GROUP INSURANCE POLICY NUMBER: **024001**

Subject to the terms and conditions of the policy issued to :

SAGE ASSURANCES ET RENTES COLLECTIVES

« the policyholder »

HUMANIA ASSURANCE INC.

« the insurer »

agrees to pay the benefits or indemnities provided in the policy, provided that the policyholder pays the required premiums.

Effective date : January 1, 2024

This booklet, as of April 1st, 2026, replaces any document previously issued bearing the number 024001.

TABLE OF CONTENT

GENERAL TERMS AND CONDITIONS

The optional benefit Health Vision Plan offered under this policy is available exclusively to insured persons of the group insurance plans for which the Policyholder acts as a third-party administrator.

The agreement document for the Vision Health Plan Insurance Contract and the outsourcing agreement signed between the Policyholder and the Insurer apply in full to this Policy.

Subgroup 00 – QUEBEC
Classes 1 - 2 ALL INSURED PERSONS – QUÉBEC

Subgroup 01 – ONTARIO
Classes 1 - 2 ALL INSURED PERSONS – ONTARIO

Subgroup 02 – MANITOBA
Classes 1 - 2 ALL INSURED PERSONS – MANITOBA

Subgroup 03 – SASKATCHEWAN
Classes 1 - 2 ALL INSURED PERSONS – SASKATCHEWAN

Subgroup 04 – ALBERTA
Classes 1 - 2 ALL INSURED PERSONS – ALBERTA

Subgroup 05 – BRITISH COLUMBIA
Classes 1 - 2 ALL INSURED PERSONS – BRITISH COLUMBIA

Subgroup 06 – NEW BRUNSWICK
Classes 1 - 2 ALL INSURED PERSONS – NEW BRUNSWICK

Subgroup 07 – NOVA SCOTIA
Classes 1 - 2 ALL INSURED PERSONS – NOVA SCOTIA

Subgroup 08 – PRINCE EDWARD ISLAND
Classes 1 - 2 ALL INSURED PERSONS – PRINCE EDWARD ISLAND

Subgroup 09 – NEWFOUNDLAND
Classes 1 - 2 ALL INSURED PERSONS – NEWFOUNDLAND

Note: Odd numbers : Single coverage
Even numbers : Family coverage

GENERAL TERMS AND CONDITIONS

Service requirement

Classes 1 - 2

The employee or member must have completed the service requirement for the eligible group's health care insurance coverage or, if this coverage is not included, have completed the service requirement for the life insurance coverage.

SCHEDULE OF BENEFITS

Subgroups **00 – 01 – 02 – 03 – 04 – 05 – 06 – 07 – 08 – 09**

Classes **1 – 2**

Insured Employee Cancer Insurance

Benefit amount:	$7,500

Vision Care Insurance

Deductible: Coinsurance: Maximum:	None 100% of eligible expenses $400

Fracture Benefit Insurance

Description:	When the person insured under the Master Policy sustains a fracture as the result of an accident, the insurer will pay the benefit indicated in the Benefit Description.

DEFINITIONS

Eligible group

An employer, association or union that holds a group insurance contract for the benefit of its employees or members, for which the policyholder acts as a third-party administrator.

Insured employee

Member of an eligible group who meets the insurability requirements and completes an enrolment form.

Insured

The Insured employee and his or her dependent(s) at the time the insurance becomes effective, according to the terms and conditions of the policy.

Dependents

An Insured employee's spouse and dependent children who have been reported to the insurer, as defined below:

Spouse

The person:

1. who is married to and resides with the insured employee; or
2. who has been living in a marital relationship with the member for at least twelve (12) consecutive months; or immediately if a child is born of their union and
   a. is designated on the "Declaration of Marital Status" form as a spouse by the employee and
   b. is publicly presented as their spouse.

However, annulment of marriage, divorce or separation entails the loss of status as the spouse.

DEFINITIONS

Dependent child

To be eligible, the child of the plan member or of the latter's spouse must be single and not working full-time, must reside in Canada and must depend on the plan member or the latter's spouse for support. In addition, the child must be:

1. under age twenty-one (21); or
2. between age twenty-one (21) and twenty-five (25) inclusive and attending a recognized educational institution as a registered full-time student; or
3. whatever their age, totally disabled since before their eighteenth (18th) birthday and totally disabled ever since then.

A

Accident (or Accidental)

An event that occurs while the Policy is in force and whose cause is external, violent, sudden, unexpected and beyond the control of the Insured, such as a fall, impact, collision or blow. False or repetitive movements that occur in the course of routine work or daily activities are not considered an accident. If an accident results in a loss that first appears more than thirty-one (31) days after the accident, the loss is considered to be the result of sickness.

B

Bodily Injury

Bodily injury resulting directly from an accident sustained by the Insured and independent of any sickness or other cause, while the Policy is in force.

C

Coinsurance

Percentage of eligible costs covered by the insurer.

D

Day

Calendar day, unless indicated otherwise under the coverage.

DEFINITIONS

Deductible

Part of the eligible expenses that the insured must pay before the insurer will make a reimbursement. The deductible is applicable only once per calendar year.

E

Extreme sports

Any sport practiced in extreme or unusual conditions that involves a higher risk of injuries compared to any other sport normally practiced.

H

Hospital

Any short-term health care institution considered to be a hospital by the applicable Canadian federal or provincial authorities, not including the long-term care unit (the beds at that institution that are used by patients who are convalescing or chronically ill).

Not considered a hospital: a clinic, a nursing home, a substance abuse treatment facility or an institution whose services consist primarily of rehabilitation or custodial care, even if this institution is part of or affiliated with a hospital.

I

Illness

A deterioration in the health or disorder of the body observed by a physician and not caused by an accident.

P

Physician

Any person legally authorized to practice medicine in Canada within the scope of his or her medical degree (MD), and who does not have a family or business relationship with the Insured or the Policyholder.

DEFINITIONS

R

Retirement date

The date on which an insured employee starts retirement according to:

1. the pension plan in which he was participating; or
2. the collective agreement in effect at his employer; or
3. the practice in use at his place of employment.

GENERAL PROVISIONS

Eligibility

Enrolment under the policy and its coverage is available only to an eligible employee or member under the classes mentioned in the general terms and conditions of the policy and who satisfies the three (3) following conditions:

1. is less than sixty-five (65) years of age;
2. meets the eligibility criteria for the group insurance policy of the eligible group by which the employee or member is employed;
3. has not cancelled any coverage held under this contract in the previous three years.

Enrolment

The eligible employee or member joins the policy by completing the form required by the policyholder.

Effective date of coverage

1. The eligible member's insurance comes into effect on:
    a. the date on which the service requirement for the qualifying group's health care insurance policy is completed or, if this coverage is not included, the date on which the service requirement for the qualifying group's life insurance is completed and when their enrolment form is received by the Policyholder before that date or within thirty (30) days immediately following the completion of the service requirement;
    b. if the enrolment is not submitted within thirty (30) days immediately following the completion of the service requirement, on the date of receipt of the enrolment form by the Policyholder.
2. The dependents' insurance comes into effect on:
    a. the same date as the effective date of the insured employee's coverage, provided the Policyholder has received the form concerning the insured employee's dependents within the thirty (30) days immediately following the effective date of the insured employee's insurance coverage;
    b. when the insured applies for it within 30 days of a life event, on the date the application is received by the Policyholder. If the insured does not apply within 30 days of a life event, the dependent cannot be added.

Notwithstanding the above, a dependent's insurance that has been cancelled cannot be reinstated. Furthermore, the effective date of the insurance of any dependent who is hospitalized at the time of the application is delayed until the date the person is discharged from the hospital.

GENERAL PROVISIONS

At no time does dependent coverage begin before the effective date of the insured employee's coverage.

Responsibilities of the policyholder

It is the duty and responsibility of the policyholder to transmit to the Insurer the enrolment forms and the modification notices of the employees eligible for group insurance, as well as all information necessary to establish the insurance class. The policyholder must also transmit the modification notices to the insurer within sixty (60) days following the date of the change.

The policyholder must submit to the insurer, on a monthly basis, the details of the insurance in force under this contract, including the details and specifications agreed between the parties.

In case of temporary lay-off or unpaid leave, the policyholder must provide to the Insurer, without delay, the list of the insured employees affected, as well as the start date of the temporary lay-off if coverage will be suspended. In this case, the policyholder must also notify the insurer at the end of the temporary lay-off or the end of the unpaid leave, including the date when the benefits are reactivated. The duration of the lay-off and/or unpaid leave is included in the minimum duration of participation under the contract.

Conditions of participation

The insurance policy is subject to the following conditions of participation:

1. for the employee or member eligible for the group insurance of an eligible group, participation is optional;
2. however, an eligible employee or member who joins must agree to maintain coverage under this contract for a minimum period of two (2) years. In the event of a life event during this two-year period, the employee may only change the coverage for their dependents within thirty (30) days of the life event.

Misrepresentations and omissions

Subject to the provisions of the law, all misrepresentations or omissions likely to influence the evaluation of the risk cancel the insurance of the said insured employee or of the said dependent.

GENERAL PROVISIONS

Obligation to inform the Insurer

The insured person is required to disclose to the insurer, within six (6) months following the date of diagnosis, any medical information relating to a diagnosis, signs, symptoms or investigation leading to a diagnosis of:

1. cancer, whether covered or excluded under the Insured Employee Cancer Insurance benefit.

Failure to disclose this information to the insurer within six (6) months of the diagnosis will give the insurer the right to refuse any claim for cancer.

Notice and proof of claim

The policyowner or the insured must inform the insurer in writing of the incident within the thirty (30) days following the date of the event.

All claims must be detailed to the insurer's satisfaction, produced in writing and sent to the head office of the insurer within ninety (90) days of the event.

Subject to the "Obligation to inform the Insurer" described above, failure to transmit the notice of claim or to provide the proof and information within the time prescribed does not prevent the payment of any benefit, as long as the claim, the proof and the information are provided as soon as it is reasonably possible to do so. However, no benefit will be paid if the claim, the proof and the information given are provided more than one (1) year after the date of the event giving rise to a claim under the contract.

Furthermore, expenses are considered as incurred as of the date that the services or the articles were provided.

In the event of cancellation of the contract, no benefits are payable by the insurer, unless the claim notice and the proofs of incurred losses are provided within the ninety (90) days following the cancellation of the contract.

Any payment is made in Canadian legal tender.

Premium amount

The premium amount is comprised of premiums for each insured employee.

Payment of premium

The premium is payable in advance, monthly, at the insurer's head office. A grace period of sixty (60) days is granted for other payments.

Premium payment must be made in a single monthly remittance covering all premiums payable under this policy.

GENERAL PROVISIONS

In the event of default of payment of the premium for certain members, the Policyholder must immediately notify the Insurer so that these members' coverage is suspended.

The Insurer also agrees that the premium charged to members of an eligible group shall be calculated on the same basis as that of its group plan, either on a monthly basis or prorated on the basis of the number of coverage days in the month.

Premium reimbursement

The insurer will only reimburse amounts resulting from the adjustment of the premium preceding the reception of a modification of insurance notice by the insurer. This retroactive reimbursement cannot, however, exceed two (2) months of premium readjustment, starting on the date the claim is received by the insurer.

Changes to governmental policies

The premium is established taking into account the benefits payable under current governmental social programs. In the event of modification to laws and programs that affect the insurer's obligations, the insurer can adjust the premium consequently and this, starting the effective date of the modification.

End of coverage

1. Coverage of the insured employee ends at the earliest of the following dates:
    a. the date of cancellation, annulment or termination of the insurance policy contract;
    b. the date on which he no longer meets the conditions of eligibility;
    c. the due date of the unpaid premium, if payment of the premium is not made before the end of the grace period;
    d. with respect to a specific coverage, as of the date where he reaches termination age for the coverage;
    e. the date on which the insured employee dies.
2. Dependent coverage ends at the earliest of the following dates:
    a. the date on which the insured employee ceases to be insured;
    b. the date the dependent ceases to be an eligible dependent;
    c. the due date of the unpaid premium, if payment of the premium is not made before the end of the grace period;
    d. as of the date upon which the dependent reaches the termination age for the coverage;
    e. as of the date the dependent insurance ends according to the terms of the contract;

f. the date on which the dependent dies.

End of policy contract

The policy ends:

1. as of the date of reception, by the insurer, of a written notice from the policyholder or as of the date stipulated in this notice, if after the reception date;
2. subject to the provisions of the law, as of the date stipulated in the termination notice given by the Insurer to the policyholder;
3. as of the due date of the unpaid premium, if payment of the premium is not made before the end of the grace period.

Continuation of coverage (unpaid leave and temporary lay-off)

Subject to the policy remaining in force, the insurance of any member and their dependents shall remain in effect by continuing the payment of premiums. If the group insurance policy of the eligible group permits the suspension of the health insurance coverage during an unpaid leave of absence or temporary lay-off, the coverage may be suspended at the request of the policyholder for a maximum period of twelve (12) months. To benefit from this privilege, the Policyholder must receive the request within thirty (30) days immediately following the start of the period of absence and this choice is not modifiable during the period of absence.

Continuation of coverage (Humania Assurance compassionate care leave)

While the policy is in force, the coverage of any insured employee who is on compassionate care leave shall be kept in force during the waiting period as well as during the period during which the insured receives compassionate care leave benefits. Said continuation of coverage shall apply subject to the maintenance of the employment relationship and the payment of premiums.

Reinstatement

The insurance cancelled during the absence for any insured employee temporarily laid off or on leave authorized by the employer can be reinstated under the condition that this absence has not exceeded three (3) months, and that the request to that effect is received by the insurer within the thirty (30) days immediately following the return-to-work date.

GENERAL PROVISIONS

Strike or lock-out

While the policy is in force, the health care insurance coverage of any insured employee and their dependents is maintained in force for a minimum of thirty (30) days, starting the date the work stopped due to a strike or a lock-out. The other coverage is suspended during the period of work stoppage, unless there is a written agreement between the policyholder and the insurer.

Renewal

The policy is automatically renewed yearly on the renewal date for a period of twelve (12) months, unless a written notice of non-renewal or of modification is transmitted by the insurer to the policyholder or to their representative of record, at least one hundred and twenty (120) days before the date of renewal.

The insurer reserves the right to modify the rates whenever changes affect the underwriting cost basis or the cost to service the group insurance policy, such as:

1. Any change in the nature of the risk;
2. Any change requested by the holder.

Contract

The policy and the enrolment forms of the insured employees constitute the policy contract.

When an effective date is stated for the termination or the modification of any coverage, the effective date occurs on that date at 12:01 a.m., at the workplace of the insured employee.

Assignment

Neither the policy contract nor the insurance of an insured employee can be transferred or mortgaged.

DESCRIPTION OF BENEFITS

INSURED EMPLOYEE CANCER INSURANCE

Subgroups **00 – 01 – 02 – 03 – 04 – 05 – 06 – 07 – 08 – 09**

Classes **1 – 2**

If an insured person is diagnosed with a cancer covered under this contract and that cancer does not result from a pre-existing condition, the Insurer shall pay, while this benefit is in force, the designated sum for that insured person, subject to the provisions of this benefit and those of the main contract.

However, the cancer insurance benefit amount is payable only if the insured person is still alive after a survival period of thirty (30) days following the date of diagnosis or during a specified period under the diagnosed covered illness, excluding any number of days during which the insured person is kept alive artificially.

Following the first payment of the cancer insurance benefit amount for a covered cancer, the Insured Employee Cancer Insurance benefit is maintained for the insured person, provided the premiums for this benefit continue to be paid. The Insurer shall pay the cancer insurance benefit amount again should the insured person suffer from another covered cancer, subject to a maximum of two (2) lifetime benefits and subject to the terms, exclusions and limitations listed in the "*Limitations relating to the payment of a second indemnity*" section.

Pre-existing conditions

No cancer insurance benefit amount is payable if a cancer covered under this contract results directly or indirectly from a pre-existing condition and such cancer is diagnosed to the insured person during the twenty-four (24) months period prior to the effective date or the date of last reinstatement of this coverage.

A pre-existing condition is an illness or condition that has appeared during the twenty-four (24) month period preceding the effective date or the date of reinstatement of this coverage and for which:

- the insured person is diagnosed or treated, hospitalized or attended to by a physician or any other health professional;
- the insured person was advised to seek treatment or to consult a physician or health professional;
- a reasonable and prudent person would have sought treatment or consulted a doctor or other health professional; or
- the insured person was prescribed or took medication, showed signs or symptoms or underwent tests or examinations.

DESCRIPTION OF BENEFITS

INSURED EMPLOYEE CANCER INSURANCE

ELIGIBLE ILLNESS

1. **Cancer (Life-Threatening**) is defined as a definite diagnosis of a tumour, which must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Types of cancer include carcinoma, melanoma, leukemia, lymphomas and sarcomas.

The diagnosis of Cancer must be made by a specialist.

Exclusions

No benefit will be payable under this condition if, within the first ninety (90) days following the later of the effective date of the coverage, or the date of last reinstatement of the coverage, the Insured Person has any of the following:

- signs, symptoms or investigations that lead to a diagnosis of Cancer (covered or excluded under this policy), regardless of when the diagnosis is made; or
- a diagnosis of Cancer (covered or excluded under this policy).

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the Insurer within six (6) months of the date of the diagnosis. If this information is not provided within this period, the Insurer has the right to deny any claim for Cancer or any Critical Illness caused by any cancer or its treatment.

No benefit will be payable for the following:

- lesions described as benign, pre-malignant, uncertain, borderline, non-invasive, carcinoma in-situ (Tis), or tumors classified as Ta;
- malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- any non-melanoma skin cancer, without lymph node or distant metastasis;
- prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;
- papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis;
- chronic lymphocytic leukemia classified less than Rai stage 1; or
- malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC Stage 2.

For the purposes of this policy, the terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 2 are to be applied as defined in the *American Joint Committee on Cancer* (AJCC) cancer staging manual, 7th Edition, 2010.

For the purposes of this policy, the term Rai staging is to be applied as set out in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: *Clinical staging of chronic lymphocytic leukemia*. Blood 46:219, 1975.

DESCRIPTION OF BENEFITS

INSURED EMPLOYEE CANCER INSURANCE

2. **Non-Life threating Cancer (partial Benefits)** is defined as :

5.1 **Ductal carcinoma in situ of the breast**
The diagnosis of this illness must be made by a specialist and confirmed by biopsy.

5.2 **Stage A (T1a or T1b) Prostate Cancer**
The diagnosis of this illness must be made by a specialist and must confirmed by a pathological examination of prostate tissue.

5.3 **Stage 1A Malignant Mélanome**
A melanoma less than or equal to l.0 mm in thickness, not ulcerated and without Clark level IV or V invasion. The diagnosis of this illness must be made by a specialist and must confirmed by biopsy.

Exclusions

No benefit will be payable under this condition if, within the first ninety (90) days following the later of the effective date of the coverage, or the date of last reinstatement of the coverage, the Insured Person has any of the following:

- signs, symptoms or investigations, that lead to a diagnosis of Cancer (covered or excluded under this policy), regardless of when the diagnosis is made; or
- a diagnosis of Cancer (covered or excluded under this policy).

The benefit amount payable for a Non-Life Threatening Cancer is equal to ten percent (10%) of the Critical Illness Amount insured, subject to a maximum of ten thousand dollars ($10,000). This benefit is payable only once while the coverage is in force, and shall be deducted from any other benefit payable under this condition. Partial payment is subject to a waiting period of ninety (90) days.

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the Insurer within six (6) months of the date of the diagnosis. If this information is not provided within this period, the Insurer has the right to deny any claim for Cancer or any Critical Illness caused by any Cancer or its treatment.

Payment Conditions

- **Diagnostic in Canada**

The diagnosis of a Critical Illness must be made by a specialist physician licensed to practice in Canada and must be confirmed by customary modern investigation techniques appropriate to that Critical Illness at the time of claim.

DESCRIPTION OF BENEFITS

INSURED EMPLOYEE CANCER INSURANCE

- **Diagnostic Outside Canada**

When a Critical Illness is diagnosed outside Canada by a specialist physician exercising in a jurisdiction deemed acceptable by the Insurer, the benefit is paid provided all the following conditions are met:

a) the Insurer has received all medical records;
b) based on the medical records received, the Insurer is certain that:
   i) the same diagnosis would have been made had the Critical Illness or accident been diagnosed by a duly licensed specialist physician practicing in Canada; and
   ii) the same treatment would have been prescribed in accordance with Canadian standards; and
   iii) the same treatment, including any necessary surgery, would have been prescribed had the treatment been administered in Canada.

The Insurer may require the insured person to undergo one or more independent medical examinations with a physician of the Insurer's choice. In the case of elective surgery, the required medical examination must be performed prior to the surgery.

Survival Period

The cancer insurance benefit amount is payable only after a survival period of thirty (30) days from the date of diagnosis or after the specific period described under the covered diagnosed illness.

Pre-existing conditions

For the insured person who is not subject to evidence of insurability, no benefit is payable during the twenty-four (24) months following the effective date of his insurance or the date of its last reinstatement if the covered cancer results directly or indirectly from a pre-existing condition.

Recurrence of cancer

The cancer insurance benefit amount will be paid only once for all serious illnesses resulting from the same disease or any related illness.

DESCRIPTION OF BENEFITS

INSURED EMPLOYEE CANCER INSURANCE

Limitations relating to the payment of a second indemnity

Following the payment of the first benefit for Cancer, the Insured Person may not make another claim for prostate cancer stage A (T1a or T1b), ductal carcinoma in situ of the breast, malignant melanoma stage 1A or loss of autonomy. In addition, the Insured Person may not make another claim for a second diagnosis of Cancer or a recurrence of Cancer even if:

a) More than sixty (60) months have elapsed since the previous diagnosis of Cancer;

b) No treatment related directly or indirectly to Cancer were received during the sixty (60) months following the previous diagnosis of Cancer (treatment does not include preventive medication and regular monitoring by a doctor);and

c) Subsequent diagnosis is made while the coverage is in force.

EXCLUSIONS

No benefits will be payable for any cancer resulting:

- from attempted suicide, injury or mutilation that the insured person is voluntarily self-inflicted, whether being considered sane or insane;
- from the insured person's participation in the commission or attempted commission of an unlawful or criminal act or crime, driving a motor vehicle or a boat under the influence of narcotic or while the concentration alcohol in his blood exceeds the legal limit;
- from drug addiction, alcoholism or use of hallucinogens, drugs or narcotics ;
- from service, as a combatant or non-combatant, in armed forces engaged in surveillance operations, training , pacification, insurrection, war (whether declared or undeclared) or any act related thereto or from the participation of the Insured Person to a popular protest;
- from a covered illness for which the Insured Person has already received, under a group insurance critical illness contract of the Insurer, an indemnity equal to or greater than the amount of critical illness insurance for the present benefit. If the compensation already paid was lower, the Insurer shall then pay the difference between the critical illness benefit already paid and this critical illness benefit;
- during the survival period of thirty (30) days from the date of diagnosis of critical illness or the specific period covered disease diagnosed.

No benefit is payable during the twenty-four (24) months period following the effective date of insurance or the date of last reinstatement, which results directly or indirectly from a pre-existing condition for the insured person subjected to this restriction.

DESCRIPTION OF BENEFITS

INSURED EMPLOYEE CANCER INSURANCE

No benefit will be payable for any cancer for the entire duration of the coverage if the date of diagnosis of any cancer, whether covered or excluded by this benefit, if such occurs within ninety (90) days of the coverage's effective date or reinstatement, or if the date on which signs or symptoms appear or on which are held medical consultations or tests that lead to the diagnosis of any cancer, covered or excluded by this benefit, occurs during the first ninety (90) days after the date effective date of the coverage or its reinstatement.

General Provisions

The general conditions and definitions apply to this cancer insurance.

Termination

When the Insured Employee Cancer Insurance benefit is in force, it shall end at the earliest of the following events:

1. when the Insured employee reaches the age of sixty-five (65);
2. the death of the insured employee;
3. the date on which a second cancer insurance indemnity is paid, with the exception of the indemnity for a non-life threatening cancer;
4. the date of cancellation of this benefit or of the insurance policy.

DESCRIPTION OF BENEFITS

VISION CARE INSURANCE

(in Canada)

Subgroups **00 – 01 – 02 – 03 – 04 – 05 – 06 – 07 – 08 – 09**

Classes **1 – 2**

When the insured employee or the dependent is insured under the present coverage, the following eligible amounts are reimbursed, for each insured person, subject to the deductible and the reimbursement level specified in the Schedule of Benefits.

Non-shared costs

EYEGLASSES AND CONTACT LENSES

Upon submission of an ophthalmologist's or optometrist's prescription, the following costs are reimbursed:

a. Eyeglasses, contact lenses: up to a maximum of $400 per period of 24 months with the exception of sunglasses, safety glasses or aesthetic glasses;

OTHER EYE CARE

Upon prescription by an ophthalmologist or a licensed optometrist, the following expenses are reimbursed up to a maximum of $500 per 48-month period:

1. **Vision care and treatment:**

   a Eye examinations performed by a healthcare professional (optometrist or ophthalmologist);

   b Laser treatments (LASIK, PRK, etc.);

   c Intraocular injections (ARMD, diabetic retinopathy) ;

   d Eye surgery (cataracts, glaucoma, retina).

2. **Low vision aids:**

   a Optical magnifier;

   b Visual assistive technology aid

DESCRIPTION OF BENEFITS

VISION CARE INSURANCE

Exclusions

The following are not reimbursed:

1. services, care or products not included in the list of eligible costs;
2. the costs covered by a government plan, even if the insured is not eligible for the said government plan or for any other insurance plan that includes medications provided during a hospital stay;
3. services rendered by a relative or a friend of the insured, with the exception of situations specifically covered herein;
4. the costs incurred as a result of an intentionally self-inflicted injury or disease or an attempted suicide, whether or not he is conscious of his actions;
5. the costs incurred following an injury sustained by the insured, which is the result of:
    a. the commission or attempted commission of a criminal act;
    b. military operation or active service in the armed forces of any country;
    c. active participation in a public confrontation, a riot or an insurrection, real or perceived, or as a result of a war or any other hostile action, whether such war is declared or undeclared;
    d. the insured driving any land or water motor vehicle while under the influence of narcotic drugs or with a blood-alcohol level that exceeds the limit allowed by applicable laws at the place of the accident or under the influence of medication not taken as prescribed or not at the dosage recommended by the manufacturer.

Coordination of benefits

If the insured is covered under the terms of another group or individual insurance plan or through a governmental plan, the sum of all benefits payable cannot exceed 100% of expenses incurred.

The order of payment of benefits is as follows:

1. the plan that does not include a coordination of benefits provision becomes the first payer; or
2. the plan that covers an insured as an employee has priority over the plan that covers the insured as a dependent; or
3. when an insured is covered by more than one plan, the order of payment is as follows:
    a. first payer: the group plan in which he or she participates as an active, full-time employee;

b. second payer: the group plan in which he or she participates as an active, part-time employee;

c. third payer: the group plan in which he or she participates as a retiree; or

4. when a person is covered as a spouse, priority is as follows:

a. first payer: the group plan in which he or she participates as an employee;

b. second payer: the group plan that covers him or her as a dependent;

If a person is covered as a spouse or surviving spouse under more than one group plan, priority is as follows:

a. First payer: the group plan covered that person for the least amount of time;

b. Second payer: the other plan;

5. When dependent children are covered under more than one group plan, priority is as follows:

a. First payer: the group plan of the parent with the earlier birthdate (month/day) in the calendar year;

b. Second payer: the group plan of the parent with the later birthdate (month/day) in the calendar year;

c. Third payer: if both parents have the same birthdate, the plan of the parent whose first name begins with the earlier letter in the alphabet.

Where coverage is available for a dependent child under a survivor benefit arrangement, the order of payment for the group plans which were in effect prior to the parent's death will be maintained, unless additional parental coverage becomes effective. If additional parental coverage becomes effective, the survivor plan becomes last payer.

In the case of single custody of a dependent child, priority for payment is established as follows:

a. First payer: the group plan of the parent with custody of the dependent child;

b. Second payer: the group plan of the spouse of the parent with custody of the dependent child;

c. Third payer: the group plan of the parent not having custody of the dependent child;

d. Fourth payer: the group plan of the spouse of the "third payer" parent.

e. quatrième payeur : le régime collectif du conjoint du parent « troisième payeur ».

General provisions

The general conditions and definitions apply to this insurance coverage.

DESCRIPTION OF BENEFITS

VISION CARE INSURANCE

Termination age

When the Vision Care Insurance benefit is in force, it will end when the insured employee reaches age sixty-five (65).

DESCRIPTION OF BENEFITS

FRACTURE BENEFIT INSURANCE

Subgroups **00 – 01 – 02 – 03 – 04 – 05 – 06 – 07 – 08 – 09**

Classes **1 – 2**

Where the person insured under the Master Policy sustains a fracture as the result of an accident, the insurer will pay the benefit indicated below.

TYPE OF FRACTURE	**INDEMNITY**
Skull	$1,500
Spine	$1,500
Pelvis	$1,500
Femur	$1,500
Hip	$1,500
Rib	$450
Sternum	$450
Larynx	$450
Trachea	$450
Scapula	$450
Humerus	$450
Patella	$450
Tibia	$450
Fibula	$450
Any other bone	$225

Beneficiary

The beneficiary is the insured person. No other person, whether natural or legal, may benefit from this coverage.

DESCRIPTION OF BENEFITS

FRACTURE BENEFIT INSURANCE

Limitations

The fracture must be diagnosed by a physician and confirmed by an X-ray within 30 days of the accident. If an X-ray is not submitted, the indemnity will be limited to 50% of the amount stipulated. Indemnities are not cumulative. Where multiple fractures are sustained, the insurer will pay the indemnity for the fracture with the highest associated benefit. As such, only one of the indemnities listed shall be paid and that indemnity is payable provided the insured person is still living 30 days immediately following the accident. Regardless of the number of Fracture Benefit coverages in force with Humania Assurance, in the event that the amount the insured person holds exceeds $10,000, the indemnity payable by the insurer shall be limited to $10,000. The total amount of indemnities payable by the insurer per insured person, for a single event under a Fracture Benefit coverage, cannot exceed $10,000.

Exclusions

No indemnity shall be payable if the fracture results:

1. from an intentionnaly self-inflicted injury, while sane or insane;
2. From the insured person's participation in an unlawful or criminal act, or from the act of driving a motor vehicle or boat while under the influence of narcotics or while the insured person's blood alcohol level exceeds the limit permitted by law;
3. from the insured person's participation in a popular demonstration, an insurrection, a war (whether declared or undeclared), or any act related thereto;
4. directly or indirectly from a physical, mental or nervous impairment of the insured person;
5. from drug addiction, alcoholism or the use of hallucinogens, drugs or narcotics;
6. from injury sustained during a flight, except where the insured person is a passenger aboard an aircraft operated by a common carrier;
7. from the insured person's participation in a race, trials or speed trial involving automobiles, motorcycles (including motocross), or any motorized vehicle or craft, as well as any activity related thereto;
8. from injury resulting from participation in any aviation activity, parachuting, underwater diving, hang-gliding, rodeo, or Extreme Sports;
9. from injury sustained before the benefit's effective date;
10. from a sport for which the insured person receives compensation or a purse.

NOTICE

To ensure the confidentiality of the personal information held on you, Humania Assurance will set up an insurance file in which will be entered the information provided on your insurance application, as well as any insurance claim information.

Only those employees or representatives responsible for underwriting, investigating and processing claims or any other person authorized by yourself will have access to this file.

Your file will be kept in the company's offices.

You are entitled to consult the personal information contained in this file and to have it rectified, if necessary, by sending a written request to the following address:

Access to information Officer

Humania Assurance Inc.

1555 Girouard Street West

Saint-Hyacinthe (Quebec) J2S 2Z6