appointment.
- (8) For services or treatments which the insured person received while attending an accredited educational institute, college or university outside of Canada.
- (9) For services or treatments for which an insured person is not required to pay, including any expenses reimbursed, assumed or allowed under any other non-contractual plan, scheme or arrangement.
- (10) For services for which the insured person receives payment as a result of legal action or settlement.
- (11) For which the insured person may apply for and receive indemnity or compensation under any Workers' Compensation Act.
- (12) For services or treatments performed by a specialist and which are only included under a Specialist's Dental Fee Guide.
- (13) For services or treatments considered by the Insurer to be experimental and not recognized by the Canadian Dental Association as an established, standard treatment for the condition.
- (14) For services or treatments which are due to or related (directly or indirectly) to implants.

DENTAL EXPENSE BENEFIT FOR MEMBERS AND DEPENDENTS

- (15) For a full mouth reconstruction, for a vertical dimension correction, or for a correction of a temporomandibular joint dysfunction.
- (16) For services or treatments performed for primarily cosmetic reasons.
- (17) For the placing of crowns to restore occlusal height or as a preventive measure.
- (18) For the permanent splinting of teeth.
- (19) For services or treatments furnished before the date on which the insured person on whose account the charge was made became insured under this Benefit.

Conversion Privilege

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

- a) his employment; or
- b) his group membership,

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

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

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

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

GENERAL INFORMATION

Your Eligibility

You are eligible, and will continue to be eligible, to be covered for the insurance described in this booklet while you meet all of the following conditions:

- (1) You are a member in good standing of the Central Ontario Standardbred Association who holds a Provincial Racing Commission License as a Caretaker, Groom, Owner, Breeder, Trainer, or Driver of Standardbred Race Horses.
- (2) You are a full-time resident of Ontario.
- (3) You are insured under the Provincial Hospital and/or Provincial Medicare Plan of your province of residence. (This condition only applies to the insurance provided under the Supplementary Health Insurance Benefit.)

Date Your Coverage Commences

Your coverage will commence on the latest of:

- (1) the date you satisfy the conditions of eligibility,
- (2) the date you complete an application for coverage, and
- (3) the date of approval by the Insurer of evidence of insurability,

provided you are not confined to a hospital or other treatment facility for the purpose of medical care or treatment. Your coverage shall not become effective until you are no longer so confined.

Date Changes In Your Coverage Take Effect

An increase in your coverage will take effect on the date you become eligible for the change in coverage. However, if on the date your coverage would otherwise increase, you are confined to a hospital or other treatment facility for the purpose of medical care or treatment, the increase in your coverage shall not become effective until you are no longer so confined.

GENERAL INFORMATION

A decrease in your coverage will take effect automatically on the date of the change.

Date Coverage On Your Dependents Commences

If you are insured, you may apply to cover your dependents. If on the date a dependent is to become covered, the dependent is confined to a hospital or other treatment facility for the purpose of medical care or treatment, the coverage with respect to the dependent shall not become effective until the date the dependent is no longer so confined. This paragraph will not result in postponing the effective date of the coverage on a child born while you have other dependents covered.

For the purposes of the Supplementary Health Insurance Benefit a dependent will not become covered unless the dependent is covered under the Provincial Hospital and/or Provincial Medicare Plan of your province of residence.

Conditions Under Which You May Waive Coverage

If your spouse is covered for benefits which are comparable to the benefits under the Supplementary Health Insurance Benefit and/or Dental Expense Benefit you may decline to cover your dependents only, for such benefits under the Group Policy.

If the coverage under your spouse's plan should cease because the plan terminated or eligibility for such coverage ceased, you may make application to cover under the Group Policy those persons who had been covered under your spouse's plan.

Such application must be made within 31 days after the cessation of the coverage under your spouse's plan and the coverage under the Group Policy shall be effective on the day following the date of termination of the coverage under your spouse's plan.

GENERAL INFORMATION

Conditions Under Which Your Coverage Terminates

Your coverage under the Group Policy terminates when your membership terminates, unless otherwise provided in the Summary of Benefits.

Submission Of Claim

Written proof stating the occurrence, character and extent of the loss for which a claim is being made must be furnished to the Insurer as follows:

- (1) With respect to Life and Accidental Death and Dismemberment Benefits, as soon as possible after the loss, but in any event within one year of the date of the loss.
- (2) With respect to the Supplementary Health Insurance Benefit and the Dental Expense Benefit, the claim must be submitted in the calendar year in which the claim was incurred or the calendar year immediately following the calendar year in which the claim was incurred. However, if the plan or your coverage under the plan should terminate, proof of the loss must be submitted to the Insurer within 90 days of the date of such termination.

The Insurer retains the right to audit all claims at any stage, including after payment has been made, for fraud or misrepresentation. If the insurer determines that you have intentionally submitted a claim that contains false or misleading information, the insurer shall have the right, at its sole discretion, to notify the policyholder, decline the claim or require reimbursement if the claim has been paid. In addition, the insurer will have the right to terminate your entire coverage under this policy including any coverage for your dependents.

Discontinuance of the Group Policy

Your Association hopes and expects to continue the plan indefinitely, but the possibility of unforeseen circumstances makes it necessary to reserve the right to amend, suspend or entirely discontinue the plan at any time.

GENERAL INFORMATION

Medical Services and/or Supplies covered by a Government Sponsored Plan or Program

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

Incontestability

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

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

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

- a) 2 years from the effective date of the insurance or benefit for which the evidence was provided; or
- b) 2 years from the effective date of the increase, addition or change to the insurance or benefit; or
- c) 2 years from the effective date of the last reinstatement of the insurance or benefit.

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

GENERAL INFORMATION

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

Beneficiary

Your beneficiary shall be the person or persons designated by you, in writing, to receive the death benefit payable under the Life Insurance Benefit, and if applicable, the Accidental Death and Dismemberment Insurance Benefit, Optional Life Insurance Benefit and Optional Accidental Death and Dismemberment Insurance Benefit. If you do not designate a beneficiary, any death benefit payable under such benefits will be payable to your estate.

All benefits, other than the Life Insurance Benefit, Accidental Death and Dismemberment Insurance Benefit, Optional Life Insurance Benefit and Optional Accidental Death and Dismemberment Benefit, will be payable only to you, or if you are deceased at the time of the payment of the benefit, to your estate.

You will be able to designate a beneficiary or change a named beneficiary by a signed written declaration, subject to the provisions of the law. The Insurer will not be responsible for the sufficiency or validity of the beneficiary designation or change of beneficiary.

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

This policy contains a provision removing or restricting the right of the group insured to designate persons to whom or for whose benefit insurance money is to be payable.

GENERAL INFORMATION

Limitation on Legal Actions

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

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

Copy of Contract and Enrolment Material

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

DEFINITIONS

The following terms are used in this Booklet.

“Dependent” shall mean:

- (1) Your spouse. Spouse shall mean either:
 - (a) an individual who is married to you by reason of a valid religious or civil marriage ceremony, while not legally separated from you,
 - or
 - (b) your common-law spouse.

If you have had more than one spouse, spouse shall mean the individual most recently qualified.

- (2) Each unmarried child, step-child, legally adopted child or common-law child of yours provided the child is not employed on a full-time basis, relies fully upon you for support and maintenance and fits one of the following descriptions:
 - (a) the child is under 21 years of age, or
 - (b) the child is at least 21 years of age but under 25 years of age and is attending an accredited educational institute, college or university on a full-time basis.
- (3) each unmarried child, step-child, legally adopted child or common-law child of yours, regardless of such child's age, if the child, due to a mental or physical handicap, is incapable of earning their own living and relies fully upon you for support and maintenance provided such handicap commenced while the child was a dependent child as defined in clause (2) and that proof of such handicap was received by the Insurer within 31 days of the applicable of the maximum ages stated in clause (2).

However, for the purpose of the Group Policy, anyone who is in the armed forces of any country or state or international organization or a civilian force auxiliary to any military force, will be excluded from this definition.

DEFINITIONS

“Common-law spouse” shall mean a person who resides with you and who has resided with you for at least 12 months and whom you publicly represent as your spouse.

“Common-law child” shall mean a child of your common-law spouse from another relationship and who resides with you and is in your and your common-law spouse's care and custody.

“Calendar year” shall mean the period from any January 1st to the next following December 31st, both inclusive.

“Emergency” means a sudden, unexpected occurrence that requires immediate medical attention.

PROTECTING PERSONAL INFORMATION

Industrial Alliance is committed to protecting the privacy of your (including your dependent's) personal information that it collects while providing services under the Group Plan issued to the Policyholder. Industrial Alliance recognizes and respects a person's right to privacy concerning his or her personal information.

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

Access to the file will be limited to Industrial Alliance employees, agents and service providers who require access in the performance of their jobs, individuals to whom you have granted access, and persons authorized by law.

At Industrial Alliance the personal information that is collected is used to perform administrative services with respect to the Group Plan. Administrative services include, but are not limited to,

- Determining eligibility under the Group Plan or a particular benefit;
- Enrolling participants under the Group Plan;
- Adjudicating claims; and
- Underwriting (includes determining the rates applicable to the Group Plan).

Your Right to Access Your Personal Information

You have the right to access your personal information and to request, in writing, that any inaccurate information be corrected. In addition, you can request that any outdated or unnecessary information be deleted.

If Industrial Alliance has medical information about you which was not obtained directly from you, Industrial Alliance will release the information to you only through your physician.

PROTECTING PERSONAL INFORMATION

To request access to your personal information or to have your name removed from the list to be shared within the Industrial Alliance Group, you must send a written request to

Industrial Alliance Insurance and Financial Services Inc.
Access Officer
1080 Grande Allée West,
P.O. Box 1907, Station Terminus
Quebec City, Quebec
G1K 7M3

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