BELL TECHNICAL SOLUTIONS INC.

Policy No.: 28188

Classes 560, 640

INDUSTRIAL ALLIANCE
INSURANCE AND FINANCIAL SERVICES INC.

GROUP INSURANCE PLAN

Policyholder: ***BELL TECHNICAL SOLUTIONS INC.***

Policy No.: ***28188***

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

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 policy will be governed solely by the terms and conditions of such policy.

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

In addition, the policyholder reserves the right to change the contribution requirements for the coverages, including coverages for retirees, provided under the group policy at any time with respect to active 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 CyberClient accessible via www.inalco.com, if offered as part of your plan.

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SUMMARY OF BENEFITS

The SUMMARY OF BENEFITS briefly describes the coverage of the group insurance 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 classes:

Classes

560 – Ontario - Non-Unionized Temporary Employees – Drugs Plan

640 – Ontario - Unionized Temporary Employees – Drugs Plan

SPECIAL PROVISIONS (cont'd)

RULES AND GUIDELINES
WITH REGARDS TO CLASS CHANGES

Membership rules for a temporary employee eligible to the plan as of January 1, 2010

A participant who becomes eligible as a temporary employee may apply for drug coverage. This choice is optional.

After one year's service, if the participant still has a temporary status, he may either keep his drug coverage, if applicable, choose an enhanced coverage, or choose not to participate to the plan. This choice is irrevocable unless a major event occurs (marriage, union, divorce, separation, death of spouse, birth or adoption of a first child, spouse's loss of coverage following termination of employment) which would cause a change in family status.

When a participant becomes permanent, he will be transferred to classes 530, 540, 610, 620, 680* or 690*, according to his option for Short-term Disability Income Insurance.

** Classes 680 and 690 shall be considered classes of permanent employees according to the collective agreement*

GENERAL PROVISIONS

ELIGIBILITY DATE

Subject to all other provisions of the group policy, a temporary employee becomes eligible to drug coverage only on his first day of service with the employer (one year of continuous service for enhanced coverage).

NORMAL RETIREMENT AGE

For the purpose of the group policy, the normal retirement age shall be the first day of the month coincident with or next following the participant's 65th birthday.

SUPPLEMENTAL HEALTH INSURANCE

MEDICAL EXPENSES INCURRED IN CANADA – DRUGS

Drugs only [1]

Deductible:	$50 per insured person, maximum of $100 per family
Reimbursement	
– Individual protection:	75% of the first $2,600 of eligible expenses per insured person, per calendar year, and 100% of the excess. This amount includes all eligible drugs under the present plan.
– Family protection:	75% of the first $5,200 of eligible expenses per family, per calendar year, and 100% of the excess. This amount includes all eligible drugs under the present plan.
Maximum	
– Obesity treatment drugs:	$1,800 per calendar year
– Preventive immunization vaccines:	Unlimited
– Antismoking aids:	$500 per calendar year
– Drugs:	Unlimited
– Other expenses:	These expenses are not covered.

[1] *If the drug is a brand name product which has a generic equivalent, the amount payable will be based on the lowest priced interchangeable product.*

Termination:

This benefit terminates on the participant's date of retirement.

DEFINITIONS

Accident: A sudden, violent and unforeseeable occurrence which is external to the person.

Actively at work: If it is a scheduled work day, the participant will be considered actively at work if he reports for work at his usual place of employment or at some other location where his employer's business requires him to be and when he so reports he is able to perform all of the usual and customary duties of his occupation on a regular and full-time basis.

If the participant is not at work due to it being a non-scheduled work day, holiday or vacation day, the participant will be considered to be actively at work if on such date he is neither (i) hospital confined nor (ii) disabled to a degree that he could not then have reported to his usual place of employment or some other location where his employer's business requires him to be and performed all of the usual and customary duties of his occupation on a regular, full-time basis.

Annual salary:

- Employees paid on a regular basis:
  The remuneration received from the employer, excluding bonuses, gratuities and any other form of remuneration.
- Hourly-paid employees on a regular schedule:
  The remuneration received from the employer, based on the hourly rate multiplied by 40 hours and by 52 weeks.
- Hourly-paid employees on a flexible schedule:
  The remuneration received from the employer, based on the weekly average regular hours worked over a period of 6 months multiplied by the hourly rate and by 52 weeks.

  The weekly average is adjusted and calculated as follows:

  January 1st: The salary is based on the average regular hours worked from June 1st to November 30th of the previous year.

July 1st: The salary is based on the average regular hours worked from December 1st of the previous year to May 31st of the current year.

Approval of evidence of insurability: The date of approval of any evidence of insurability shall mean the date the insurer receives the last document which allows it to accept the risk on the person.

Assignee: A person who is entitled to an insurance settlement.

Calendar year: The period from any January 1st to the next December 31st, both inclusive.

Day: A calendar day, except if otherwise defined in the group policy.

Dependent: The participant's spouse or a child of the participant or of the spouse. If dependents are insured under the group policy, "spouse" and "child" shall have the following meanings:

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 one year, or less, if a child is born from their union.

However, for a de facto spouse, a separation of more than 3 months will result in the person no longer qualifying as the participant's spouse for the purposes of the group policy.

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).

Eligibility period: The period, as specified in the Summary of Benefits, during which an employee must be actively at work before being eligible for coverage under the group policy.

Employee: A person who is employed by his employer on a temporary, full-time or part-time basis.

Full-time resident of Canada: Has a permanent residence in Canada and resides in Canada for at least 182 days a year.

Illness: Any deterioration in health requiring regular, continuous and curative care actively provided by a physician.

Insured person: A participant or a dependent of a participant who is insured under the group policy.

Monthly salary: The participant's annual salary divided by 12.

However, for calculating benefits for regular temporary employees, the monthly salary is calculated by using the average regular hours worked in a period of 6 months preceding the disability multiplied by the hourly rate on the date of the disability.

Non-unionized temporary employee: A person hired as an employee on call, as required by the employer, and who is not affiliated with any union.

Normal retirement age: The age indicated in the Summary of Benefits.

Participant: An employee who is insured under the group policy.

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

Specialist: A physician licensed by the appropriate provincial licensing authority to practice medicine with a specialization.

Temporary employee: A person hired as an employee on call, as required by the employer.

Unionized temporary employee: A person hired as an employee on call, as required by the employer, and who is affiliated with the Communications, Energy and Paperworkers Union of Canada.

Weekly salary: The participant's annual salary divided by 52.

However, for calculating benefits for regular temporary employees, the weekly salary is calculated by using the average regular hours worked in a period of 6 months preceding the disability multiplied by the hourly rate on the date of the disability.

CHANGES IN GOVERNMENT PLANS

The benefits provided under the group policy are complementary to the benefits provided by government plans. Any modifications to these plans after the effective date of the group policy will not modify the benefits provided under the group policy, unless an agreement to modify the benefits is signed by the authorized signing officers of the insurer and the policyholder.

Notwithstanding the preceding paragraph, this 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 an insurer provide a certain type or level of coverage or the means of providing a certain type of coverage, the group policy 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 policy for any expenses related, directly or indirectly, to any medical services and/or supplies which would have been covered by a government sponsored plan or program if the insured person had not elected to receive the services and/or supplies on a private basis from a medical practitioner, medical facility, clinic or hospital, whether private or public, unless the services and/or supplies are explicitly stated as being covered under the group policy.

INCONTESTABILITY

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

a) insurance or a benefit for a participant or a dependent; or

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

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

a) 2 years from the effective date of the insurance or benefit for which the evidence was provided; or

b) 2 years from the effective date of the increase, addition or change to the insurance or benefit; or

c) 2 years from the effective date of the last reinstatement of the insurance or benefit.

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

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

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

A participant who is eligible for Supplemental Health Insurance and whose spouse is covered for comparable insurance may decline coverage under the group policy for such insurance.

The refusal of insurance under the group policy may be in respect of the participant and his dependents or his dependents only.

If the insurance under the spouse's policy ceases because of termination of such policy or because eligibility for the insurance ceases, then application may be made to insure under the group policy those persons whose insurance has terminated.

The application must be made within 31 days after cessation of the insurance under the spouse's policy and the insurance under the group policy shall be effective on the day following the date of termination of the insurance under the spouse's policy.

ELIGIBILITY

Employee

An employee will become eligible to be insured under the group policy as a participant on the date (his "eligibility date") on which he satisfies the following conditions:

a) He satisfies the definition of employee in the group policy.

b) He is a full-time resident of Canada.

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

d) He has satisfied the eligibility period specified in the Summary of Benefits.

However, an employee will not be eligible to become insured under the Long-Term Disability Income Insurance benefit if he will attain age 65 before the end of the elimination period specified for the benefit under the Summary of Benefits.

Dependents

A person will become eligible to be insured under the group policy as a dependent on the date (his "eligibility date") on which he satisfies the following conditions:

a) He satisfies the definition of dependent in the group policy.

b) He is a full-time resident of Canada.

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

d) The employee of whom he is a dependent has become eligible to be insured under the group policy.

APPLICATION FOR GROUP INSURANCE

An employee who is eligible to become insured under the group policy 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.

EFFECTIVE DATE OF INSURANCE

Whether membership under the group policy is compulsory or voluntary, the employee's insurance and dependents' insurance, if any, will take effect on the person's eligibility date, if the application for group insurance has been received by the insurer.

However, if the application for group insurance is not received within 31 days of the eligibility date for the dependents of a participant, the insurance will not take effect until the date on which the insurer receives and approves the person's evidence of insurability. The evidence of insurability will be provided at no expense to the insurer.

However, if

a) the employee was not actively at work on the date his insurance would otherwise become effective, the insurance will not take effect until the earliest date thereafter on which he is again actively at work; or

b) the dependent is hospitalized on the date his insurance would otherwise become effective, the insurance 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 insurance which is in excess of the non-evidence maximum(s) specified in the Summary of Benefits will not take effect until the date the insurer receives and approves the employee's evidence of insurability. If the participant's evidence of insurability should not be approved by the insurer, any future increases in the non-evidence maximum(s) will not automatically result in an increase in the participant's insurance. The increase in the non-evidence maximum(s) will only result in an increase in the participant's insurance if he submits evidence of his insurability and it is approved by the insurer.

TERMINATION OF INSURANCE

Participant

A participant's insurance automatically terminates on the earliest of the following dates:

a) The date the group policy is terminated;

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

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

d) The date the participant is no longer a full-time resident of Canada;

e) The date the participant is no longer covered by his provincial health plan;

f) The date of the participant's death;

g) The later of the following dates:

   i) the date indicated on a written notice received from the policy-holder;

   ii) the date this notice was received by the insurer;

h) The date the participant is incarcerated after committing a criminal offence for which he was found guilty;

i) The date the participant ceases to qualify as an employee as defined in the group policy.

   Insurance 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 policyholder for further information.

Dependents

A dependent's insurance 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 policy;

b) The date the dependent ceases to be a dependent as defined in the group policy;

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

d) The date the dependent is no longer a full-time resident of Canada;

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

f) The later of the following dates:

   i) the date indicated on a written notice received from the policy-holder;

   ii) the date this notice was received by the insurer.

The above terms and conditions also apply in the case of the partial cancellation of insurance owing to the cancellation of one or more benefits.

CLAIMS

- **Supplemental Health Insurance:**

  The insurer must receive notice of any claim for a Supplemental Health Insurance benefit within 18 months of the date of the event which gives entitlement to the benefit.

  However, if the group policy terminates, notice of claim for a Supplemental Health Insurance benefit must be submitted to the insurer within 90 days following termination of the group policy.

All notices of claims must be submitted to the insurer on the forms provided for that purpose by the insurer and must include all information that the insurer deems necessary for the assessment of the claim. If all information that is required by the insurer is not received, the insurer will have the right to deny the claim.

The insurer reserves the right to require additional proof or information regarding a claim whenever it deems necessary.

If notice of claim is not received by the insurer within the periods set out above or additional proof or information requested by the insurer is not provided, the insurer will have the right to deny the claim.

At the time of claim for a benefit which is based on the participant's salary, the amount of salary that will be used to determine the benefit will be the lesser of

a) the salary that the policyholder had last reported to the insurer and which has been used in the calculation of the premium payable; and

b) the participant's actual salary at the time of the event for which a claim is being made, as determined in accordance with the definition of salary included in the group policy.

However, for regular temporary employees, the amount of salary that will be used to determine the benefit is equivalent to the average regular hours worked in a period of 6 months preceding the disability multiplied by the hourly rate on the date of the disability.

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

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 has intentionally submitted a claim that contains false or misleading information, the insurer shall have the right, at its sole discretion, to notify the policyholder, decline the claim or require reimbursement if the claim has been paid. In addition, the insurer will have the right to terminate the participant's entire coverage under this policy including any coverage for the participant's dependents, and will have the right to undertake the prosecution of the participant in accordance with provincial and/or federal law.

BENEFICIARY

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, and if applicable, the Participant's Accidental Death and Dismemberment Insurance benefit, Participant's Optional Life Insurance benefit and Participant's Optional Accidental Death and Dismemberment 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, Participant's Accidental Death and Dismemberment Insurance benefit, Participant's Optional Life Insurance benefit and Participant's Optional Accidental Death and Dismemberment 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 Policyholder's prior group policy, such designation will be applicable to the insurance provided under this policy, unless the participant has changed the designation in writing with the insurer. The participant should review the beneficiary designation made under the Policyholder's prior group policy

to ensure that it reflects the participant's current intentions in regard to his insurance.

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

INSURER'S RIGHT TO EXAMINATION OF A CLAIMANT

The insurer, at its own expense, shall have the right and opportunity, whenever it deems necessary, to require a medical examination, by a physician designated by it, of any person for whom a claim is submitted and to make an autopsy in case of death, where it is not forbidden by law. In addition, the insurer reserves the right to obtain the report of any medical practitioner who has examined the person for whom a claim was submitted.

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

SUBROGATION

(This provision is not applicable to the Life Insurance and Accidental Death and Dismemberment benefits, if applicable.)

Where a benefit is payable under the group policy 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 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 (i) past, present or future loss of income, loss of wages, or loss of earnings, and (ii) any other benefits paid or payable under the group policy. The participant or dependent shall reimburse the insurer up to the amount of any benefits paid in the past or that are payable in the future under the group policy 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, the insurer 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 shall also be entitled to be reimbursed an amount, as determined by the insurer, which reasonably reflects the value of the future benefits payable to the participant or dependent under the group policy. The insurer's recovery in this regard shall not exceed the participant or dependent's gross damages or settlement recovered. 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 or otherwise allocated.

In the event that the participant or dependent fails to reimburse the insurer in accordance with the group policy, no future benefits will be paid by the insurer until such time as the insurer 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, the total amount or value of any future benefits payable to the participant or the dependent. The insurer's recovery in this regard shall not exceed the participant or dependent's gross damages or settlement recovered. The insurer shall also have the right to seek recovery directly from the participant or dependent in the event that any overpayment has resulted from the lack of reimbursement.

The participant shall notify the insurer 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 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 the dependent will ensure that the subrogated rights of the insurer are advanced in any third party action and shall instruct his solicitor accordingly. The insurer 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 reserves the right to retain its own counsel and/or pursue its subrogated rights against the third party and, in this respect, the participant/dependent and his solicitor shall fully cooperate with the insurer in the pursuit of its claim.

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

LIMITATION ON LEGAL ACTIONS

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

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

SUPPLEMENTAL HEALTH INSURANCE

The insurer undertakes to reimburse the medical expenses defined herein which are due to an injury, illness or pregnancy and which are incurred after the insured person became covered under this benefit, subject to the terms and conditions of this benefit and the group policy.

DEFINITIONS

As used in this benefit:

Disability and Disabled: A state of total and continuous incapacity, resulting from illness or accidental injury, which wholly prevents the participant from performing:

a) all of the essential duties of his regular employment during the first 26 weeks of disability and during the 24 months immediately following this period, regardless of the availability of such occupation; and

b) afterwards, any remunerated function or work for which he is reasonably qualified by training, education or experience, regardless of the availability of such occupation.

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.

Convention: Drugs which by law do not require a prescription, but which would not ethically be dispensed by a pharmacist without one.

MEDICAL EXPENSES INCURRED IN CANADA

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

Drugs (including preventive immunization vaccines, the vaginal ring Nuvaring and antismoking aids) which are dispensed by a pharmacist or a physician and which can only be obtained with a written prescription of 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.

Drugs which by convention require a prescription such as, but not limited to, maintenance drugs that are used daily to treat an ongoing medical condition for an extended period of time, such as anti-anginal drugs, parasympathomimetics, anticholinergics, anti-arrhythmics, enzymatic debridements, cardiotropics, anti-coagulants and oral fibrinolytic agents, and drugs for the treatment of asthma, diabetes, cholesterol, hyperthyroidism, tuberculosis, glaucoma, potassium replacements or parkinsons, provided they are prescribed by a healthcare provider who is legally licensed to prescribe such drugs and dispensed by a pharmacist or a physician.

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

Injectable drugs.

Compounded prescriptions containing one eligible ingredient.

Obesity treatment drugs, if an exception form completed by a physician is provided and pre-approval from the insurer has been obtained.

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 34 day period, except in the case of drugs for long-term therapy (maintenance drugs) for which up to a 100 day supply is allowable.

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

If the drug is a brand name product which has a generic equivalent, the amount payable will be based on the lowest priced interchangeable product.

EXCLUSIONS AND REDUCTIONS

This benefit does not cover any expense

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 which was voluntarily self-inflicted, while sane or insane;

c) For an illness or injury resulting from civil unrest, insurrection or war, whether war be declared or not, or participation in a riot;

d) For treatment or appliances to correct vertical dimension or any temporomandibular joint dysfunction;

e) For care or treatment which is not medically required, which is given for cosmetic purposes or for any reason other than curative, which exceeds the normal care or treatment given in accordance with current therapeutic practice, or is of an experimental nature;

f) 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;

g) For care or treatment of an illness or injury that is not recognized as normal, customary and common practice for such illness or injury;

h) 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;

i) For any care or treatment rendered free of charge or which would have been free of charge were it not for insurance coverage or which is not chargeable to the insured person;

j) For care or follow-up treatment given at home by a medical auxiliary;

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;

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 insured person's participation in sports 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, smoking, drug addiction and alcoholism, 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 or the vaginal ring Nuvaring), except if mention is made that these expenses are 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 or a physician:

- 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, except if specifically mentioned as being covered under this benefit;
- 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;

v) 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;

w) For any care or treatment received outside of Canada due to a medical emergency which is related to (i) a pregnancy, if the medical emergency occurs after the 32nd week of gestation or (ii) the deliberate inducement of a miscarriage;

x) 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 reasonable opinion of the insurer, does not meet the industry standards relevant to his profession.

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 or settlement.

CALCULATION OF REIMBURSEMENT

Deductible

The deductible, if any, must be paid by the insured person during the calendar year before any benefits are payable under this benefit. The deductible is specified in the Summary of Benefits.

Reimbursement

The insurer will reimburse the percentage of covered expenses incurred, as specified in the Summary of Benefits, once the deductible has been satisfied.

Maximum Benefit Per Insured Person

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

Co-ordination of Benefits

When an insured 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 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,

ii) any government sponsored plan, and

iii) any non-insured employee benefit plan.

SURVIVOR BENEFIT

If the participant dies while covered under this benefit and prior to any extension of coverage as provided for under the Extension of Benefits provision, insurance under this benefit shall continue for his dependents who were covered under this benefit at the time of his death, without premium payment, until the earliest of

a) 12 months after the participant's death;

b) The date on which the dependents' insurance would have terminated had the participant then been living;

c) The termination date of this benefit.

EXTENSION OF BENEFITS

If on the date an insured person's coverage under this benefit is discontinued, the insured 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 his own occupation; 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.

WAIVER OF PREMIUMS

a) A participant who becomes disabled will be eligible to have his premiums waived for this benefit provided:

   i) the participant was less than 65 years of age at the onset of disability;

   ii) the participant became disabled as defined under this benefit, while insured under this benefit and before any termination of employment;

   iii) the participant has been disabled for at least 6 continuous months;

   iv) proof of disability, satisfactory to the insurer, was submitted to the insurer within 12 months of the onset of the disability. The evidence will be submitted at no expense to the insurer.

b) The participant's premiums will begin to be waived on the day following a continuous period of disability of 26 weeks.

c) The participant whose premiums are waived under this section must provide the insurer with proof of disability, as often as the insurer may

reasonably require. Such proof will be provided at no expense to the insurer.

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

   i) the date on which the participant ceases to be disabled;

   ii) the date on which the participant fails to submit to an examination by the physician designated by the insurer;

   iii) the date on which the participant retires or reaches the normal retirement age under the employer's pension plan, but never beyond the normal retirement age indicated in the Summary of Benefits of the group policy;

   iv) the date on which the participant fails to provide any proof of disability required by the insurer;

   v) the date on which the participant is incarcerated after committing a criminal offence for which he was found guilty;

   vi) the date on which the benefit is terminated;

   vii) the date on which the group policy is terminated.

CONVERSION PRIVILEGE

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

a) his employment; or

b) his group membership,

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

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

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

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

COPY OF CONTRACT AND ENROLLMENT MATERIAL

A participant may request from the insurer a copy of the policy, his enrollment form and any written documents (provided as evidence of insurability) 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.

SUBMITTING CLAIMS

Health Claims

The participant must 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.

PROTECTING PERSONAL INFORMATION

Industrial Alliance 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. Industrial Alliance recognizes and respects a person's right to privacy concerning his or her personal information.

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

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

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

- Determining eligibility under the Group Plan or a particular benefit;
- Enrolling participants under the Group Plan;
- Adjudicating claims;
- 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 Industrial Alliance has medical information about the participant which was not obtained directly from the participant, Industrial Alliance 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 Group, 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

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