GROUP
INSURANCE

YOUR GROUP INSURANCE BOOKLET

iA Financial Group

SCARBOROUGH HEALTH NETWORK

Class(es) 603, 612
Active and Retired Canadian Union of Public Employees

GROUP INSURANCE PLAN

Planholder: **SCARBOROUGH HEALTH NETWORK**

Plan No.: **27141**

Plan Effective Date: **April 1, 2018**

This booklet is provided for the purpose of explaining the benefits provided under the group plan.

Possession of this booklet does not confer or create any contractual rights. All rights and obligations with respect to the benefits provided under the group plan will be governed solely by the terms and conditions of such plan.

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

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

For questions regarding the information in this booklet or if additional information about the benefits is required, the Participant should contact his Employer.

This booklet can also be viewed on our secure website My Client Space accessible via ia.ca, if offered as part of your plan. For any question about coverage options, contact iA Financial Group at 1 877 422-6487.

Industrial Alliance Insurance and Financial Services Inc. is the insurer for the following benefits:

* PARTICIPANT'S LIFE INSURANCE
* LONG-TERM DISABILITY INSURANCE

Industrial Alliance Insurance and Financial Services Inc. is the Administrator for the following self-insured benefits that the Planholder has implemented for the Participants:

* SUPPLEMENTAL HEALTH
* DENTAL CARE

iA Special Markets is the insurer for the following benefits:

* BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

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SUMMARY OF BENEFITS

The SUMMARY OF BENEFITS briefly describes the coverage of the group plan, based on the class the Participant belongs to.

The following pages give a full description of the GENERAL PROVISIONS and of each BENEFIT.

SPECIAL PROVISIONS

For the purposes of this booklet, the masculine form includes the feminine unless a different meaning is required from the context. In addition, the singular shall include the plural where required.

Participants are insured under the following class(es):

Class(es)

603 - Active Canadian Union of Public Employees

612 - Retired Canadian Union of Public Employees

GENERAL PROVISIONS

ELIGIBILITY DATE

Subject to all of the terms and conditions other provisions of the group plan, an Employee shall become eligible on the latest of the following dates:

Class(es): 603

a) The Effective Date of the plan, if, at that date, the Employee has completed the Eligibility Period;

or

b) On the date the Employee has completed the Eligibility Period.

ELIGIBILITY PERIOD

For Long-Term Disability Income Insurance:

The continuous period of 6 months, during which the Employee must be Actively at Work.

All benefits, other than Long-Term Disability Income Insurance:

The continuous period of 3 months, during which the Employee must be Actively at Work.

PARTICIPANT'S LIFE INSURANCE

Class(es)	Sum Insured
603	**Participants under age 65:** 2 times the Annual Earnings, the result being rounded to the nearest $500, if not already a multiple thereof.
Termination:	The insurance under this benefit terminates on the earliest of: the Participant's 65th birthday; or his date of retirement; or such other earlier date indicated in this benefit or in the General Provisions of the group plan.
603, 612	**Active Participants age 65 and over and post retirement coverage:** $300 times the number of completed years of service** at date of retirement, as determined by the Employer, to a maximum of $4,500.
Termination:	The insurance under this benefit terminates on the Participant's death.

*If the Participant accumulated years of service with the current Participating Employer and/or with another Participating Employer as a full-time Employee and a part time Employee in the 15 year period immediately preceding the earlier of age 65 or retirement, the amount of post retirement coverage is pro-rated according to the number of completed years of service in each capacity.

**Completed years of service means continuous service, any qualifying period and any period during which premiums are waived due to Total Disability.

Reductions, Exclusions and Limitations:

This benefit and any sum insured payable thereunder are subject to any other reductions, exclusions and limitations indicated in this benefit or in the General Provisions of the group plan.

LONG-TERM DISABILITY INSURANCE

Class(es)	Monthly Indemnity
603	**Length of continuous service – at least 6 months but less than 20 years.** 65% of the Monthly Earnings, the result being rounded to the next higher dollar, if not already a multiple thereof. **Length of continuous service – at least 20 years but less than 30 years.** 70% of the Monthly Earnings, the result being rounded to the next higher dollar, if not already a multiple thereof. **Length of continuous service – at least 30 years.** 75% of the Monthly Earnings, the result being rounded to the next higher dollar, if not already a multiple thereof.
Minimum Benefit Payment	In any event, the amount of Long-Term Disability Benefit before age 65, after reductions will not be less than $50 per month.
Reductions, Exclusions and Limitations:	This benefit and any amounts payable thereunder are subject to any reductions, exclusions and limitations indicated in this benefit or in the General Provisions of the group plan.
Elimination Period:	30 consecutive weeks

LONG-TERM DISABILITY INSURANCE (cont'd)

Maximum Benefit Payment Period:

To the Participant's 65th birthday.

If the Elimination period ends after the Participant's 64th birthday but before the Participant's 65th birthday, and the Participant continues to be Totally Disabled, benefits will continue 12 months after the Elimination Period.

If the Participant became Totally Disabled after completing at least 10 years of service and who continues to be Totally Disabled, benefits will continue until Participant's death.

Benefit Payments are taxable.

Termination:

The insurance under this benefit terminates on the earliest of: the Participant's 65th birthday; or his date of retirement; or such other earlier date indicated in this benefit or in the General Provisions of the group plan.

SUPPLEMENTAL HEALTH EFFECTIVE MAY 1, 2018

Class(es): 603, 612

HOSPITALIZATION IN THE PROVINCE OF RESIDENCE

Deductible:	Reimbursement:	Daily maximum:
None	100%	Private room rate
		Maximum per Covered Person: Unlimited

DRUGS

Deductible:	Included in Medical Expenses in Canada
Reimbursement:	100%
Maximum:	Unlimited

SUPPLEMENTAL HEALTH (cont'd)

ALL OTHER MEDICAL EXPENSES INCURRED IN CANADA

Deductible:	
- Eyeglasses, Contact Lenses, and Corrective Laser Surgery:	No deductible
- Chronic Care Hospital:	No deductible
- Homewood Health Centre:	No deductible
- All other covered expenses:	$22.50 per Covered Person, maximum of $35 per family
Reimbursement:	100%
Maximum:	Unlimited

Reductions, Exclusions and Limitations:

This benefit and any amounts payable thereunder are subject to any reductions, exclusions and limitations indicated in this benefit or in the General Provisions of the group plan.

Termination:

Class(es): 603

The coverage under this benefit terminates on the earliest of: the Participant's date of retirement; or such other date indicated in this benefit or in the General Provisions of the group plan.

SUPPLEMENTAL HEALTH (cont'd)

Class(es): 612

Participant:
The coverage under this benefit terminates on the earliest of: the last Day of the month following the Participant's 65th birthday; or such other date indicated in this benefit or in the General Provisions of the group plan.

Spouse

The coverage under this benefit terminates on the earliest of: the last Day of the month following the Spouse's 65th birthday; or such other date indicated in this benefit or in the General Provisions of the group plan.

SUPPLEMENTAL HEALTH (cont'd)

Medical Expenses

Covered Expenses	Maximums Per Covered Person
All covered expenses included under the Medical Expenses Incurred in Canada section of the Supplemental Health Insurance benefit, other than those listed below	Unlimited.
Preventive immunization vaccines	Unlimited.
Drugs for the treatment of infertility	$2,500 per Calendar Year.
Anti-obesity drugs	Unlimited.
Room and board charges made by a chronic care Hospital	$3 per Day; maximum of 120 Days per period of 12 consecutive months. The maximum amount payable is the difference between the cost of a ward and semi-private room.
Private Hospital other than Homewood Health Centre	$10 per Day, subject to a maximum of 120 Days per lifetime.

SUPPLEMENTAL HEALTH (cont'd)

Medical Expenses (cont'd)

Covered Expenses	Maximums Per Covered Person
Diabetic monitoring equipment (dextrometers, glucometers, reflectometers)	$700 per lifetime.
Breast prostheses	Maximum of 1 breast prostheses per affected breast per period of 24 consecutive months.
Surgical brassieres	Maximum of 2 surgical brassieres per Calendar Year.
Medical elastic stockings	Maximum of 6 pairs per Calendar Year.
Orthopedic shoes (off the shelf or modified off the shelf)	$100 per Calendar Year.
Orthopedic shoes (custom made or custom molded)	$500 per Calendar Year.
Foot Orthoses (custom made)	$400 per Calendar Year.
Wigs	Maximum of 1 per lifetime.
Stump socks	Maximum of 5 pairs per Calendar Year.

SUPPLEMENTAL HEALTH (cont'd)

Medical Expenses (cont'd)

Covered Expenses	Maximums Per Covered Person
Hearing aids or any related devices	Maximum of 1 device per period of 36 consecutive months.
Homewood Health Centre (Substance abuse treatment facility)	Limited to the difference between ward and semi-private room. Maximum of 1 treatment in any 12 month period.
Wheelchairs	Limited to the cost of a manual wheelchair.
Eye examinations	Maximum of 1 examination per period of 24 consecutive months.
Eyeglasses (including sunglasses), Contact lenses and Corrective laser surgery	$300 per period of 24 consecutive months.
Medically required contact lenses	$250 per period of 24 consecutive months.
Lymphedema sleeves	Maximum of 4 sleeves per arm every 6 consecutive months.
Scooters	Maximum of $4,000 per period of 5 consecutive years.

SUPPLEMENTAL HEALTH (cont'd)

Medical Expenses (cont'd)

Covered Expenses	Maximums Per Covered Person
Fees for the following paramedical practitioners: Chiropodist (Applicable in Ontario and Saskatchewan only) [1] and Podiatrist [1]	Combined maximum of $500 per Calendar Year. [1] Including 1 x-ray(s) for all practitioners.
Fees for the following paramedical practitioners: Chiropractor and Physiotherapist [2] [2] *The services must be recommended and approved, in writing, by a physician*	Maximum of $375 per Calendar Year for each practitioner.
Fees for the following paramedical practitioners: Massage Therapist [2] [2] *The services must be recommended and approved, in writing, by a physician*	$7 per visit(s) to a maximum of 12 visit(s) per Calendar Year.
Fees for the following paramedical practitioners: Psychologist, Psychotherapist and Social Worker	Combined maximum of $800 per Calendar Year.

SUPPLEMENTAL HEALTH (cont'd)

Medical Expenses (cont'd)

Covered Expenses	Maximums Per Covered Person
Fees for the following paramedical practitioners: Speech Therapist [2]	Maximum of $500 per Calendar Year.

[2] *The services must be recommended and approved, in writing, by a physician*

DENTAL CARE EFFECTIVE MAY 1, 2018

Class(es)		
603, 612	Deductible:	None
	Reimbursement:	
	– Preventive treatments:	100%
	– Basic treatments:	100%
	– Major treatments:	50%
	Maximum per Covered Person:	
	– Preventive treatments:	Unlimited
	– Basic treatments:	Unlimited
	– Major treatments: Dentures – removable	$1,000 per Calendar Year
	– Major treatments: Bridges and crowns	$1,000 per Calendar Year

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

Reductions, Exclusions and Limitations:

This benefit and any amounts payable thereunder are subject to any reductions, exclusions and limitations indicated in this benefit or in the General Provisions of the group plan.

DENTAL CARE (cont'd)

Termination:

Class(es): 603

The coverage under this benefit terminates on the earliest of: the Participant's date of retirement; or such other earlier date indicated in this benefit or in the General Provisions of the group plan.

Class(es): 612 Participant

The coverage under this benefit terminates on the earliest of: the last Day of the month following the Participant's 65th birthday; or such other date indicated in this benefit or in the General Provisions of the group plan.

Spouse

The coverage under this benefit terminates on the earliest of: the last Day of the month following the Spouse's 65th birthday; or such other earlier date indicated in this benefit or in the General Provisions of the group plan.

GENERAL PROVISIONS

DEFINITIONS

Accident means any event due to a sudden and unforeseeable external cause that inflicts bodily injuries directly and independently of any other cause, all of which is certified by a Physician.

Actively at Work means:

If it is a Working Day, the Employee is deemed to be Actively at Work for his Employer if he reports to work and performs all the essential duties of his regular occupation for the total number of scheduled hours for such Working Day.

If it is a weekend, holiday or a vacation day, the Employee is deemed to be Actively at Work for his Employer if:

a) On that day, he would have been able to report to work and perform all the essential duties of his regular occupation for the total number of scheduled hours had it been a Working Day; and

b) On his last Working Day, he reported to work and performed all of the essential duties of his regular occupation for the total number of scheduled hours for that Working Day.

Approval of Evidence of Health means the Administrator accepts, in writing, the risk applied for after receiving each and every document required to assess such risk.

Calendar Year means the period from any January 1st to the next December 31st, both inclusive.

Covered Person/Insured Person means a Participant or a Dependent of a Participant who is covered under the group plan.

Day means a calendar day, except if otherwise defined in the group plan.

Day Surgery means surgery which is performed in a Hospital or out-patient clinic affiliated with a Hospital and requiring local, regional or general anaesthesia, but will not include minor surgery that can be performed in the Physician's office.

Dependent means the Participant's Spouse, or a Child of the Participant or of the Spouse, who are covered under the group plan and who satisfy the following respective definitions:

a) Spouse

The person who is married to or is in a civil union with the Participant, or the person designated by the Participant, whom he declares publicly to be his Spouse and with whom he has been living on a permanent basis for at least 12 months.

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

b) Child

An unmarried Child of the Participant or of his Spouse who wholly depends on the Participant for support and maintenance and who meets at least one of the following conditions:

i) He is under 21 years of age; or

ii) He is under 26 years of age and is attending a recognized educational institution on a full-time basis; or

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

Earnings means:

Annual Earnings means the Participant's annual remuneration as reported to the Administrator by the Planholder.

Monthly Earnings means the Participant's Annual Earnings divided by 12.

Indexed Pre-Total Disability Gross Monthly Earnings means the Participant's Monthly Earnings immediately prior to the date his Total Disability commenced, increased by the Consumer Price Index (as published by the Government of Canada during the immediately preceding Calendar Year) each March 1st coincident with or next following the anniversary of the date on which the Participant became entitled to a Long-Term Disability benefit.

Pre-Total Disability Gross Monthly Earnings means the Participant's Monthly Earnings immediately prior to the date his Total Disability commenced.

Pre-Total Disability Net Monthly Earnings means the Participant's Monthly Earnings immediately prior to the date his Total Disability commenced, less the deductions for Income Tax, Canada or Quebec Pension plan, Employment Insurance and the Quebec Parental Insurance plan.

Amount of Earnings to Be Used

Where any benefit paid under the group plan is based on the Participant's Earnings, including any of the variations of the definition of Earnings above, the amount of Earnings that will be used to determine the benefit will be the lesser of:

a) The Earnings last reported to the Administrator by the Planholder, Employer, Employer's agent; or

b) The Participant's actual Earnings received from his Employer at the time of the event for which a claim is being made; or

c) If the Participant is not Actively at Work at the time of the event for which the claim is being made, the Earnings on the last Working Day he was Actively at Work.

Eligibility Period means the continuous period, as specified in the Summary of Benefits, ending on or after the Effective Date of the group plan, during which the Employee must be Actively at Work.

Employee means a person who is actively employed by the Employer:

a) On a permanent, full-time basis for a minimum of 30 hours per week, or

b) On a permanent, part-time basis for a minimum of 30 hours per week.

Seasonal workers, contract workers and temporary workers are excluded from the definition of Participant.

Employer means the Planholder and any entities listed as Subsidiary or Associated Companies in the Summary of Benefits.

Full-time Resident of Canada means to have a permanent residence in Canada, and to reside in the province of residence the minimum number of days a year required to be covered under the applicable provincial health plan of that province of residence.

Hospital means an institution which:

a) Is legally licensed by the appropriate government body; and

b) Is intended for the care of bedridden patients; and

c) Provides at all times the services of Physicians and registered nurses.

Hospitalization or Hospitalized means the occupancy of a Hospital room as an admitted bedridden patient where a room and board charge has been charged in connection with the confinement. Day Surgery is considered to be a period of Hospitalization.

Illness means any deterioration in health requiring continuous and curative care actively provided by a Physician and, where required by the group plan, by a Specialist in the field of medicine which is applicable to the Illness.

Legal Capacity To Work means that the Participant must have each and every license, permit or other certification required to legally work in Canada.

Medically Required means broadly accepted and recognized by the Canadian medical profession as effective, appropriate, and essential in the treatment of an Illness or injuries, including injuries due to an Accident, in accordance with Canadian medical standards.

Participant means an Employee or Retired Employee who is covered under the group plan.

Participating Employer means an Employer that is part of the Ontario Hospital Association or is participating in this policy.

Physician means a person who is legally licensed and authorized to practice medicine and who is operating within the scope of his license.

Planholder means any entities listed as the Planholder on the cover page of the group plan.

Retired Employee means an Employee who is at least 55 years of age and has terminated membership in the Hospital of Ontario Pension Plan (HOOPP) and / or another pension plan provided by the Participating Employer, and who is in receipt of a normal or early retirement pension.

Specialist means a Physician licensed by the appropriate provincial licensing authority to practice medicine with a specialization.

Working Day means a Day on which the Participant is scheduled to work for his Employer and perform all of the essential duties of his regular occupation for the total number of scheduled hours.

CHANGES IN GOVERNMENT PLANS

The benefits provided under the group plan are complementary to the benefits provided by government plans. Any modifications to these government plans after the Effective Date of the group plan will not modify the benefits provided under the group plan, unless modification of the benefits is authorized by the Planholder.

Notwithstanding the preceding paragraph, the group plan will be modified to reflect any changes to the maximum insurable earnings as determined under the Employment Insurance Act. In addition, if either federal or provincial legislation mandates that the group plan provide a certain type or level of coverage or the means of providing a certain type of coverage, the group plan will be deemed to have been amended to reflect the requirements of the legislation.

MEDICAL SERVICES AND/OR SUPPLIES COVERED BY A GOVERNMENT SPONSORED PLAN OR PROGRAM

There will be no coverage under the group plan 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 Covered 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 plan.

INCONTESTABILITY

The following clause is applicable to self-insured benefits provided by the Planholder:

Whenever Evidence of Health is required to approve coverage for a Participant or a Dependent, or to approve one of the benefits, the statements made with respect to the evidence will be, except in the case of an error in age or fraud, accepted as true and incontestable after the Participant's or Dependent's coverage or benefit has been in force for 2 years.

If the coverage is cancelled and then reinstated, the 2 year period will begin again as of the date the coverage has been reinstated.

The following clause is applicable to insured benefits for which Industrial Alliance Insurance and Financial Services Inc. is the insurer:

Where Evidence of Health is required by the insurer in order to approve:

a) insurance under the plan or insurance under a benefit for a Participant or Dependent; or

b) an increase, addition or change in such insurance or benefit for a Participant or Dependent;

The statements provided by the Participant or Dependent as Evidence of Health will be accepted as true and will not be contested by the insurer after the latest of the following dates, provided the Participant or Dependent is alive at the time:

a) 2 years from the Effective Date of the insurance for which the evidence was provided; or

b) 2 years from the Effective Date of the increase, addition or change to the insurance; or

c) 2 years from the Effective Date of the last reinstatement of the insurance.

However, this restriction on the insurer’s right to contest the Evidence of Health will not apply in cases of fraud or misstatements of age.

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

LAWFUL CURRENCY

All payments hereunder will be made in the lawful currency of Canada and according to the exchange rates effective at the time the event giving entitlement to a benefit took place.

COVERAGE ELSEWHERE
(Applicable only to Active Participants)

A Participant who is eligible for the Supplemental Health benefit or Dental Care benefit may decline to enroll in these benefits if he has comparable coverage under the group plan or another plan.

The refusal to enroll in these benefits may be in respect of the Participant and his Dependents or his Dependents only.

If the other comparable coverage terminates, an application may be made to insure under the group plan those persons whose coverage has terminated.

The application must be made within 31 Days after cessation of the comparable coverage and coverage under the group plan shall be effective on the Day following the date of termination of the comparable coverage.

CO-ORDINATION OF BENEFITS

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

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

ii) Any government sponsored plan, and

iii) Any non-insured employee benefit plan.

CONVERSION PRIVILEGE

A Participant whose coverage under the group plan is cancelled due to termination of:

a) His employment; or

b) His group membership,

will be able to convert his Supplemental Health and/or Dental Care to an individual contract without having to submit Evidence of Health to the Administrator. Failure to convert his Supplemental Health will prevent the Participant from converting his Dental Care.

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

The Participant must make application and pay all required premiums for the individual contract within 60 Days of the termination date of his coverage under the group 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 Administrator.

AGENTS

The Planholder and the Employer are not agents of the insurer or Administrator. The insurer or Administrator shall not be bound by nor be liable for any act, or failure to act, on the part of the Planholder or the Employer. The insurer or Administrator shall also not be bound by any collective agreement the Planholder is involved in.

ERRORS

Clerical or inadvertent errors by the Planholder, Employer, insurer or Administrator shall not operate to:

a) Continue coverage otherwise validly terminated.

b) Increase any existing coverage.

c) Place in force any coverage which would, but for such error, not be validly in force.

d) Otherwise prejudice the Planholder in any other way.

The Planholder may, retroactively and at its sole discretion, in addition to any other legal remedy it may have, exercise any or all of the following rights:

a) Terminate or rescind any such associated coverage.

b) Reduce the amount of coverage to the amount it should have been but for the error.

c) Take such other action as may be required to correct the error.

ELIGIBILITY

Employee

An Employee will become eligible to be covered under the group plan as a Participant on the date (his “eligibility date”) on which he satisfies all of the following conditions:

a) He satisfies the definition of Employee in the group plan; and

b) He is a Full-Time Resident of Canada; and

c) He is covered under the provincial health plan of his province of residence; and

d) He has satisfied the Eligibility Period specified in the Summary of Benefits.

However, an Employee will not be eligible to become covered under the Long-Term Disability benefit if he will attain the termination age specified for this

benefit in the Summary of Benefits before the end of the Elimination Period specified for this benefit.

Retired Employee

A Retired Employee will become eligible to be covered under the group plan as a Participant on the date (his “eligibility date”) on which he satisfies all of the following conditions:

a) He satisfies the definition of Retired Employee in the group plan.

Dependents

A person will become eligible to be covered under the group plan as a Dependent on the date (his “eligibility date”) on which he satisfies all of the following conditions:

a) He satisfies the definition of Dependent in the group plan; and

b) He is a Full-Time Resident of Canada; and

c) He is covered under the provincial health plan of his province of residence; and

d) The Employee or Retired Employee of whom he is a Dependent is covered under the group plan as a Participant.

APPLICATION FOR GROUP COVERAGE

An Employee who is eligible to become covered under the group plan as a Participant must complete and submit an application for himself and for each of his Dependents, on their respective eligibility dates, on forms supplied by, or satisfactory to the insurer, the Administrator or the Planholder.

EFFECTIVE DATE OF COVERAGE

Whether membership under the group plan is compulsory or voluntary, the Employee's coverage and Dependents' coverage, if any, will take effect on the person’s eligibility date, if the application for group coverage has been received by the Planholder on or prior to such date, or within 31 Days after such date.

If the application for group coverage is not received within 31 Days of the eligibility date, the coverage will not take effect until the date on which the

Administrator receives Evidence of Health and provides Approval of Evidence of Health.

However:

a) If the Employee was not Actively at Work on the date his coverage would otherwise become effective, the coverage will not take effect until the earliest date thereafter on which he is again Actively at Work.

b) If the Dependent is Hospitalized on the date his coverage would otherwise become effective, the coverage will not take effect until the earliest date thereafter on which he is no longer Hospitalized. (This clause shall not apply to the Life Insurance benefit or in the case of a newborn Child).

Any amount of coverage which is in excess of the non-evidence maximum specified in the Summary of Benefits will not take effect until the date on which the insurer or Administrator receives Evidence of Health and provides Approval of Evidence of Health. If the insurer or Administrator does not provide Approval of Evidence of Health for the Participant, any future increases in the non-evidence maximum will not automatically result in an increase in the Participant's coverage. The increase in the non-evidence maximum will only result in an increase in the Participant's coverage if he submits evidence of his Health and the insurer or Administrator provides Approval of Evidence of Health.

Notwithstanding the above, a Retired Employee and his Dependents, if any, shall be covered on the effective date of this group plan.

TERMINATION OF COVERAGE

Participant

A Participant's coverage automatically terminates on the earliest of the following dates:

a) The date the group plan is terminated; or

b) The date on which the Participant retires, unless otherwise specified in the Summary of Benefits; or

c) The date the Participant reaches the age limit specified in the Summary of Benefits, if an age limit is indicated; or

d) The date the Participant is no longer a Full-time Resident of Canada; or

e) The date the Participant loses his Legal Capacity to Work in Canada; or

f) The date the Participant is no longer covered by his provincial health plan; or

g) The date of the Participant's death; or

h) The date the Planholder terminates coverage for the Participant; or

i) The date on which the Participant pleads guilty or is found guilty of an offence for which he is confined in a penitentiary, prison, correctional facility, forensic psychiatric facility or any similar institution; or

j) The date the Participant ceases to qualify as an Employee, or ceases to be Actively at Work, as defined in the group plan.

Coverage may be extended to a Participant during periods the Participant has ceased to be actively at work due to, but not limited to, Illness, injury, temporary layoff or a leave of absence. The Participant should contact the Planholder for further information.

Dependents

A Dependent's coverage automatically terminates on the earliest of the following dates:

a) The date the Participant of whom he is a Dependent ceases to be covered under the group plan; or

b) The date the Dependent ceases to be a Dependent as defined in the group plan; or

c) The date the Dependent reaches the age limit specified in the Summary of Benefits, if an age limit is indicated; or

d) The date the Dependent is no longer a Full-Time Resident of Canada; or

e) The date the Dependent is no longer covered by the provincial health plan; or

f) The date the Planholder terminates coverage for the Dependent.

The above terms and conditions also apply in the case of the partial cancellation of coverage for a Participant or a Dependent owing to the cancellation of coverage under one or more benefits.

PORTABILITY
(Applicable only to Active Participants)

If the Participant's insurance under this policy was terminated due to the termination of his employment, the Participant that is re-hired by any Participating Employer within 6 months immediately following the termination of his insurance, will be eligible for the reinstatement of his insurance on the date he resumes employment, provided application for reinstatement is made within 31 Days of eligibility. If, due to an illness or injury, the Participant is not Actively at Work on that date, coverage will not begin until the employee has completed:

i) 7 consecutive scheduled working days if a full-time Employee; and

ii) All of the consecutive scheduled working days within the immediately preceding 10 calendar days if a part-time Employee.

The Participant must ask the new Participating Employer to arrange for the transfer of coverage within 1 month of his first day of employment and inform the new Participating Employer of all prior service to be counted toward coverage. If the Employee fails to do so, Evidence of Insurability will be required, at the Participant's own expense, to complete the transfer of coverage.

NOTICE AND PROOF OF CLAIM

Notice and proof of any claim must be submitted to the insurer or Planholder in the format required by the insurer or Planholder. The proof of claim must include all information that the insurer or Planholder requires and deems necessary as to the circumstances and extent of the loss, or which the insurer or Planholder otherwise requests in order to complete its assessment of a claim. The insurer or Planholder will not be liable for any claim that is not submitted in accordance

with all of the terms and conditions and time limits prescribed under the group plan.

- **Supplemental Health and Dental Care:**

  Notice and proof of any claim must be submitted to the insurer or Administrator within 12 months after the end of the year in which the expense was incurred.

- **Life:**

  Notice and proof of any claim must be submitted within 6 years of the date of the event which gives entitlement to the benefit.

- **Long-Term Disability:**

  Notice and proof of claim must be submitted within 6 months of the end of the Participant's Elimination Period. For the recurrence of Total Disability, written notice of a claim must be submitted to the insurer within 31 days of the date of recurrence and written proof within 60 days of the date of recurrence.

NOTICE AND PROOF OF CLAIM IN CASE OF TERMINATION

The following clause is applicable to insured benefits for which Industrial Alliance Insurance and Financial Services Inc. is the insurer:

In the event of the termination of the group plan or the termination of the Participant's insurance, the notice and proof of claim for any claim other than a Long-Term Disability claim, must be submitted to the insurer within 120 Days of the date of the termination of the group plan and, in the case of the termination of the Participant's insurance, within 120 Days of the termination of such insurance.

Notice and proof of claim for a Long-Term Disability claim must be submitted within 180 Days of the date of the termination of the group policy and, in the case of the termination of the Participant's insurance, within 120 Days of the termination of such insurance.

FRAUDULENT CLAIMS

The Planholder will offer reasonable assistance and collaboration to the Insurer in detecting and investigating fraudulent claims under the group plan.

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

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

The insurer retains the right to audit all claims at any stage, including after payment has been made, for fraud or misrepresentation. If the insurer determines that a Participant or Dependent has submitted any claim that contains false or misleading information, the insurer shall have the right, at its sole discretion, to notify the Planholder, decline the claim or require reimbursement if the claim has been paid. In addition, and notwithstanding any other provision in the group plan, the insurer will have the right to terminate the Participant's entire coverage under the group plan including any coverage for the Participant's Dependents, and will have the right to undertake the prosecution of the Participant and/or the Dependent in accordance with provincial and/or federal law.

APPEAL PROCESS

Where the Administrator has made a decision to decline or terminate a claim or coverage under this Plan, the decision to decline or terminate may be appealed as long as this right of appeal is exercised within 60 Days of the initial letter of decline or termination.

The appeal must be in writing and must include the grounds of appeal, any new information to support the appeal and any further information that may be requested by the Administrator.

EXPENSES

Unless the group plan expressly states otherwise, the Participant is solely responsible for all expenses and costs related directly and indirectly to submitting a claim, proof of a claim, appeals of any kind, or any other obligation

the Participant has under the group plan, including but not limited to submitting any application or appeal, or obtaining any medical reports, clinical records, test results, or any other information.

INSURER'S RIGHT TO EXAMINATION, RECORDS AND INVESTIGATION

The insurer, at its own expense and its sole discretion, shall have the right, whenever and how often it deems it necessary, to:

a) Require any medical, psychiatric, psychological, functional, vocational or any other examinations of a Participant who has submitted a claim or of any other Covered Person for whom a claim has been submitted. The insurer may designate, at its sole discretion, a Physician, a Specialist, a healthcare provider or any other examiner for such examination(s). The Participant or any other Covered Person being examined must comply with any terms and conditions of an examination that are required by such examiner; and

b) Require an autopsy, where it is not forbidden by law.

The insurer reserves the right to obtain the clinical notes and records or any other reports of a Participant who has submitted a claim or of any other Covered Person for whom a claim has been submitted, from any Physician or Specialist, including but not limited to, a psychologist, a psychiatrist, a healthcare provider or any other examiner who has treated, examined or assessed such Participant or Covered Person. The Participant and any Covered Person must cooperate fully with the insurer in obtaining any such records or reports.

The insurer, at its own expense and its sole discretion, shall have the right to conduct any investigation, or an examination under oath, of a Participant who has submitted a claim, or of any person for whom a claim has been submitted, whether or not a legal action has been commenced by such Participant or person.

SUBROGATION

Where a benefit is payable under the group plan with respect to a Participant or to a Dependent of a Participant and if such person has a right to recover damages from an individual or organization, the insurer or Planholder will be subrogated to the rights to recovery of the Participant or Dependent against such

individual or organization to the extent of all benefits paid in the past and all benefits payable in the future.

Without limiting the generality of this provision, the term damages will include any lump sum or periodic payments received on account of:

a) Past, present or future loss of income, wages, or Earnings; and

b) Any other benefits paid or payable under the group plan.

The Participant or Dependent shall reimburse the insurer or Planholder up to the amount of any benefits paid in the past or that are payable in the future under the group plan out of the gross damages recovered whether recovered at trial, or prior to trial by way of any form of settlement, and without regard to whether the Participant or Dependent has obtained full recovery of his losses.

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

In the event that the Participant or Dependent fails to reimburse the insurer or Planholder in accordance with the group plan, no future benefits will be paid by the insurer or Planholder until such time as the insurer or Planholder recovers:

a) The total amount of benefits paid to the Participant or Dependent; and

b) An amount that reasonably reflects, as determined by the insurer or Planholder, the total amount or value of any future benefits payable to the Participant or Dependent.

The insurer's or Planholder's recovery in this regard shall not exceed the Participant or Dependent gross damages recovered or gross settlement.

The insurer or Planholder shall also have the right to seek recovery directly from the Participant or Dependent, or exercise any other right or remedy it may have under the group plan or under the law, in the event that any overpayment has resulted from the lack of reimbursement.

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

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

OVERPAYMENT

If the insurer or Planholder determines that a benefit has been overpaid, the Participant or any other person to whom such benefit was overpaid is liable to reimburse the insurer immediately and in full as soon as the insurer requests such reimbursement.

In the event the overpayment is not reimbursed, the insurer shall have the right, at its sole discretion and in addition to any other legal remedy it may have, to recover such overpayment by exercising any or all of the following rights:

a) Reduce to zero the disability benefit payments payable to the Participant under this policy until such time as the overpayment is fully recovered.

b) Reduce any other benefits payable under this plan by up to 100% of the amount of the outstanding overpayment, whether such benefits are payable to the Member or to the Dependents.

LIMITATION ON LEGAL ACTIONS

The following clause is applicable to insured benefits for which Industrial Alliance Insurance and Financial Services Inc. is the insurer.

No action or proceeding against the insurer will be commenced within the first 60 Days following the date on which written proof of claim is provided to the insurer in accordance with all of the terms and conditions of the group plan.

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 of Quebec) in the Participant's province.

PARTICIPANT'S LIFE INSURANCE

Upon the death of the Participant while insured under this benefit, the insurer undertakes to pay to the beneficiary the sum insured as indicated in the Summary of Benefits, subject to all of the terms and conditions of this benefit and the group plan.

BENEFICIARY

The following clause is applicable to insured benefits for which Industrial Alliance Insurance and Financial Services Inc. is the insurer:

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

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

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

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

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

The group plan 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.

DEFINITIONS

As used in this benefit:

Total Disability and Totally Disabled means:

1) During the first 2 years of disability,
   a) The Participant is absent from work and not engaged in any Gainful Employment, and
   b) The Participant is in a state of incapacity, resulting from an Illness or Accident, which wholly prevents him from performing the regular duties of the occupation in which he participated immediately prior to the onset of Total Disability;

2) Once the first 2 years of Disability have elapsed,

   The Participant continues to be in a state of incapacity, resulting from an Illness or Accident, which wholly prevents him from working in any Gainful Employment for which he is suited by education, Training and Experience.

   If a Participant is able to earn an income that is equal to or greater than the amount of Monthly Disability Benefit payable under the Long Term Disability Benefit, he is no longer considered to be Totally Disabled.

Training and Experience means all of the knowledge and skills the Participant acquired while in school, in the performance of his current or former professional activities or during his non-working hours.

Gainful Employment means any occupation, any employment or any other activity for compensation or profit, for which the Participant is reasonably qualified (or may so become) by training, education or experience, and from which the Participant is able to earn an income that is equal to, or greater than, the amount of monthly Disability benefits payable under the Long-Term Disability Insurance, he will no longer be considered to be Totally Disabled.

CONVERSION PRIVILEGE

A Participant whose life insurance is reduced or cancelled on or prior to his 65th birthday due to the reduction of the sum insured or the termination of:

a) His employment; or

b) His group membership,

will be able to convert all or part of his life insurance to an individual life insurance policy without having to provide Evidence of Health.

The Participant may choose to convert to one of the following types of insurance:

a) Permanent; or

b) Term to age 65; or

c) One year term convertible into permanent or term to age 65 at the end of one year.

The amount that can be converted to an individual life policy will include all amounts of life insurance that the Participant was insured for under this benefit, an optional life insurance benefit and any other group insurance policy issued by the insurer, and will not exceed the lesser of:

a) The amount selected by the Participant; or

b) The amount for which the Participant was insured immediately prior to the termination of his insurance; or

c) The difference between the amount for which the Participant was insured immediately prior to the termination of his insurance, and the amount for which he is eligible under a new group insurance policy; or

d) $200,000.

The individual life insurance policy shall not include a disability benefit, nor an accidental death and dismemberment benefit, and the premium shall be based on the insurer's rates in effect which apply to the type and amount of such policy, according to the Participant's sex and attained age.

The individual life policy will only be issued if the insurer receives a written request to that effect, together with a deposit covering the monthly premium for a one year term policy within 31 Days of the date of the termination of the

Participant's life insurance, and will take effect only at the expiration of that period.

Should the Participant die during the period of 31 Days following the termination of his life insurance, the insurer shall pay an amount equal to that which he could have converted whether or not he made application for the individual life policy.

WAIVER OF PREMIUMS

Class(es): 603

a) A Participant who becomes Totally Disabled will be eligible to have his premiums waived for this benefit, if he is under age 65 and is eligible to receive a benefit under the Long-Term Disability Insurance benefit, if included in the group plan.

   If the Participant is not eligible to receive a benefit under the Long-Term Disability Insurance benefit or there is no Long-Term Disability Insurance benefit included in the group plan, he will be eligible to have his premiums waived for this benefit provided:

   i) The Participant was under 65 years of age at the onset of Total Disability; and

   ii) The Participant became Totally Disabled as defined under this benefit, while insured under this benefit and before any termination of employment; and

   iii) The Participant has been Totally Disabled for at least 6 continuous months; and

   iv) Proof of Total Disability, satisfactory to the insurer, was submitted to the insurer within 12 months of the onset of the Total Disability.

b) The amount of insurance for which the waiver of premiums applies will be that which was in force on the Participant's life at the onset of the Total Disability, and will be subject to any reductions and termination indicated in the Summary of Benefits, or otherwise indicated in this benefit or in the General Provisions of the group plan, which would have been applicable to the Participant if he had been Actively at Work.

c) The Participant's premiums will begin to be waived on the earliest of the following dates:

   i) The Day following completion of the Elimination Period under the Long-Term Disability Insurance benefit, if applicable; or

   ii) The Day following a continuous period of Total Disability of 6 months.

d) The Participant whose premiums are waived under this section must provide the insurer with proof of Total Disability, as often as the insurer may reasonably require.

e) The waiver of premiums will terminate on the earliest of the following dates:

   i) The date on which the Participant ceases to be Totally Disabled; or

   ii) The date on which the Participant fails to submit to an examination in accordance with the terms and conditions of the group plan, if required by the insurer; or

   iii) The date on which the Participant retires or reaches age 65; or

   iv) The date on which the Participant reaches the termination age for his life insurance benefit as indicated in the Summary of Benefits, if applicable; or

   v) The date on which the Participant fails to provide any proof of Total Disability required by the insurer; or

   vi) The date on which the Participant pleads guilty or is found guilty of an offence for which he is confined in a penitentiary, prison, correctional facility, forensic psychiatric facility or any similar institution; or

   vii) The date on which the Participant refuses to actively and continuously participate and cooperate in a Rehabilitation program, if required by the insurer.

f) If on the date the waiver of premiums terminates with respect to the Participant, he is not eligible to be insured under the Participant’s Life

Insurance benefit, he will be eligible to exercise the Conversion Privilege as provided for under this benefit.

Class(es): 612

The waiver of premiums does not apply.

LIVING BENEFIT

Upon request by the Participant for the Benefit and upon receipt by the Insurer of due proof that the Participant has incurred a terminal condition, the Insurer will pay a Living Benefit to the Participant provided the conditions set out below are satisfied. The amount will be equal to 90% of the sum insured, and may be paid to the Participant, subject to approval by the insurer.

As used in this benefit, "terminal condition" shall mean an injury or illness that is expected to result in death within 12 months and from which there is no reasonable prospect of recovery as determined by the Insurer.

Conditions

The Living Benefit will be subject to the following conditions, unless otherwise agreed to by the Insurer and the Policyholder.

a) The Participant must provide all medical information requested by the Insurer so as to allow the Insurer to determine whether or not the Participant is suffering a terminal condition as defined in this Benefit.

b) The Participant will be required to sign the "Living Benefit Agreement" prior to a Living Benefit being payable.

c) The Participant's amount of life insurance benefit under this policy will be reduced by the amount paid under this benefit and any interest on such amount which may be charged by the Insurer.

d) The Participant is under age 64 at the time he makes the election.

REDUCTIONS

The sum insured is reduced as indicated in the Summary of Benefits. The sum insured is also subject to any applicable reductions indicated in this benefit or in the General Provisions of the group plan.

TERMINATION

The insurance under this benefit terminates as indicated in the Summary of Benefits, or such other earlier date indicated in this benefit or in the General Provisions of the group plan.

LONG-TERM DISABILITY INSURANCE

If a Participant becomes Totally Disabled while insured under this benefit and while he is Actively at Work, the insurer will undertake to pay the Participant the amount of the Long-Term Disability benefit specified in the Summary of Benefits for each month or part of a month during which such Total Disability lasts, subject to all of the terms and conditions of this benefit and the group plan.

DEFINITIONS

As used in this benefit:

Total Disability and Totally Disabled means that, during the first 24 months following the onset of the disability, the Participant is, due to an Illness or Accident, continuously unable to perform all the essential duties of his Regular Occupation.

After the first 24 months following the onset of the disability, **Total Disability and Totally Disabled** means that the Participant is, due to an Illness or Accident, continuously unable to perform any Gainful Employment, as determined by the insurer.

Except as specifically permitted by the Rehabilitation Program provision of the group plan or specifically approved by the insurer, if a Participant engages in any occupation, any employment, or any other activity for compensation or profit, he will be deemed to no longer be Totally Disabled.

The following will not be taken into consideration in determining the Total Disability:

a) The availability of the Regular Occupation or any Gainful Employment; and

b) The loss, revocation, withdrawal, or non-renewal of a professional or occupational, license, permit or any other certification required to perform such Regular Occupation or Gainful Employment.

Gainful Employment means any occupation, any employment or any other activity for compensation or profit, for which the Participant is reasonably qualified, or may so become, by training, education or experience, and from which the Participant is able to earn an income that is equal to, or greater than,

the amount of monthly Disability benefits payable under the Long-Term Disability Insurance, he will no longer be considered to be Totally Disabled.

Regular Occupation means the occupation that the Participant was regularly performing immediately before the date of Total Disability.

Elimination Period means the period specified in the Summary of Benefits during which the Participant must be continuously absent from work due to a Total Disability before he can begin to receive Long-Term Disability benefits.

Satisfactory Application means that the Participant has made an application and has taken all necessary steps to appeal any denial of that application to the highest level of appeal, all within the time limits prescribed for such application or appeal.

PARTICULARS

Beginning of Benefit Payments

Payment of the Long-Term Disability benefit begins following completion of the Elimination Period specified in the Summary of Benefits.

Amount of Benefit Payments

The amount of the Long-Term Disability benefit payable is determined according to the formula set forth in the Summary of Benefits and will not exceed the monthly maximum amount specified.

REDUCTION OF BENEFIT PAYMENTS

Satisfactory Application

The Participant is required to make a Satisfactory Application for all Direct Reductions to which, in the opinion of the insurer, he is or may become entitled.

Direct Reductions

The Long-Term Disability benefit payable by the insurer will be reduced by the following amounts which are payable or which would have been payable to the Participant had a Satisfactory Application been made:

a) The Quebec or Canada Pension Plan disability benefits, excluding benefits payable on behalf of a Dependent Child; and

b) Workers' compensation benefits and any other similar benefits; and

c) Income loss or replacement benefits payable under provincial automobile insurance legislation; and

d) The Quebec or Canada Pension Plan retirement benefits where the effective date on which the retirement benefits commenced is after the date of Total Disability; and

e) Any amounts of disability or Retirement Pension received from an Employer's Pension Plan.

The amounts which would have been payable to the Participant had a Satisfactory Application been made will be estimated in accordance with the Provisional Reductions provision of this benefit.

All Sources

The Long-Term Disability benefit payable is subject to the All Sources maximum benefit payable, which is 100%

All Sources means:

a) The Long-Term Disability benefit under the group plan; and

b) Any of the Direct Reductions listed above; and

c) The Quebec or Canada Pension Plan retirement benefits where the effective date on which the retirement benefits commenced is within the 12 months prior to the date of Total Disability; and

d) Any other group, association or franchise plan for the same or related Total Disability; and

e) Any other governmental body or government plan; and

f) Any form of employment, self-employment or business which has not already been taken into account in the reductions applicable to this benefit.

Lump Sum Payments

Should any of the amounts listed in subparagraphs (b) to (f) of the All Sources be paid to the Participant as a lump sum, the insurer shall be entitled to reduce the Long-Term Disability benefit payment, whether retroactively or in the future, by the monthly amount that would have been payable to the Participant had the lump sum been paid on a monthly basis. The insurer shall be entitled to calculate such monthly amount that would have been payable based on the period of time the lump sum represents. Where no period of time is stipulated for the lump sum, the insurer shall have the right to determine a reasonable period of time.

Rehabilitation Program Reductions

If the Participant is receiving income under an approved Rehabilitation Program, this income will be coordinated with the monthly benefits payable under this Long-Term Disability benefit. The monthly benefits payable will be reduced by 50% of the monthly rate of rehabilitation remuneration, except that the monthly benefits and the sources of income under reduction section will be added to the rehabilitation income to provide an amount not exceeding 100% of the pre-disability Earnings.

Further Reductions

After the first reductions made from any of the amounts listed in subparagraphs (b) to (f) of All Sources as defined above, future cost of living adjustments made to amounts payable from such sources will not bring about further reductions.

Provisional Reductions

The insurer reserves the right to provisionally reduce the amount of the Participant's Long-Term Disability benefit by the amounts estimated by the insurer, which are payable or which would have been payable to a Participant had a Satisfactory Application been made, from any of the Direct Reductions listed in subparagraph (a) to (d), and the All Sources listed in subparagraphs (c) to (f) in the following circumstances:

a) If, in the opinion of the insurer, a Satisfactory Application for such All Sources has not been made; or

b) A Satisfactory Application has been made but has not yet been approved or denied; or

c) A Satisfactory Application has been made and has been denied and such denial is being appealed by the Participant.

However, the insurer will not make a provisional reduction of the estimated amount provided the Participant:

a) With respect to the Canada Pension Plan:

   i) Applies for disability benefits under the Canada Pension Plan as requested by the insurer or, where applicable, appeals a denial of such benefits as requested by the insurer, and provides evidence in the form required by the insurer that such application or appeal has actually been made; and

   ii) Signs an “Irrevocable Consent to Deduct and Pay an Insurer” form, a “Consent for Service Canada and Insurer to Communicate Disability Benefit Information” form, and any other related forms as may be requested by the insurer.

b) With respect to workers compensation benefits:

   i) Applies for workers compensation benefits; and

   ii) Signs an undertaking and reimbursement agreement in the form provided by the insurer and any other related forms as may be requested by the insurer.

If the amount estimated by the insurer turns out to be different than the correct amount payable to the Participant, the insurer will adjust the Participant’s Long-Term Disability benefit in accordance with this benefit once the correct amount is provided to the insurer.

TERMINATION OF BENEFIT PAYMENTS

The Long-Term Disability benefit payments cease on the earliest of the following dates:

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

b) The date on which the Participant ceases to be Totally Disabled; or

c) The date on which the Participant reaches the termination age specified in the Summary of Benefits for the Long-Term Disability benefit; provided the Participant who became Totally Disabled after his 64th birthday but prior to his 65th birthday receives 12 months of benefit payments after the Elimination Period. However, if the Participant had a minimum of 10 years of service, the benefit payments will continue to death; or

d) The date on which the Participant retires or reaches the normal retirement age under the Employer's pension plan; or

e) The date of the Participant's death; or

f) The date on which the Participant fails to submit to an examination in accordance with the group plan, as required by the insurer; or

g) The date on which the Participant fails to provide any evidence of Total Disability required by the insurer; or

h) The date on which the Participant refuses to actively and continuously participate and cooperate in a Rehabilitation Program, as required by the insurer; or

i) The date on which the Participant pleads guilty or is found guilty of an offence for which he is confined in a penitentiary, prison, correctional facility, forensic psychiatric facility or any similar institution; or

j) The date a Participant engages in any occupation, any employment, or any other activity for compensation or profit, except as specifically permitted by the Rehabilitation Program provision of the group plan and specifically approved by the insurer.

SUCCESSIVE PERIODS OF TOTAL DISABILITY

During the Elimination Period

If a Participant who was Totally Disabled returns Actively at Work before the end of his Elimination Period, and then becomes Totally Disabled again while his insurance under this benefit is in force, such successive period of Total Disability will be considered to be a recurrence of the previous Total Disability only if:

a) It is due to the same cause or related causes as the previous Total Disability; and

b) The Participant was Actively at Work for less than 3 consecutive weeks from the end of the previous Total Disability.

After the Elimination Period

If a Participant who was Totally Disabled returns Actively at Work after the end of his Elimination Period, and then becomes Totally Disabled again while his insurance under this benefit is in force, such successive period of Total Disability will be considered to be a recurrence of the previous Total Disability only if:

a) It is due to the same cause or related causes as the previous Total Disability; and

b) The Participant was Actively at Work for less than 6 consecutive months from the end of the previous Total Disability.

Recurrence of the Previous Total Disability

When a successive period of Total Disability is determined by the insurer to be a recurrence of the previous Total Disability according to this provision, the Elimination Period will not have to be satisfied in full again. If the Elimination Period was not satisfied in full during the previous Total Disability, only that portion of the Elimination Period that was not satisfied will be applied.

The Long-Term Disability benefit payable for a recurrence of the previous Total Disability will be determined in accordance with all of the terms and conditions of the group plan based on the Participant's Earnings as at the date of the previous Total Disability. Benefits for all recurrences will not be paid for a

combined period longer than the maximum benefit period applicable to the previous Total Disability as shown in the Summary of Benefits.

New Total Disability

If the insurer determines that a successive period of Total Disability is not a recurrence of the previous Total Disability according to this provision, such successive period of Total Disability will be considered to be a new Total Disability and a new Elimination Period will apply.

EXCLUSIONS

No Long-Term Disability benefit will be payable for a Total Disability resulting directly or indirectly from, or which is in any manner or degree associated with or occasioned by, any of the following causes:

a) Civil unrest, insurrection or war, whether war be declared or not, or a riot.

b) Committing or attempting to commit any offence under any criminal code or similar law in any jurisdiction, if the Participant has been charged or convicted.

c) Any addiction, including but not limited to drugs and alcohol, unless for such addiction, the Participant is actively participating and co-operating in an in-patient medical treatment program.

The Long-Term Disability benefits payable to the Participant will be determined in accordance with this benefit, but in no case will it exceed the maximum amount and duration of the Long-Term Disability benefits of the prior insurer.

LIMITATIONS

The Long-Term Disability benefit will not be payable during any of the following periods:

a) The Participant is not under continuous and curative care actively provided by a Physician who is a Specialist in the field of medicine which is applicable to his Total Disability.

b) The Participant is not undergoing medical treatment which, in the opinion of the insurer, is required.

c) The Participant is out of Canada for a period of 90 consecutive Days or more.

TOTAL DISABILITY THAT BEGINS WHILE A PARTICIPANT IS NOT ACTIVELY AT WORK

No benefits will be payable for a Total Disability that begins while a Participant is not Actively at Work except as expressly set out in this provision.

If a Participant is not Actively at Work due to one of the Absences specified in this provision, Long-Term Disability benefits for a Total Disability that begins during such Absence will only be payable if all of the Conditions set out in this provision are satisfied:

As used in this provision, Absence means:

- A leave taken in accordance with any provincial or federal legislation including but not limited to maternity, parental or family-related leave;
- A temporary layoff.

As used in this provision, Conditions means:

a) The Participant's insurance under this benefit was:

   i) In force as of the date of Total Disability; and

   ii) Kept in force during the entire Absence in accordance with the terms and conditions for extending such insurance under this benefit and plan, including but not limited to the Termination of Insurance provision of the group plan; and

b) Any premiums due for the Participant during the Absence were paid to the insurer; and

c) Had the Participant not been on the Absence he would have otherwise been able to satisfy the definition of Actively at Work; and

d) The Participant satisfies all of the terms and conditions of this benefit and group plan during the Absence and as of the date of Total Disability.

If the Conditions set out above are satisfied, any Long-Term Disability benefits that are payable to a Participant will only commence on the latest of:

a) The date the Elimination Period is satisfied; or

b) The date the Participant was scheduled to return Actively at Work following the scheduled end of his Absence.

REHABILITATION PROGRAM

The insurer may, at its sole discretion, require a Participant who is Totally Disabled to participate in a Rehabilitation Program after completion of his Elimination Period.

Rehabilitation Program means any program or activity that, in the opinion of the insurer, would assist a Totally Disabled Participant in being able to return to his Regular Occupation or any Gainful Employment. Such Rehabilitation Program must be approved in advance and in writing by the insurer.

A Rehabilitation Program may include any form of the following activities or programs:

a) Work hardening or return to work program on a gradual, modified, trial or part-time basis.

b) Functional or occupational assessments, services for job placements or job searches.

c) Treatment or access to healthcare services or assistive devices or any other equipment.

d) Skills or knowledge development or upgrading, training, retraining or educational courses.

e) Any other programs or activities that the insurer, at its sole discretion, determines to be appropriate and reasonable as a Rehabilitation Program taking into account factors such as the nature and expected duration of the Participant's Total Disability, his training, education or experience, and the nature, scope and cost of the program or activity.

The approval of a Rehabilitation Program by the insurer does not constitute an ongoing approval of such Program into the future. The insurer may, therefore and at its sole discretion, terminate a Rehabilitation Program at any time and for any reason.

Active and Continuous Participation Required

The Participant must actively and continuously participate and cooperate in the Rehabilitation Program. Long-Term Disability benefits will terminate if, in the opinion of the insurer, a Participant is not actively or continuously participating or cooperating in such a Rehabilitation Program.

WAIVER OF PREMIUMS

A Participant whose life insurance premiums are waived in accordance with the Waiver of Premiums provision of the Participant's Life Insurance benefit will also be entitled to waiver of premiums for this benefit, under the same conditions.

TERMINATION

The insurance under this benefit terminates as indicated in the Summary of Benefits, or such other earlier date indicated in this benefit or in the General Provisions of the group plan.

SUPPLEMENTAL HEALTH

The Planholder undertakes to reimburse the medical expenses defined herein which are due to an injury, Illness or pregnancy and which are incurred by a Covered Person after the Covered Person became covered under this benefit subject to all of the terms and conditions of this benefit and the group plan.

DEFINITIONS

As used in this benefit:

Day Surgery: Surgery which is performed in a Hospital or out-patient clinic affiliated with a Hospital and requiring local, regional or general anaesthesia, but will not include minor surgery that can be performed in the Physician's office.

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

General Dental Practitioner: A licensed dentist who practices dentistry without specialization.

Hospitalization and Hospitalized: Occupancy of a Hospital room as an admitted bedridden patient where a room and board charge has been made in connection with the confinement. Day Surgery will be considered to be a period of Hospitalization.

Medical Emergency: A sudden or unexpected occurrence that requires immediate medical attention.

Medically Required: Broadly accepted and recognized by the Canadian medical profession, and, where applicable, the Canadian dental profession as effective, appropriate and essential in the treatment of an Illness or injuries, including injuries due to an Accident, in accordance with Canadian medical standards, or, where applicable, Canadian dental standards.

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

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

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

HOSPITALIZATION IN THE PROVINCE OF RESIDENCE

Room and board charges made by a Hospital in the Covered Person's province of residence which are in excess of the amount reimbursed by the government health plan, up to the daily maximum specified in the Summary of Benefits, provided:

a) The Covered Person is confined to the Hospital on an in-patient basis; and

b) The level of accommodation was specifically requested by the Covered Person; and

c) The Covered Person was Hospitalized for acute care and not chronic or convalescent care.

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

The following medical expenses are covered, up to the maximums specified in the Summary of Benefits:

a) Drugs which are dispensed by a pharmacist and which have been prescribed by a healthcare provider who is legally licensed to prescribe drugs, other than those drugs that are excluded under the Exclusions and Reductions provision of this benefit.

   Insulin supplies, such as needles, syringes, lancets and diagnostic testing materials.

Contraceptive patches, contraceptive rings, intrauterine devices and sclerosing injections.

Dispensing Limitations

The quantity of drugs which may be dispensed for any one prescription will be limited to that amount sufficient for up to a 100 Day period.

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

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

The Administrator reserves the right, at its sole discretion, to exclude coverage of any drug under certain circumstances as provided in the terms and conditions of the group plan.

If the drug is an Original Drug which has a Generic equivalent, the amount payable will be based on the Lowest Priced Interchangeable Drug. 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.

As used above, Lowest Priced Interchangeable Drug will include, but is not limited to

i) An alternative drug to the Original Drug deemed interchangeable by law; or

ii) A subsequent entry biologic.

b) Services rendered at the Covered Person's home by a registered nurse or certified nursing assistant provided:

i) The services were prescribed by a Physician and pre-approved by the Administrator; and

ii) The services are Medically Required; and

iii) The services fall within the scope of services provided by a registered nurse or certified nursing assistant; and

iv) The registered nurse or certified nursing assistant is unrelated to the Covered Person and does not normally reside with him.

c) Licensed ambulance service in a Medical Emergency for transportation to the nearest Hospital equipped to provide the required treatment, or for transportation therefrom, when the physical condition of the Covered Person precludes the use of any other means of transportation.

d) Charges for diagnostic laboratory tests:

i) Coverage for the tests are not prohibited by provincial legislation; and

ii) The tests are performed in a facility licensed to perform such tests and services; and

iii) The tests are required for the diagnosis of an Illness or injury or to determine the effectiveness of the treatment being prescribed or received.

e) Room and board charges made in a facility licensed to provide chronic care provided:

i) The Insured Person is under the regular supervision of a Physician or registered nurse; and

ii) The confinement was recommended by a Physician; and

iii) The confinement is for chronic care.

However, there will be no coverage for nursing homes, rest homes, home for the aged or chronically ill, sanatorium, convalescent hospital or a facility for treating alcohol or drug abuse.

f) Room and board charges made by a Private Hospital.

g) Charges for the rental of, or at the Planholder's option, the purchase of the following medical appliances and supplies provided they are prescribed by a Physician:

i) Oxygen tent and oxygen supplies

ii) Aerosol equipment, mist tents and nebulizers for cystic fibrosis, acute emphysema, chronic obstructive bronchitis or chronic asthma

iii) Artificial eyes, including repairs and replacements

iv) Artificial prostheses, excluding myoelectric and electric prostheses, including repairs and replacements

v) Manual wheelchairs

vi) Manually operated Hospital beds or electrically operated Hospital beds when the Covered Person is incapable of operating a manually operated Hospital bed due to a medical condition, including bed rails and trapeze bars

vii) Apnea monitors for respiratory dysrhythmias

viii) Diabetic monitoring (dextrometers, glucometers, reflectometers) other than the insulin supplies such as needles, syringes, lancets and diagnostic testing materials

ix) Percutaneous or transcutaneous nerve stimulator

x) Intermittent positive pressure breathing machine

xi) Continuous positive pressure breathing machine

xii) Breast prostheses

xiii) Surgical brassieres

xiv) Medical elastic stockings prescribed for the treatment of varicose veins or required as a result of severe burns or surgery

xv) Orthopedic shoes which are Medically Required by a health practitioner operating within the scope of his license and which have been custom made, custom modified or custom molded for the Covered Person by a certified specialist in orthopedic footwear. Off the shelf orthopedic shoes which have not been custom made, modified or molded for the Covered Person will be eligible for coverage

xvi) Foot orthoses which are Medically Required by a health practitioner operating within the scope of his license and which have been specifically designed and constructed for the Covered Person by a certified specialist in foot orthoses. Off the shelf foot orthoses which have not been specifically designed and constructed for the Covered Person will not be eligible for coverage

xvii) Braces with rigid support; back supports; shoulder harnesses; head halters and cervical collars

xviii) Splints, other than dental splints, and casts

xix) Canes, crutches and walkers

xx) Hernia belts

xxi) Wigs required as a result of chemotherapy

xxii) Colostomy and ileostomy apparatus and supplies

xxiii) Catheters

xxiv) Compression garments for severe burns

xxv) Stump socks

xxvi) Blood and plasma transfusions

xxvii) Compressors, breathing unit and respirators

xxviii) Lymphedema sleeves

xxix) Scooters

h) Dental care given out of Hospital by a General Dental Practitioner which is required as a result of an Accident to whole, healthy, natural teeth, provided:

i) The Accident occurs while the Covered Person is covered under this benefit; and

ii) The care is the least expensive that will provide a professionally adequate treatment; and

iii) The charges do not exceed the amount shown for the treatment in the current provincial fee schedule for General Dental Practitioners in the Covered Person's province of residence; and

iv) The care is received within 12 months of the date of the Accident.

Any charges for dental care which are not directly related to the Accident will not be covered.

i) Charges for hearing aids or any related devices (including repairs and replacements but not batteries), and the professional services given by a hearing aid acoustician following the purchase of the hearing aid or related device provided they have been prescribed by a Physician or an audiologist.

j) Charges made by a Homewood Health Centre (substance abuse treatment facility) (including cost of room and board and nursing care) provided:

i) The provincial health care plan pays the equivalent of ward level accommodation;

ii) The facility is a legally licensed facility providing care and treatment on a regular basis to individuals who are involved with substance abuse and is operating in accordance with the laws of the jurisdiction in which it is located, and

iii) The Administrator has approved the facility prior to the charges being incurred.

k) Charges for eye examinations when performed by an ophthalmologist or an optometrist.

l) Charges for eyeglasses (including sunglasses) when prescribed by an ophthalmologist or an optometrist.

m) Charges for contact lenses, when prescribed by an ophthalmologist or an optometrist.

n) Charges for corrective laser surgery, when prescribed by an ophthalmologist or an optometrist.

o) Charges for contact lenses which are medically necessary, when prescribed by an ophthalmologist or an optometrist.

Contact lenses will be considered medically necessary if:

i) they were prescribed for severe corneal astigmatism, a severe corneal scar, a keratoconus (conical cornea) or an aphakia; and

ii) visual acuity can only be improved to at least 20/40 with contact lenses.

p) Fees for the care (including charges for x-rays, if specifically mentioned as being covered under the Summary of Benefits) provided by one of the paramedical practitioners listed in the Summary of Benefits provided the practitioner is licensed by the appropriate provincial or federal organization to practice his profession in accordance with the rules of his profession.

If the services of the practitioner are covered by the provincial health plan, no coverage will be provided under this benefit for any amount payable for such services under the provincial plan.

EXCLUSIONS AND REDUCTIONS

This benefit does not cover any of the following expenses:

a) Payable or reimbursable under a workers' compensation act or would have been payable if the claim had been submitted.

b) For an Illness or injury or any expenses resulting, directly or indirectly, from a self-inflicted injury unless medical evidence establishes that the injury was directly related to a mental health illness.

c) For an Illness or injury or any expenses resulting, directly or indirectly, from civil unrest, insurrection or war, whether war be declared or not, or a riot.

d) For an Illness or injury or any expenses resulting, directly or indirectly, from the commission of an offence under any criminal code or similar law in any jurisdiction, if the Covered Person has been charged or convicted.

e) For treatment or appliances to correct vertical dimension or any temporomandibular joint dysfunction.

f) For care or treatment which is not Medically Required, or which is given for cosmetic purposes, or for any reason other than curative, or which exceeds the normal care or treatment given in accordance with current therapeutic practice, or is of an experimental nature.

g) For any care or treatment included in the protocol of a research and development program for a product whose use has not been recommended by the manufacturer or which does not comply with government standards.

h) For care or treatment of an Illness or injury that is not recognized as normal, customary and common practice for such Illness or injury.

i) For any portion of a charge for care or treatment which is in excess of the reasonable and customary charge normally incurred for an Illness or injury of the same nature and severity in the locality where the service is provided.

j) For any care or treatment rendered free of charge or which would have been free of charge were it not for coverage or which is not chargeable to the Covered Person.

k) For rest cures or travel for reasons of health.

l) For eye examinations, except if specifically mentioned as being covered under this benefit.

m) For eyeglasses and contact lenses, except if specifically mentioned as being covered under this benefit.

n) For care or treatment related to fertility or infertility, except if specifically mentioned as being covered under this benefit.

o) For the purchase or rental of any comfort or massage apparatus, and of domestic accessories that are not exclusively required for medical purposes.

p) For any services or supplies which are for the sole purpose of facilitating the Covered Person's participation in sports, or for fitness and training (except if specifically mentioned as being covered under this benefit), or recreational activities and not for daily living activities.

q) For care or treatment of (including breaking the addiction to) such conditions as, but not limited to, obesity and smoking except if specifically mentioned as being covered under this benefit.

r) For preventive immunization vaccines or the administration of serums, vaccines and injectable medications, except if specifically mentioned as being covered under this benefit.

s) For contraceptives (other than oral), except if specifically mentioned as being covered under this benefit.

t) For the following products unless such products can only be obtained with a written prescription of a healthcare provider who is legally licensed to prescribe them and they are required to be dispensed by a pharmacist:

- products for the care of contact lenses;
- proteins or dietary supplements, amino acids;
- baby food;
- mouthwash, bandages and throat lozenges;
- shampoos, oils, creams;
- toilet products including soaps and emollients;
- skin softeners and protectors;
- vitamins, vitamin supplements or multivitamins;
- minerals;
- homeopathic products;
- anabolic steroids.

u) For any drugs which are considered lifestyle drugs such as, but not limited to, drugs for the treatment of infertility, erectile dysfunction, loss of hair or lack of growth, except if specifically mentioned as being covered under this benefit.

v) For any drugs which are excluded from coverage by the Administrator under the Dispensing Limitations provision of this benefit.

w) For any prescriptions which are dispensed by a clinic or by any non-accredited Hospital pharmacy or for treatment as an out-patient in a Hospital, including emergency status and investigational status drugs.

x) For any care or treatment received outside the province of residence due to a Medical Emergency which is related to (i) a pregnancy, false labour, delivery or resulting complications, if the Medical Emergency occurs after the 32nd week of gestation; or (ii) the deliberate inducement of a miscarriage.

y) For any care or treatment which was provided by a healthcare provider who, or a service provider that:

   i) Has been charged with professional misconduct or improper practices; or

   ii) Is under investigation by an official body resulting from a law or regulation; or

   iii) Is under investigation by the insurer in regards to his professional conduct or practice; or

   iv) Is a member of a profession that is not regulated by an officially recognized federal or provincial regulatory body in the jurisdiction where the services were provided and, in the opinion of the insurer, does not meet the insurer's standards relevant to his professional conduct or practice, or

   v) Is an employee, contractor, principal, or member of

      - any business, group or association who is the subject of any of the matters set out in subparagraphs (i) to (v) above; or

- any entity that is affiliated with or related to such business, group or association

The amount of benefit payable will be reduced by any benefit that is payable or reimbursable (i) under a government plan, a group plan or an individual plan, or that would have been payable had the Covered Person submitted a claim under such plan or (ii) by a third party as a result of a legal action or settlement.

CALCULATION OF REIMBURSEMENT

Deductible

The Deductible, if any, must be paid by the Covered Person during the Calendar Year before any benefits are payable under this benefit. The Deductible is specified in the Summary of Benefits.

Carry-over Provision

If the Deductible for a Calendar Year is satisfied in whole or in part by the payment of covered expenses incurred during the last 3 months of the Calendar Year, the amount of covered expenses incurred in such 3 month period and which were applied toward satisfaction of the Deductible for that Calendar Year, shall be carried over and applied toward satisfaction of the Deductible for the next Calendar Year.

Reimbursement

The Planholder will reimburse the percentage of covered expenses incurred, as specified in the Summary of Benefits, once the Deductible, if any, has been satisfied.

Maximum Benefit Per Covered Person

The maximum amount that will be reimbursed by the Planholder under this benefit is specified in the Summary of Benefits.

EXTENSION OF BENEFITS

If on the date a Covered Person's coverage under this benefit is discontinued, the Covered Person is Disabled, a benefit will be payable for covered health care expenses directly related to the Disability provided:

a) The expenses are incurred within 90 Days of the date the coverage was discontinued; and

b) This benefit is in force when the expenses are incurred.

As used in this provision, Disabled and Disability mean:

a) With respect to a Participant, his complete incapacity due to an Illness or injury to perform any work for which he is reasonably qualified by education, training or experience; and

b) With respect to a Dependent, that the Dependent, due to a medically determinable physical or mental impairment, is confined to a Hospital or is receiving treatment by a Physician.

TERMINATION

The coverage under this benefit terminates as indicated in the Summary of Benefits, or such other earlier date indicated in this benefit or in the General Provisions of the group plan.

DENTAL CARE

The Planholder undertakes to reimburse the Covered Person's dental care expenses which are incurred after the Covered Person became covered under this benefit, subject to all of the terms and conditions of this benefit and the group plan.

DEFINITIONS

As used in this benefit:

General Dental Practitioner: A licensed dentist who practices dentistry without specialization.

Dental Specialist: A General Dental Practitioner person licensed by the provincial licensing authority to practice dentistry with specialization.

Denturist: A person licensed by the provincial licensing authority to work as a practitioner supplying and fitting dentures.

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

Expenses Incurred: Any fee corresponding to a professional procedure which has been performed. Expenses are considered to be incurred only when treatment has actually been given, even if a treatment plan has been submitted to and approved by the Planholder.

For dentures, expenses are considered to be incurred only on the date the dentures are installed.

Dental Hygienist: A person licensed by the provincial licensing authority to work as a practitioner specializing in the cleaning of teeth and assisting the patient in proper oral health.

Medically Required: Broadly accepted and recognized by the Canadian medical profession, and, where applicable, the Canadian dental profession, as effective and appropriate and essential in the treatment of an Illness or injuries,

including injuries due to an Accident, in accordance with Canadian medical standards, or, where applicable, Canadian dental standards.

Reimbursement: The Reimbursement is the percentage of the covered Expenses Incurred that is reimbursed by the Planholder after the Deductible has been satisfied. The percentage is specified in the Summary of Benefits.

DENTAL EXPENSES

Only those items included below which are specified in the Summary of Benefits will be considered "eligible expenses" provided they were rendered by a General Dental Practitioner, a Dental Specialist on the recommendation of a General Dental Practitioner or by a Dental Hygienist.

Preventive Treatments

a) Examinations and Diagnoses

i) Complete oral examination:

Once every 3 years

ii) Recall examination:

Once every 9 months

iii) Emergency oral examination

iv) Specific oral examination

b) X-rays

i) Intra-oral - periapical:

One complete series every 36 months

ii) Intra-oral - occlusal

iii) Intra-oral – interproximal (bitewings):

Once every 9 months

iv) Extra-oral

v) Sialography

vi) Panoramic:

Once every 36 months

vii) Radiopaque dyes

c) Tests and Laboratory Examinations

i) Microbiologic culture

ii) Biopsy of oral tissue - soft

iii) Biopsy of oral tissue - hard

iv) Cytologic smear

v) Pulp vitality tests

vi) Caries susceptibility tests

d) Preventive Services

i) Polishing of coronal portion of teeth (prophylaxis):

1 unit(s) every 9 months

ii) Scaling of coronal portion of teeth:

1 unit(s) every 9 months

If Periodontic services are provided under this benefit, any additional scaling will be combined with root planing under the Periodontics section.

iii) Topical application of fluoride:

Once every 9 months

iv) Oral hygiene instruction:

Once every 9 months

e) Space maintainers, other than stainless steel crown types, for persons under age 18: maintenance of a maintainer will be limited to twice every 12 months.

Basic Treatments

a) Basic Services

- i) Finishing restorations
- ii) Pit and fissure sealant
- iii) Caries control
- iv) Interproximal disking
- v) Prophylactic odontotomy

b) Restorative

- i) Amalgam restorations
- ii) Composite restorations

c) Endodontics

- i) Pulp capping
- ii) Pulpotomy (excluding final restoration)
- iii) Emergency pulpotomy
- iv) Endodontic trauma
- v) Root canal therapy
- vi) Endodontic surgery
- vii) Apexification

d) Periodontics

- i) Surgical services
- ii) Provisional matching
- iii) Adjunctive periodontal procedure
- iv) Periodontal scaling

Root planing is covered. Coverage will be combined with any units of scaling which are in excess of the limit stated under the Preventive Services section.

e) Dentures - removable
   i) Adjustments
   ii) Repairs
   iii) Rebasing and relining
   iv) Prophylaxis and polishing

f) Oral Surgery
   i) Removal of erupted tooth (uncomplicated)
   ii) Surgical removals (complicated)
   iii) Surgical exposure and movement of tooth
      - transplantation
      - surgical repositioning
   iv) Enucleation of tooth
   v) Remodelling and recontouring of oral tissues
      - alveoloplasty
      - gingivoplasty and/or stomatoplasty
      - vestibuloplasty
      - remodelling of floor mouth
      - extension of mucous folds
   vi) Surgical excision and incision
      - excision of tumors and cysts
      - enucleation of cysts/granulomas
      - cheiloplasty (lip shave)
      - graft of bone to jaw
      - marsupialization

- incision and drainage and/or exploration
- incision for removal of foreign bodies

vii) Treatment of fractures

- mandibular or maxillary (including wiring)
- alveolar fractures
  - debridement, teeth removed
  - replantation of avulsed tooth (includes splinting)
  - repositioning of traumatically displaced tooth
  - repairs and lacerations

viii) Frenectomy/frenoplasty

ix) Antral surgery

g) Adjunctive General Services

i) Anaesthesia

Major Treatments

a) Dentures - removable

i) Complete dentures

ii) Partial dentures

b) Bridges

i) Cast post

ii) Pontic

iii) Butterfly bridge

iv) Abutments

v) Retainers (excluding transitional retainers) and retentive pins for retainers

- stress breakers and/or precision attachments

- telescoping of crown unit

Replacement of removable dentures or bridges will be covered only if it is necessary for one of the following reasons:

i) Extraction of one or more additional natural teeth, while the Covered Person is covered under this benefit or a similar benefit; or

ii) The removable dentures or bridges are at least 5 years old and can no longer be used; or

iii) Replacement of temporary dentures fitted less than 12 months before.

However, in no event will replacement dentures be covered if due to lost or stolen dentures.

c) Crowns

i) Crowns

ii) Gold foil restorations (if other substances are inappropriate)

iii) Metal inlay and onlay restorations

iv) Porcelain inlay and onlay restorations (if other substances are inappropriate)

v) Prefabricated post (pivot)

vi) Recementing of inlays, onlays and crowns

vii) Removal of inlays, onlays and crowns

Initial provision of crowns, inlays or onlays will be covered only if the tooth of the Covered Person is broken down by decay or injury and cannot be restored with an amalgam or composite restoration.

Replacement of crowns, inlays or onlays will be covered only if:

i) The Covered Person's tooth is further broken down by decay or injury and cannot be restored with an amalgam or composite restoration; and

ii) A period of 5 years has elapsed since the last date on which the crown, inlay or onlay was provided.

d) Space Maintainers (for loss of primary teeth)

i) Stainless steel crown types

e) Implants – These expenses are not covered.

EXCLUSIONS AND REDUCTIONS

In addition to the exclusions and reductions outlined in the Exclusions and Reductions provision of the Supplemental Health, if such a benefit is included in the group plan, the Dental Care does not cover any expenses:

a) Related directly or indirectly to a full mouth reconstruction, to correct vertical dimension or any temporomandibular joint dysfunction;

b) Related to any appliance which is to be worn by the Covered Person during his participation in sports or recreational activities;

c) Which are payable or reimbursable under a workers' compensation act, or would have been payable if the claim had been submitted;

d) For services and supplies resulting, directly or indirectly, from a self-inflicted injury unless medical evidence established that the injury was directly related to a mental health illness;

e) For services and supplies resulting, directly or indirectly, from civil unrest, insurrection or war, whether war be declared or not, or a riot;

f) For services and supplies which are not Medically Required, which are given for cosmetic purposes or for any reason other than curative, or which exceed the normal services and supplies given in accordance with current therapeutic practice;

g) For services and supplies rendered free of charge or which would be free of charge were it not for coverage or which are not chargeable to the Covered Person;

h) For services and supplies related directly or indirectly to implants;

i) For services and supplies or any expenses resulting, directly or indirectly, from the commission of an offence under any criminal code or similar law in any jurisdiction, if the Covered Person has been charged or convicted.

The amount of benefit payable will be reduced by any benefit that is payable or reimbursable (i) under a government plan, a group plan or an individual plan, or that would have been payable had the person submitted a claim under such plan, or (ii) by a third party as a result of a legal action of settlement.

TREATMENT PLAN

If the total cost of a course of treatment is expected to exceed $500, a Treatment Plan should be submitted to the Administrator who will determine, before commencement of the treatment, the amount of eligible expenses.

Treatment Plan means a written description of the course of treatment which, in the opinion of the General Dental Practitioner, will be required, including x-rays in support of such opinion, and specification of the probable date and cost of the treatment.

PAYMENT OF BENEFITS

Fees

Eligible expenses will be reimbursed according to the appropriate Fee Guide of the year specified in the Summary of Benefits, subject to any limits stated in the benefit.

Expenses incurred in Canada, other than expenses related to services provided by a Denturist, will be limited to the normal rate suggested for General Dental Practitioners in the Covered Person's province of residence.

Expenses incurred for services provided by a Denturist are limited to the normal suggested fee for Denturists in the Covered Person's province of residence.

Expenses incurred outside Canada are limited to the normal rate suggested for General Dental Practitioners in the Covered Person's province of residence.

Proof

Before paying benefits, the Planholder may require, at no expense to the Planholder, a complete diagram showing the Covered Person's state of dentition prior to the beginning of the treatment for which a claim is submitted. The Planholder may also, if it deems necessary, require laboratory or Hospital reports, x-rays, casts, molds or models used for examination purposes, or any other similar evidence.

Alternative Treatment Plan

If more than one type of treatment exists for the dental condition of the Covered Person, the Planholder will limit Reimbursement to the least expensive treatment that will produce a professionally adequate result with respect to the Covered Person's condition.

CALCULATION OF REIMBURSEMENT

Reimbursement

The Planholder will reimburse the percentage of eligible Expenses Incurred as specified in the Summary of Benefits.

Maximum Benefit Per Covered Person

The maximum amount that will be reimbursed by the Planholder is specified in the Summary of Benefits.

EXTENSION OF BENEFITS

If coverage under this benefit is terminated, covered Expenses Incurred after the termination date are not payable, regardless of the fact that a Treatment Plan may have been filed and benefits approved by the Administrator, unless the dental treatment is provided within 31 Days following the termination date and, as of the date of termination:

a) The impression had been taken for full or partial dentures but the dentures have not yet been installed; or

b) The tooth had been prepared for fixed bridges, crowns, onlays, inlays or gold restorations; or

c) The pulp chamber had been opened for root canal therapy.

TERMINATION

The coverage under this benefit terminates as indicated in the Summary of Benefits, or such other earlier date indicated in this benefit or in the General Provisions of the group plan.

The following provision only applies to benefits insured under this group plan for which Industrial Alliance Insurance and Financial Services Inc. is the insurer:

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

Health and Dental Claims

To benefit from an accelerated processing, a Participant may submit claims in any of the following ways, if offered as part of his group insurance plan:

- **on our secure website *My Client Space* accessible via *ia.ca*; or**
- **via *iA Mobile***

The Participant may also submit a completed claim form with the original receipts (if applicable) to the following address:

For Participants residing in Quebec

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

For Participants residing outside Quebec

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

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

Disability Claims

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

For Participants residing in Quebec

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

For Participants residing outside Quebec

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

PROTECTING PERSONAL INFORMATION

Industrial Alliance Insurance and Financial Services Inc. is committed to protecting the privacy of a Participant's (including his or her Dependent's) personal information that it collects while providing services under the group plan issued to the Policyholder. The Industrial Alliance Insurance and Financial Services Inc. recognizes and respects a person's right to privacy concerning his or her personal information.

When a Participant enrolls under the group plan, the Industrial Alliance Insurance and Financial Services Inc. will establish a confidential file containing the personal information collected. The file will be kept at Industrial Alliance Insurance and Financial Services Inc. offices.

Access to the file will be limited to the Industrial Alliance Insurance and Financial Services Inc. employees, agents and service providers who require access in the performance of their jobs, individuals to whom the Participant has granted access, and persons authorized by law.

At the Industrial Alliance Insurance and Financial Services Inc., the personal information that is collected is used to perform administrative services with respect to the group plan. Administrative services include, but are not limited to,

- Determining eligibility under the group plan or a particular benefit;
- Enrolling Participants under the group plan;
- Adjudicating claims;
- Underwriting (includes determining the rates applicable to the group plan).

Participant's Right to Access His or Her Personal Information

A Participant has the right to access his or her personal information and to request, in writing, that any inaccurate information be corrected. In addition, the Participant can request that any outdated or unnecessary information be deleted.

If the Industrial Alliance Insurance and Financial Services Inc. has medical information about the Participant which was not obtained directly from the Participant, the Industrial Alliance Insurance and Financial Services Inc. will release the information to the Participant only through the Participant's physician.

To request access to his or her personal information or to have his or her name removed from the list to be shared within the Industrial Alliance Insurance and Financial Services Inc., the Participant must send a written request to:

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

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Applicable to Class(es): 603
Policy No. 100011872
issued by iA Special Markets,
a division of Industrial Alliance Insurance and Financial Services Inc.

COVERAGE

You are covered for any injury sustained as the result of an accident anywhere in the world - 24 hours per day - on or off the job.

AMOUNT OF INSURANCE

Your amount of insurance (Principal Sum) is an amount equal to the amount of your current Basic Group Life Insurance.

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

BENEFITS

Accidental Death, Dismemberment and Specific Loss Indemnity

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

Life	100%
Both Hands or Both Feet	100%
Entire Sight of Both Eyes	100%
One Hand and One Foot	100%
One Hand and Entire Sight of One Eye	100%
One Foot and Entire Sight of One Eye	100%
Speech and Hearing in both Ears	100%
One Arm or One Leg	80%
One Hand or One Foot	75%
Entire Sight of One Eye	75%
Speech or Hearing in both Ears	75%
Thumb and Index Finger of Either Hand	40%
Four Fingers of Either Hand	40%
Hearing in One Ear	40%
All Toes of One Foot	33 1/3%
Quadriplegia (total paralysis of all four limbs)	200%
Paraplegia (total paralysis of the lower limbs)	200%
Hemiplegia (total paralysis of one side of the body)	200%

Bereavement Benefit ($2,500)

If an injury results in loss of life, the Company will pay the reasonable and necessary expenses actually incurred by the Spouse and Dependent Children for up to six sessions of grief counselling, by a professional counsellor.

Brain Damage Benefit

If an injury results in brain damage, the Company will pay the principal sum, less any amount paid or payable under the Accidental Death, Dismemberment and Specific Loss Indemnity as the result of the same accident, provided that the insured incurs brain damage within 120 days from the date of the accident, is hospitalized as a result at least 7 of the first 120 days, and a physician determines and the Company is satisfied that the insured has evidence of brain damage for at least 6 consecutive months.

Contagious Disease Benefit

If, during the performance of his duties, an insured contracts and/or becomes infected by Hepatitis B, Hepatitis C, Tuberculosis, Meningoccal Meningitis or Yersinia Pestis, resulting in loss of life within 12 months following such exposure, the Company will pay the Principal Sum. There must be supporting medical evidence that the disease was acquired from exposure which has been confirmed, and the disease must first manifest itself and be diagnosed by a physician while the policy is in force.

Continuation of Coverage

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

Conversion Option

Upon termination of active employment with the Policyholder, an insured may convert his/her insurance to an individual accident insurance plan, with no evidence of insurability, for an amount of principal sum equal to or lower

Conversion Option (Cont'd)

than the amount of principal sum in force at the time of termination. Application for conversion must be made within 31 days. Premiums become payable annually in advance. This benefit is restricted to Canadian residents only.

Day Care Benefit ($5,000)

If an injury results in loss of life, the Company will pay 5% of the principal sum for each year the dependent child is enrolled in a legally licensed day care (not to exceed 4 years) for each dependent child who is under 13 years of age and enrolled in the day care centre on the date of, or within 12 months following the accident.

Education Benefit ($10,000)

If an injury results in loss of life, the Company will pay 5% of the principal sum for each year the dependent child continues education as a full-time student in an institution of higher learning beyond the secondary school level (not to exceed 4 years) for each dependent child who was enrolled as a full-time student in an institution of higher learning beyond the secondary school level, or at the secondary school level but enrolls in an institution of higher learning beyond the secondary school level within 12 months following the accident. If, at the time of loss, none of the dependent children are eligible for the Education Benefit, the Company shall pay an additional amount of $2,500 to the designated beneficiary.

Family Transportation Benefit ($20,000)

If an injury results in confinement as an inpatient in a hospital located at least 150 km from the insured's residence, and such injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity, the Company will pay the expenses actually incurred by a member of the immediate family for hotel accommodation and transportation by the most direct route to the confined insured.

If transportation occurs in a private vehicle, then reimbursement of transportation expenses will be limited to a maximum of $0.35 per kilometre travelled.

Funeral Expense Benefit ($5,000)

If an injury results in loss of life, an additional amount is payable for funeral expenses actually incurred.

Indemnity payable under this part shall be limited to only one policy if this benefit is contained in two or more policies issued by the company.

HIV Adjustment Benefit ($25,000)

If, during the performance of his duties as set forth by the Policyholder, the insured sustains an injury which results in his acquiring and testing positive for the Human Immunodeficiency Virus (HIV) within 12 months following the date of the accident, the Company will pay a lump sum amount of $25,000.00.

Home Alteration and Vehicle Modification Benefit ($50,000)

If an injury requires the use of a wheelchair to be ambulatory, the Company will pay the cost of alterations to the insured's principal residence and/or the cost of modification to one motor vehicle utilized by the insured, provided such injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity, subject to the greater of $15,000 or 10% of the principal sum to a maximum of $50,000.

Hospital Indemnity Expense Benefit ($2,500)

A daily benefit of 1/30th of 1% of the principal sum will be payable when the insured is in a hospital if such period of hospitalization is necessary for the treatment of an injury which results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity and begins while this insurance is in force, subject to the above-mentioned monthly maximum.

A period of hospitalization necessary for an injury other than for a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity will be covered as stated above, provided such hospitalization is of at least a four-day period.

Identification Benefit ($20,000)

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

Rehabilitation Benefit ($20,000)

If an injury requires that the insured undergo special training in order to be qualified to engage in a special occupation in which the insured would not have engaged except for such injury, the Company will pay the reasonable and necessary expenses incurred for such training within 3 years of the date of the accident, provided such injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity.

Repatriation Benefit ($20,000)

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

Seat Belt Benefit ($25,000)

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

Spousal Retraining Benefit ($20,000)

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

Waiver of Premium Benefit

In the event of total disability and waiver of premium has been approved and accepted by the group life carrier, then premium under this plan will be waived until the earlier of: death, recovery, attainment of age 65 or the date the policy is cancelled.

Workplace Modification and Accommodation Benefit ($5,000)

If an injury requires special adaptive equipment and/or workplace modification for an insured to return to active full-time employment with the policyholder, the Company will pay the reasonable and necessary expenses actually incurred, provided the policyholder agrees in writing to provide such modification and accommodation to the workplace for the purpose of making it accessible and adaptable to the needs of such insured; and the policyholder acknowledges in writing that the performance of the essential duties of such insured's occupation may be altered.

Limited Air Travel Coverage

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

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

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

Limited Air Travel Coverage (Cont'd)

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

EXCLUSIONS

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

TERMINATION OF INSURANCE

Coverage will terminate immediately on the earliest of:

(a) the policy termination date;

(b) the premium due date if the Policyholder fails to pay the insured's premium, except as a result of an inadvertent error;

(c) the premium due date coinciding with or immediately following the date an insured attains age 65;

(d) the premium due date next following the date an insured is ineligible for coverage, except as provided under the part titled "Continuation of Coverage".

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (cont'd)

BENEFICIARY

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

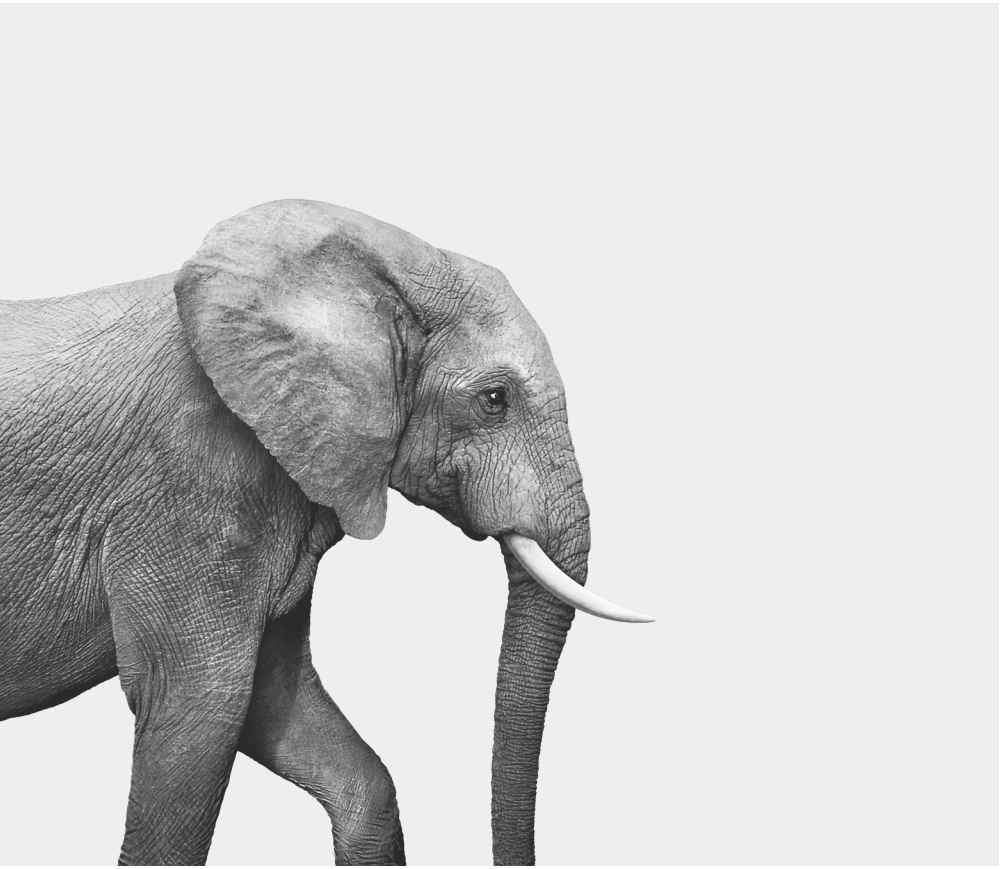
- Bereavement Benefit
- Day Care Benefit
- Education Benefit
- Family Transportation Benefit
- Funeral Expense Benefit
- Identification Benefit
- Repatriation Benefit
- Spousal Retraining Benefit
- Workplace Modification and Accommodation Benefit

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

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

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

NOTES



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