GROUP
INSURANCE

YOUR GROUP INSURANCE BOOKLET

iA
Financial Group

GROUP INSURANCE PLAN

Policyholder: ***QUÉBEC PROVINCIAL ASSOCIATION OF TEACHERS***

Policy No.: ***97,000-B / 97,001***

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 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 1 866 585-8843.

iA Financial Group is a business name and trademark of **Industrial Alliance Insurance and Financial Services Inc.**

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INTRODUCTION

Industrial Alliance Insurance and Financial Services Inc. presents this booklet which reflects the benefits insured with our company from which you may benefit as a member of the QPAT.

We suggest that you read this booklet and keep it in a safe place for future reference.

New Participant

To participate in the present plan, you have to fill out the form *Participation Request F54-018A(16)*, indicate the chosen benefits and transmit it to your school board. This form is available at your school board.

Modification to the Coverage

Any modification to the coverage of a participant should be transmitted to your school board on the form *Participation Request F54-018A(16)*. This form is available at your school board.

Claims

a) **Life Insurance**

If you die, a member of your family should communicate as soon as possible with the person designated by the school board.

b) **Waiver of Premiums and Long-term Disability**

You have to present a proof of your disability within five (5) months following the beginning of the disability. You have to fill out the form *Claim Request F54-360A* and transmit it to your school board. This form is available at your school board.

c) **Health Insurance**

i) **Drugs**: Present your drug card to your pharmacist. The required information to process your claim will be electronically transmitted to us. If the drug card system is not offered in your area, you have to fill out the form *Claim Request F54-326 (16)*, available at your school board or at your school.

ii) **Other expenses**: Fill out the form *Claim Request F54-326 (16)*, available at your school board or at your school.

All claims should be sent to the following address:

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

For more information, you can communicate with the person designated by your school board, with your local union, with the QPAT or with Industrial Alliance Insurance and Financial Services Inc.

Administration Department

For any information regarding your choice of benefits, plan costs or information related to the administration (modifications such as: name, date of birth, sex, communication language, change of address), you can communicate with our Administration Department at the following number:

1 866 585-8843

Claims Department

For any question related to eligible expenses or for any claim, you can communicate with our Claims Department at the following number:

1 866 585-8843

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

Full-time Teachers

Part-time Teachers

GENERAL PROVISIONS

ELIGIBILITY DATE

Subject to all other provisions of the group policy, each member shall become eligible on the latest of the following dates:

a) on the effective date of the plan, if he is then in the employer's service,

or

b) if he is not in the employer's service:

   i) on the scheduled date of the beginning of service if his employment contract takes effect between the first working day and the last working day of the work year;

   or

   ii) on the date of the first working day of the work year, if his employment contract takes effect before or on the first working day of the work year.

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.

PARTICIPANT'S LIFE INSURANCE

Sum Insured

1 to 6 units of $25,000, at the participant's choice.

Maximum: $75,000 without evidence of insurability
(if the application is submitted within 60 days of the eligibility date)
or
$150,000 with evidence of insurability

Reduction and Termination:

This benefit does not include any reduction based on the participant's age and terminates on the participant's date of retirement.

PARTICIPATION TO THIS BENEFIT IS <u>OPTIONAL</u>.

PARTICIPANT'S ADDITIONAL LIFE INSURANCE

Sum Insured

Units of $25,000

Maximum: $100,000 with evidence of insurability

Termination:

This benefit terminates on the first day of the month coinciding with or following the participant's 65th birthday or the date of retirement, if earlier.

PARTICIPATION TO THIS BENEFIT IS OPTIONAL.

DEPENDENTS' LIFE INSURANCE

Sum Insured

Spouse: $10,000

Each child

- under 24 hours of age: None
- 24 hours of age or older: $5,000

Termination:

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

PARTICIPATION TO THIS BENEFIT IS OPTIONAL.

PARTICIPANT'S OPTIONAL CRITICAL ILLNESS INSURANCE

Sum Insured

Units of $5,000

Minimum: $25,000

Maximum: $500,000

All amounts of optional critical illness insurance require evidence of insurability and are subject to the insurer receiving the required evidence of insurability and providing approval of evidence of insurability in accordance with all of the terms and conditions of this benefit or in the General Provisions of the group policy.

Termination:

The insurance under this benefit terminates on the first day of the month coinciding with or following the participant's 70th birthday or the date of retirement, if earlier.

However, with respect to a participant who is absent from work due to a disability, and who is under age 63 when such disability commences, the insurance under this benefit terminates on the participant's 65th birthday, unless the participant returns actively at work before his 65th birthday.

With respect to a participant who is absent from work due to a disability, and who is age 63 or older but less than age 70 when such disability commences, the insurance under this benefit terminates after 24 consecutive months of disability unless the participant returns actively at work within the first 24 months of disability.

PARTICIPATION TO THIS BENEFIT IS <u>OPTIONAL</u>.

SPOUSE'S OPTIONAL CRITICAL ILLNESS INSURANCE

Sum Insured

Units of $5,000

Minimum: $25,000

Maximum: $500,000

All amounts of optional critical illness insurance require evidence of insurability and are subject to the insurer receiving the required evidence of insurability and providing approval of evidence of insurability in accordance with all of the terms and conditions of this benefit or in the General Provisions of the group policy.

Termination:

The insurance under this benefit terminates on the first day of the month coinciding with or following the spouse's 70th birthday or the participant's date of retirement, if earlier.

PARTICIPATION TO THIS BENEFIT IS OPTIONAL.

CHILDREN'S OPTIONAL CRITICAL ILLNESS INSURANCE

Sum Insured

Units of $5,000

Minimum: $5,000

Maximum: $10,000

Evidence of insurability will be required with respect to a child who becomes covered on the date the participant elected to cover his children under this benefit. No evidence of insurability will be required for a child who becomes covered under this benefit while the participant has other children covered under this benefit.

If the participant should elect to increase the amount of optional critical illness insurance, evidence of insurability will be required for the increase and will be subject to the insurer receiving the required evidence of insurability and providing approval of evidence of insurability in accordance with all of the terms and conditions of this benefit or in the General Provisions of the group policy. If the evidence of insurability with respect to a child is not approved, there will be no increase in the amount of optional critical illness insurance for any of the insured children of the participant.

Termination:

For each insured child, the insurance under this benefit terminates on the first day of the month coinciding with or following the participant's 70th birthday or the date of retirement, if earlier.

PARTICIPATION TO THIS BENEFIT IS <u>OPTIONAL</u>.

LONG-TERM DISABILITY INCOME INSURANCE

Monthly Indemnity

50% of the basic monthly salary payable at the beginning of benefit payments, the result being rounded to the next higher dollar.

However, the overall maximum must not exceed 85% of the net monthly salary payable at the beginning of benefit payments.

Elimination Period: 104 weeks

Maximum Benefit Period: To the participant's 65th birthday

Maximum Annual Indexation Rate 2%

Benefits are non-taxable.

Termination:

This benefit terminates on the participant's 65th birthday or the date of retirement, if earlier.

PARTICIPATION TO THIS BENEFIT IS MANDATORY FOR FULL-TIME TEACHERS AND OPTIONAL FOR PART-TIME TEACHERS.

SUPPLEMENTAL HEALTH INSURANCE

HOSPITALIZATION IN THE PROVINCE OF RESIDENCE

Deductible:	Reimbursement:	Daily maximum:
none	100%	Semi-private room rate

EMERGENCY MEDICAL EXPENSES INCURRED OUTSIDE THE PROVINCE OF RESIDENCE and EMERGENCY OUT OF PROVINCE ASSISTANCE

Deductible:	Reimbursement:	Maximum per insured person:
none	100%	$5,000,000 per lifetime

ALL OTHER MEDICAL EXPENSES INCURRED IN CANADA

Deductible

– participant only:	$25
– participant and spouse:	$50
– participant and children:	$50
– participant, children and spouse:	$50

Reimbursement

– drugs: 80% of the first $8,200 (for the year 2025) * per certificate and 100% of the excess

If the maximum contribution (1) has been satisfied by the participant or spouse during the calendar year, the level of reimbursement will be 100% for the rest of the calendar year for such person and, if applicable, his dependent children.

– other expenses: 80% (except if otherwise specified)

Maximum: Unlimited

* *This amount is indexed by $200 on January 1st of each year.*

(1) *Maximum contribution for the participant and spouse during the calendar year: As stated under the Act respecting prescription drug insurance (R.S.Q., chapter A-29.01).*
The participant's maximum contribution will include any amounts paid as a deductible and/or coinsurance for a dependent child.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

Dependents, if applicable, are covered under the present benefit.

Termination:

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

PARTICIPATION TO THIS BENEFIT IS MANDATORY.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

Part-time Teachers may, with regard to their dependents, choose to have coverage for all eligible expenses of this benefit or only medication part of this benefit, subject to the deductible and percentage of reimbursement specified in the Summary of Benefits.

Medical Expenses

Covered Expenses	Maximums Per Insured 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	$500 per calendar year **These expenses are subject to the deductible and reimbursement percentage for drugs.**
Fees for nursing care	$500 per day; maximum $10,000 per calendar year.
Fees for remote areas (travelling expenses)	$100 per day, $500 per calendar year. **These expenses are reimbursed at 100%.**

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

Medical Expenses (cont'd)

Covered Expenses	Maximums Per Insured Person
Breast prostheses	$300 per 24 consecutive months.
Medical elastic stockings	3 pairs per calendar year.
Room and board in a rehabilitation institution or a convalescent home	Semi-private room rate, without limit as to the number of days. **These expenses have no deductible and are reimbursed at 100%.**
Cost of laboratory analyses, electrocardiograms, electro-encephalograms, nuchal scans, prenatal screening tests, radiation treatments, gastrointestinal diagnostic programs and x-rays performed in a commercial establishment or a private clinic	**These expenses are reimbursed at 50% of the first $500 of eligible expenses incurred in a calendar year and at 75% of the following $1,500.**
Eyeglasses following cataract surgery	$1,000 per pair of eyeglasses.
Contact lenses or intraocular lenses following cataract surgery	$500 per eye per lifetime.
Wigs and hairpieces	$500 per calendar year.
Sclerosing injections	$20 per visit.
Cannabis for medical purposes	$500 per calendar year.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

Medical Expenses (cont'd)

Covered Expenses	Maximums Per Insured Person
Paramedical fees for a physiotherapist, a physical rehabilitation therapist, a chiropractor [1], an osteopath [1], a podiatrist [1] (chiropodist *) [1], a dietician [1] and an acupuncturist [1]	Combined maximum of $1,000 per Calendar Year. One (1) treatment per day. [1] *X-rays are included in the maximum.*
* *in Ontario and Saskatchewan only*	
Paramedical fees for a speech therapist, an audiologist and an occupational therapist	Unlimited. One (1) treatment per day.
Paramedical fees for a psychologist (including psychoanalysis services), a psychiatrist, a psychotherapist, a social worker and an orientation counsellor	Maximum of $1,000 per calendar year for all professionals combined. **These expenses are reimbursed at 50%.**
Diabetic monitoring equipment	One (1) device per lifetime.

SUPPLEMENTAL HEALTH INSURANCE (cont'd)

Medical Expenses (cont'd)

Covered Expenses	Maximums Per Insured Person
Closed treatment program for alcoholism or drug addiction (participant only)	$175 per day, 35 days per treatment program. One (1) treatment program per lifetime. **These expenses are reimbursed at 100%.**
Eye examinations and vision care	Eye examinations, eyeglasses (frame and lenses) or contact lenses up to a combined maximum of $200 or in excess of this amount for contact lenses, if medically required and purchased following surgery and if purchase is made within 12 months of the operation. Only one of these maximums is applicable per period of 24 consecutive months. **Vision care expenses are subject to the deductible and are reimbursed at 100%.**

DEFINITIONS

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

Accidental Injury: Any bodily injury sustained while the insurance is in force, directly and solely due to an external, sudden, violent and unintentional cause and requiring within 30 days of the accident the care of a physician.

Actively at Work: The status of a participant who is performing his or her usual duties on a continuous basis. Wherever there is mention of a number of full-time work days, public holidays are considered full-time work days.

Annual salary: The remuneration to which a teacher is entitled by reason of his or her experience level and category, according to the salary scale provided in the collective agreement, as stated by the employer.

Acceptance of evidence of insurability: The date of acceptance of any evidence of insurability shall mean the first day of the month following the date the insurer receives the last document required for risk assessment.

Association: The *Québec Provincial Association of Teachers* (QPAT).

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.

A de facto 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 his spouse, or both, or a child living with the participant for whom procedure of adoption is underway, who wholly depends on the participant for support and maintenance and who meets at least one of the following conditions:

i) He is under 18 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 has a mental or physical disability and is incapable of earning his own living due to such disability provided such disability commenced while he was a child as defined in (i) or (ii).

Disability: A state of incapacity resulting from an illness, including surgery directly related to family planning, an accident or pregnancy complication, which requires medical care and which, during the elimination period and the first 12 months of disability following the elimination period, completely prevents the participant from performing the usual duties of his or her job and any other similar job involving similar compensation that is offered to him or her by the employer and, after the first 12 months of disability following the elimination period, completely prevents the participant from performing any gainful occupation for which he or she is reasonably qualified by his or her education, training and experience, without regard for the availability of this type of job.

Disability Period: Any continuous period of disability or series of successive disability periods separated by less than:

- 35 days of active, full-time work or availability for full-time work; or

- 8 days of active, full-time work if the disability period that precedes the participant's return to work is equal to or less than 3 calendar months, not including the period between the end of the work year and the beginning of the next work year and the annual vacation period for teachers in the adult education and vocational education sectors,

unless the participant can present satisfactory proof that a subsequent disability period is attributable to an illness or accident completely unrelated to the cause of the previous disability.

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.

Elimination Period: The continuous period indicated in the Summary of Benefits during which a participant must be absent from work due to disability before he or she can begin to receive disability income benefit payments under a disability income benefit.

Employee: A full-time or part-time teacher, covered by a bargaining certificate with a union affiliated with QPAT, as well as any person employed by a school board and accepted for insurance by mutual agreement between CPNCA and QPAT, and arrangements agreed between them.

Employer: A school board covered by a bargaining certificate with a union affiliated with QPAT.

Gross monthly salary payable at the beginning of benefit payments: The monthly salary the participant would have received immediately prior to the beginning of benefit payments had he been actively at work.

Illness: Any deterioration in health requiring regular, continuous and curative care actively provided by a physician and satisfactory to the insurer, and whose default would bring deterioration of the person's health.

Indexed gross monthly salary payable at the beginning of benefit payments: The monthly salary the participant would have received immediately prior to the beginning of benefit payments had he been actively at work, increased each March 1st coincident with or next following the anniversary of the date on which the participant became entitled to a monthly indemnity benefit by the Consumer Price Index (as published by the Government of Canada) during the immediately preceding calendar year.

Insured Person: The participant and the dependents of the participant insured under this plan.

The insured person must at all times be covered under a government health plan and live in Canada permanently (at least 182 days a year), in order to be eligible under the present plan and to maintain his or her rights to insurance, unless otherwise agreed previously with the insurer or unless mention to the contrary is made in the present plan.

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

Net monthly salary payable at the beginning of benefit payments: The monthly salary the participant would have received immediately prior to the beginning of benefit payments had he been actively at work, less the deductions for Income Tax, Canada or Quebec Pension Plan, Employment Insurance and the Quebec Parental Insurance Plan.

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

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

Physician: A person who is legally authorized to practice medicine.

Salary (Net): The participant's annual salary that he or she would have received during the last week of the elimination period of the long-term disability income benefit under this plan had he or she not been disabled, less the following deductions:

a) the employee's annual Employment Insurance premium;

b) the employee's annual Québec or Canada Pension Plan contribution;

c) income tax deducted according to the tax tables established under the Canadian Income Tax Act and the income tax act of the participant's province of residence;

d) the employee's annual Quebec Parental Insurance Plan contribution.

School board: A school board covered by a bargaining certificate with a union affiliated with QPAT.

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

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

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 above, the insurer can modify the present plan after its effective date, if a modification in a government plan changes the insurer's risk, including the ability of the insurer to apply a reduction to a benefit payable by the insurer. Any modification to the present plan made according to this paragraph applies as of the effective date to all participants, whether or not actively at work, and to their dependents.

Notwithstanding the preceding paragraphs, 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 the Supplemental Health Insurance benefit may decline to enroll in these benefits if he has comparable coverage under this 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 this policy those persons whose coverage has terminated.

The application must be made within 31 days after cessation of the comparable coverage and coverage under this policy shall be effective on the day following the date of termination of the comparable coverage.

ELIGIBILITY

Employee

a) The following persons are eligible for the Participant's Life Insurance, the Participant's Additional Life Insurance, the Dependents' Life Insurance, the Supplemental Health Insurance and the Long-Term Disability Income Insurance benefits:

   i) any Full-time Teacher;

   ii) any Part-time Teacher;

   iii) any person or group of persons employed by a school board, according to a mutual agreement between CPNCA and QPAT, and arrangements agreed between them, except otherwise stated hereinafter.

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.

b) Any person who was insured under a former group insurance plan with QPAT as the policyholder immediately prior to the effective date of this plan are eligible for the present benefits.

c) An employee's eligibility begins:

i) on the effective date of this plan, if he or she is working for a school board on that date;

ii) in all other cases, on the date stipulated in the Summary of Benefits, if applicable.

Dependents

Any dependent of a participant is eligible for the insurance, either on the same date as the participant if he or she is already a dependent, or on the date on which he or she becomes a dependent.

When a dependent ceases to be insured under a group insurance plan that includes similar benefits, he or she is eligible for this insurance on the date on which he or she ceases to be insured under the said plan.

PARTICIPATION TO THE SUPPLEMENTAL HEALTH INSURANCE BENEFIT

a) Participation to this insurance is mandatory for all employees who fulfil the requirements with regard to eligibility described in the ELIGIBILITY provision above.

However, with prior written notice from his or her employer, a participant may refuse or cease participation to the said benefit as of the end of the premium period stipulated in the notice, provided he or she can provide satisfactory proof that he or she is insured under group insurance coverage with similar benefits.

A participant under age 65 who refused or ceased participation to the Supplemental Health Insurance benefit, in accordance with the

provisions of the preceding paragraph, may participate in this insurance under the following conditions:

i) He or she must establish to the insurer's satisfaction that:

- he or she was formerly insured under the said benefit, or under a health insurance component of some other plan containing similar benefits;
- he or she is no longer able to continue participation in the said benefit or plan;
- his or her application is presented within a period of 60 days following termination of his or her insurance. If he or she applies more than 60 days following the termination of his or her insurance, the insurance provided under the Supplemental Health Insurance benefit will not take effect until the first day of the month following the end of a 60 day period beginning on the date the application is received by the insurer.

ii) For employees who, prior to their application, were not insured under the Supplemental Health Insurance benefit, the insurer cannot be held responsible for the payment of benefits that may be payable by the previous insurer under an extended coverage or conversion provision.

b) Any employee having one or more dependents may insure himself or herself as an employee without dependents, or as an employee with dependents, as the case may be, by completing a form and sending it to the insurer via the employer.

In the case of part-time teachers, if this form is completed more than 60 days following the date on which his or her dependents become eligible, the employee must, at his or her expense, provide satisfactory evidence of insurability for his or her dependents. Dependents will be eligible for coverage under the drug coverage of this plan on the date of the application, and all additional benefits on the date the evidence of insurability is accepted by the insurer.

c) Any Full-time Teacher may insure his or her dependent children, or his or her spouse and dependent children under the Supplemental Health Insurance benefit.

d) Any Part-time Teacher may insure his or her dependent children, or his or her spouse and dependent children, under the Supplemental Health Insurance benefit or the drug section of this plan.

PARTICIPATION TO THE LIFE INSURANCE BENEFIT

Participation to the Life Insurance benefit is optional, and assumes participation to the Supplemental Health Insurance benefit unless an exemption is granted under the provisions described in the PARTICIPATION TO THE SUPPLEMENTAL HEALTH INSURANCE BENEFIT section.

Any eligible employee who wishes to participate in this benefit must complete an application, and submit evidence of insurability deemed satisfactory by the insurer for any amount in excess of the non-evidence maximum.

Any employee may insure his or her dependent children, or his or her spouse and dependent children, under the Dependents' Life Insurance benefit.

PARTICIPATION TO THE LONG-TERM DISABILITY INCOME INSURANCE BENEFIT

Participation to this benefit assumes participation to the Supplemental Health Insurance benefit unless an exemption is granted under the provisions described in the PARTICIPATION TO THE SUPPLEMENTAL HEALTH INSURANCE BENEFIT section.

Participation to the Long-term Disability Income Insurance benefit is mandatory for Full-time Teachers, and optional for Part-time Teachers.

However, a Full-time Teacher may be exempted from participating if he or she submits a request to his or her employer, and establishes to the insurer's satisfaction that he or she fulfils at least one of the following conditions:

a) He or she is a member of the *Teachers' Pension Plan (TPP)*;

b) He or she is a member of the *Régime de retraite des fonctionnaires (RRF)*, the *Régime de retraite de certains enseignants (RRCE)*, or the *Régime de retraite des employés du gouvernement et des organismes public (RREGOP)*, and is at least 53 years of age;

c) He or she is a member of a professional association and is insured under a similar group insurance benefit (proof that the said participant's

insurance is in force, along with a copy of the policy, must be attached to the participation exemption request);

d) He or she requests or has requested a retirement departure without the option of returning, if the said retirement departure must be taken within 2 years from the date of the request for exemption from participation in this coverage (a copy of the departure agreement must be attached to the participation exemption request).

Any eligible employee who wishes to participate in this benefit must complete an application to this effect and send it to the insurer via his or her employer.

No evidence of insurability is required for employees who become eligible after the effective date of this plan, and who have completed and sent an application to the insurer within 60 days from the date on which they became eligible under this benefit.

EFFECTIVE DATE OF INSURANCE UNDER THE SUPPLEMENTAL HEALTH INSURANCE BENEFIT

a) The employee's insurance, regardless of his or her insurability status, takes effect on the effective date of this plan, if he or she fulfils the requirements with regard to eligibility at that time, otherwise it takes effect on the day he or she fulfils these requirements.

In accordance with the stipulations of the PARTICIPATION TO THE SUPLLEMENTAL HEALTH INSURANCE BENEFIT provision, the insurance of an employee who refused or ceased participation in the plan, under the stipulations of the said provision, take effect on the first day of the month during which the insurer receives the application.

b) The dependents' insurance takes effect on the later of the following dates:

i) the date on which the employee's insurance takes effect; or

ii) the date on which they become dependents of the employee; or

iii) the date the application is received, if the dependent meets the conditions of the plan.

In the case of Part-time Teachers, if the application for dependents' coverage is received after the 60 days following their eligibility date, evidence of insurability will be required.

Dependents will be eligible for coverage under the drug section of this plan on the date of the application, and all additional benefits on the date the evidence of insurability is accepted by the insurer.

EFFECTIVE DATE OF INSURANCE UNDER THE LIFE INSURANCE BENEFIT

a) Current employees who were insured under the former life insurance benefit in force immediately prior to the effective date of this plan:

The insurance for such employees begins on the effective date of the plan, provided they were then actively at work, otherwise, on the date of their return to work.

b) Employees who become eligible after the effective date of this plan:

The insurance for such employees begins on the date they become eligible, provided they complete an application and send it to the insurer within 60 days of this date, and provided they were then actively at work, otherwise, on the date of their return to work.

If the application is completed and received by the insurer after this 60 day period, the employee must provide, at his or her expense, satisfactory evidence of insurability. He or she is enrolled in the insurance on the first day of the month following receipt by the employer of the insurer's approval of the application if the said evidence was accepted within a period of 30 days following receipt of the last evidence to be provided by the employee, provided he or she was then actively at work, otherwise, on the date of his or her return to work.

If the evidence of insurability is not accepted by the insurer within the said 30 day period, the insurance will take effect on the date that corresponds to the first day of the month following a period of 30 days following receipt of the last evidence to be provided by the employee, provided he or she was then actively at work, otherwise, on the date of his or her return to work, provided that the evidence of insurability is, in the end, accepted by the insurer.

c) The dependents' insurance takes effect on the latest of the following dates:

i) the date on which the employee's insurance takes effect;

ii) the date that corresponds to the first day of the month following the employer's receipt of the insurer's acceptance of the evidence of insurability;

iii) the date on which he or she becomes a dependent of the employee.

EFFECTIVE DATE OF INSURANCE UNDER THE LONG-TERM DISABILITY INCOME INSURANCE BENEFIT

a) Current employees who were insured under the former long-term disability income insurance benefit in force immediately prior to the effective date of this plan:

The insurance for such employees begins on the effective date of the plan, provided they were then actively at work, or actively at work on the last day they should normally have been at work, otherwise, on the date of their return to work.

b) Employees who become eligible after the effective date of this plan:

The insurance for such employees begins on the date on which they become eligible, provided they complete an application and send it to the insurer within 60 days of this date, and provided they were then actively at work, otherwise, on the date of their return to work.

If the application is completed and received by the insurer after this 60 day period, the employee must provide, at his or her expense, satisfactory evidence of insurability. He or she is enrolled in the insurance on the first day of the month following the employer's receipt of the insurer's approval of the application if the said evidence was accepted within a period of 30 days following receipt of the last evidence to be provided by the employee, provided he or she was then actively at work, otherwise, on the date of his or her return to work.

If the evidence of insurability is not accepted by the insurer within the said 30 day period, the insurance will take effect as of the date that corresponds to the first day of the month following a period of 30 days

following receipt of the last evidence to be provided by the employee, provided he or she was then actively at work, otherwise, on the date of his or her return to work, provided that the evidence of insurability is, in the end, accepted by the insurer.

TERMINATION OF INSURANCE

Supplemental Health Insurance Benefit

The insurance of any participant automatically terminates at midnight on the earliest of the following dates:

a) The termination date of the benefit or of this plan;

b) The date on which the participant ceases to meet the eligibility requirements;

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

d) The date on which the participant is no longer covered by his or her provincial health plan;

e) The date on which the participant ceases to participate under the terms of the PARTICIPATION TO THE SUPPLEMTAL HEALTH INSURANCE BENEFIT provision of this plan;

f) The date the participant is incarcerated after committing a criminal offence for which he or she was found guilty.

Other Benefits

The insurance of any participant under the benefit in question terminates at midnight on the earliest of the following dates:

a) The termination date of this plan;

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

c) The date on which the participant ceases to participate to the Supplemental Health Insurance benefit, unless he or she is exempted as provided in the PARTICIPATION TO THE SUPPLEMENTAL HEALTH INSURANCE BENEFIT provision of this plan;

d) The termination date of the benefit in question;

e) Upon the death of the participant;

f) The date the participant is incarcerated after committing a criminal offence for which he or she was found guilty.

- For the Life Insurance benefit, on the earliest of the following dates:

  a) At the age indicated in the Summary of Benefits;

  b) On the participant's retirement date if he or she failed to submit a request to keep the insurance in force within the prescribed period.

- For the Long-term Disability Income Insurance benefit, the date on which the participant turns 63, if he or she is not totally disabled.

- The insurance for all dependents terminates at midnight on the earliest of the following dates:

  a) The termination date of the benefit in question or of this plan;

  b) The termination date of the insurance with respect to the participant of whom he or she is a dependent;

  c) The date on which he or she ceases to be a dependent under the terms of this plan;

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

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

  f) The first day of the month following receipt by the employer of a written notice to the effect that the participant insured with dependents chooses to become insured without dependents.

INTERRUPTION OF A PARTICIPANT'S INSURANCE

a) In the case of a temporary absence without pay as stipulated in the agreement, participation is suspended (with the exception of the Supplemental Health Insurance benefit of this plan, provided premiums continue to be paid) for the duration of the absence, and resumes automatically upon active return to work with pay. However, the participant may maintain his or her participation in all benefits in force by paying, via

his or her employer, the total premium stipulated under this plan in accordance with the situation that prevailed prior to the beginning of this temporary absence without pay.

b) In the case of a temporary absence with pay, participation remains in force for all benefits.

c) In the case where a participant is dismissed and the dismissal is contested by way of a grievance or arbitration under the labour law, the participant may maintain in force the insurance provided under the benefits in which he or she was participating in accordance with the situation prior to the date of the contested dismissal, by paying, via the employer, the total premium stipulated in the plan, until judgment is made.

d) Participants who do not take advantage of the provisions under this clause enabling them to maintain the insurance in force from the beginning of their temporary absence without pay cannot do so later during this absence.

e) If the insurance remains in force, a disability beginning during a temporary interruption in work is considered to have begun on the date on which the participant should normally return to work.

CLAIMS NOTICE

- **Supplemental Health Insurance:**

  The insurer must receive notice of any claim within 12 months of the date of the event which gives entitlement to the benefit.

  However, no delay in the submission of the documents required by the insurer can be withheld against the participant, if he demonstrates that the documents have been delivered as soon as possible.

  However, if the group policy terminates, notice of claim must be submitted to the insurer within 90 days following termination of the group plan.

- **Life Insurance, Additional Life Insurance and Dependents' Life Insurance:**

  The insurer must receive notice of any claim as soon as possible after the date of the event which gives entitlement to the benefit, but in any event within one year of the event.

  However, no delay in the submission of documents required by the insurer can be withheld against the participant (or his or her successors, if any) if he demonstrates that the documents have been delivered as soon as possible.

- **Critical Illness Insurance:**

  The insurer must receive notice of any claim for a Critical Illness Insurance benefit as soon as possible after the date of the occurrence of the covered condition or surgery, but in any event within one year of the date of the occurrence of the covered condition or surgery, unless specified otherwise under the Critical Illness Insurance benefit.

- **Long-term Disability Income Insurance:**

  The insurer must receive notice of any claim within 90 days of the end of the participant's elimination period.

  However, no delay in presenting the documents required by the insurer may be held against the participant (or his or her claimants, if applicable) if he or she demonstrates that the documents were submitted as soon as possible.

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 school board 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.

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.

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.

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 Participant's Additional 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 and Participant's Additional 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, unless otherwise indicated.

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 the group 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.

The group 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.

BENEFIT PAYMENT

The insurer will pay the insured amounts, in accordance with the terms of the contract, within 30 days of receipt of evidence satisfactory to the insurer. However, in the case of disability claims, the 30 days commence from the expiry of the elimination period if such date is subsequent to submitting evidence satisfactory to the insurer. Payments are made according to the terms and conditions of the contract with retroactive adjustments.

Disability income benefits payable to a participant incapable of managing his or her assets and giving receipt are paid to the guardian or curator. However, after a 6 month period following the date the participant was declared unfit by a

physician, the insurer will continue to pay the benefits provided the institution of a protective supervision is undertaken.

SUBROGATION

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:

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

b) 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 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 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 dependent.

The insurer's recovery in this regard shall not exceed the participant or dependent gross damages recovered or gross settlement.

The insurer 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 policy or under the law, 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 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 and 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 and dependent in accordance with its rights under the group policy or under the law.

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 the group 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.

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 the terms and conditions of this benefit and the group policy.

CONVERSION PRIVILEGE

A participant whose life insurance is cancelled on or prior to his 65th birthday due to termination of:

a) his employment;

b) his group membership; or

c) the group policy and he has been continuously insured under a life insurance benefit provided by the policyholder for at least 5 years,

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

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

a) permanent;

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 policy will include all amounts of life insurance that the participant was covered 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;

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

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;

d) $200,000 ($400,000 for participants living in the province of Quebec).

The individual 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 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 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 insurance, the insurer shall pay an amount equal to that which he could have converted whether or not he made application for the individual policy.

WAIVER OF PREMIUM

a) A participant who becomes 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 Income Insurance benefit, if included in the group policy.

   If the participant is not eligible to receive a benefit under the Long-Term Disability Income Insurance benefit or there is no Long-Term Disability Income Insurance benefit included in the group policy, he 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 9 months of the onset of the disability. The evidence will be submitted at no expense to the insurer.

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 beginning of the Long-Term Disability Incore Insurance benefit payments, and will be subject to any reductions and termination indicated in the Summary of Benefits 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 the day following a continuous period of disability of 6 months.

d) 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.

e) 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 reaches age 65;

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

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

f) If on the date the waiver of premiums terminates with respect to the participant, he is not eligible to be covered under the Participant’s Life Insurance benefit, he will be eligible to exercise the conversion privilege as provided for under this benefit.

PARTICIPANT'S ADDITIONAL LIFE INSURANCE

A participant under age 65 may obtain an additional amount of life insurance provided that he or she applies for it and provides evidence of insurability deemed necessary by the insurer.

A participant at the time of retirement may maintain an additional amount of life insurance without having to submit evidence of insurability if he or she applies for it within 31 days of retirement.

The sum insured that will be applicable to the participant will be the amount of insurance requested as provided for in the Summary of Benefits.

The insurer undertakes to pay the beneficiary the sum insured at the time of the participant's death, subject to the following terms and conditions.

EXCLUSION

If a participant commits suicide, regardless of any impairment, illness, or state of mind, less than 12 months after the beginning of his coverage under this benefit, no benefit will be paid. The insurer will only refund the premiums paid in respect of such participant and such refund will constitute a full discharge of the insurer's liability under this benefit.

The 12 month period starts anew on the date:

a) the additional life insurance is reinstated;

b) the additional life insurance amount is increased at the participant's request, but only for the supplementary amount of insurance.

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 have the premiums for this benefit waived, under the same terms and conditions.

SPECIAL PROVISIONS

Any other provisions of the PARTICIPANT'S LIFE INSURANCE benefit forms an integral part of the present benefit.

DEPENDENTS' LIFE INSURANCE

Upon the death of a dependent while insured under this benefit, the insurer undertakes to pay to the participant the sum insured, as indicated in the Summary of Benefits, subject to the terms and conditions of this benefit and the group policy.

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 have the premiums for this benefit waived, under the same terms and conditions.

Moreover, if the participant is not covered under the PARTICIPANT'S LIFE INSURANCE benefit, he or she is entitled to waiver of premiums for the present benefit, subject however to all other provisions described under *Waiver of Premiums* of the PARTICIPANT'S LIFE INSURANCE benefit.

CONVERSION PRIVILEGE

A participant whose spouse's life insurance is cancelled on or prior to the earlier of (i) his 65th birthday and (ii) his spouse's 65th birthday, due to the termination of

a) his employment;

b) his group membership; or

c) the group policy and his spouse had been continuously insured under a Dependents' Life Insurance benefit provided by the policyholder for at least 5 years,

will be able to convert all or part of his spouse's life insurance to an individual life insurance policy without having to provide evidence of insurability.

A spouse whose life insurance is cancelled on or prior to the earlier of (i) his 65th birthday and (ii) the 65th birthday of the participant, due to the death of the participant, will be able to convert all or part of his life insurance to an individual life insurance policy without having to provide evidence of insurability.

The participant or spouse, if applicable, will be able to convert the life insurance to one of the following types of insurance:

a) permanent;

b) term to age 65; or

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

The amount that can be converted to an individual policy will include all amounts of life insurance that the spouse is covered for under the group policy, 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 the spouse, if applicable;

b) the amount for which the spouse was insured immediately prior to the termination of his insurance; and

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

d) $200,000 ($400,000 for participants living in the province of Quebec).

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

The individual 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 spouse's insurance and will take effect only at the expiration of that period.

Should the spouse die during the period of 31 days following the termination of his insurance, the insurer shall pay an amount equal to that which could have been converted to the participant, or the participant's estate if he is no longer living, whether or not application had been made for the individual policy.

PARTICIPANT'S OPTIONAL CRITICAL ILLNESS INSURANCE

A participant may obtain an amount of optional critical illness insurance if he so requests it in writing to the insurer and furnishes evidence of insurability satisfactory to the insurer, and the insurer provides approval of evidence of Insurability.

The sum insured that will be applicable to the participant will be the amount of insurance requested as provided for in the Summary of Benefits.

If the participant suffers any of the conditions or undergoes any of the surgeries which are described in the Covered Conditions and Surgeries provision of this benefit, the insurer undertakes to pay to the participant the sum insured, subject to the terms and conditions of this benefit and the group policy.

If at the time the payment is to be made, the participant is no longer living, the payment will be made to the participant's estate.

CONDITIONS

Payment will be made for the covered condition or surgery provided:

a) The condition was diagnosed or the surgery took place while the participant was insured under this benefit; and

b) The date of diagnosis of the covered condition or surgery must be later than:

   i) The date the participant became insured under this benefit; or

   ii) The latest reinstatement date of the participant's coverage; and

c) The participant survived for at least 30 days after the date the condition was diagnosed, or the surgery took place, unless otherwise indicated under this benefit.

In the case of cancer recurrences or metastases, no payment will be made for any recurrence or metastases of a cancer if that cancer was originally diagnosed prior to the date the participant became insured under this benefit, regardless of the date of the recurrence or metastases.

Once a participant has received payment due to a covered condition or surgery under one of the categories specified in the Covered Conditions and Surgeries provision of this benefit, no further payment will be made under this category of covered conditions and surgeries, unless otherwise indicated in the limitations of this category.

However, if a participant has received payment due to a covered condition or surgery as a result of an injury, accident, illness or disease, the participant will not be covered under a different category of covered conditions and surgeries for another claim that is:

a) Caused by, contributed to or occurs as a result of the same injury, accident, illness or disease; or

b) A result of any medical or surgical treatment for that same injury, accident, illness or disease.

In the event a participant should receive a simultaneous diagnosis of multiple covered conditions or surgeries, the insurer undertakes to pay to the participant the covered condition or surgery benefit for one covered condition or surgery only. The covered condition or surgery for which the covered condition or surgery benefit is paid will be the covered condition or surgery which appears in the lowest category of covered conditions and surgeries shown in the Covered Conditions and Surgeries provision of this benefit, starting with Category 1 – Covered Conditions and Surgeries.

DEFINITIONS

As used in this benefit:

Date of diagnosis means the date on which a specialist diagnoses the participant with one of the covered conditions or surgeries.

Diagnosis means the certified diagnosis of the participant with a covered condition or surgery by a specialist.

Irreversible means a condition cannot be improved by medical or surgical treatment at the time of diagnosis. Notwithstanding the foregoing, a condition is considered irreversible if, in the opinion of the participant's physician, medical or surgical treatment to improve the condition would present a risk to the participant's health which would outweigh the expected benefits of such treatment.

Life support means the participant is under the regular care of a licensed physician for nutritional, respiratory and/or cardiovascular support when irreversible cessation of all functions of the brain has occurred.

Specialist means a physician licensed to practice medicine who:

a) Has been trained in the specific area of medicine relevant to the covered condition or surgery for which a benefit is being claimed; and

b) Has been certified by a specialty examining board; and

c) Is currently practicing in his area of specialty in Canada or the United States.

Specialist includes, but is not limited to, cardiologist, neurologist, nephrologist, oncologist, ophthalmologist, burn specialist and internist. The specialist must not be the participant, the spouse, a relative, or a business associate of the participant.

In the absence or unavailability of a specialist, and as approved by the insurer, a covered condition or surgery may be diagnosed by a qualified medical practitioner practicing in Canada or the United States.

Surgery means medically required surgery performed on the written advice of a specialist. The surgery must be performed by a physician in Canada or the United States.

Survival period means 30 consecutive days immediately following the date of diagnosis of a covered condition or the date of a surgery, as applicable, unless a longer period is specified in the definition of the applicable covered condition or surgery. The survival period with respect to a diagnosis of major organ transplant means 30 consecutive days immediately following the participant's

transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow. The survival period does not include the number of days of life support. The participant must be alive at the end of the survival period and must not have experienced irreversible cessation of all functions of the brain. For those covered conditions or surgeries which have a qualifying period, for example 90 days for bacterial meningitis and paralysis, the survival period runs concurrently with that covered condition or surgery's qualifying period.

COVERED CONDITIONS AND SURGERIES

Category 1 – Covered Conditions and Surgeries

Cancer

Cancer means a definite diagnosis of a malignant tumour, which must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Types of cancer include carcinoma, melanoma, leukemia, lymphoma, and sarcoma.

For payment to be made under this benefit, the diagnosis of cancer must be made by a specialist and must be confirmed by a pathology report.

For purposes of this benefit,

a) **T1a or T1b prostate cancer** means a clinically inapparent tumour that was not palpable on digital rectal examination and was incidentally found in resected prostatic tissue.

b) The term **Gastrointestinal stromal tumours (GIST) classified as AJCC stage 1** means:

   i) Gastric and omental GISTs that are less than or equal to 10 cm in greatest dimension with five or fewer mitoses per 5 mm^2, or 50 per HPF; or

   ii) Small intestinal, esophageal, colorectal, mesenteric and peritoneal GISTs that are less than or equal to 5 cm in greatest dimension with 5 or fewer mitoses per 5 mm^2, or 50 per HPF;

c) The terms “Tis, Ta, T1a, T1b, T1 and AJCC Stage 1” are to be applied as defined in the American Joint Committee on Cancer (AJCC) Cancer Staging Manual, 8th Edition, 2018.

d) The term Rai stage 0 as defined in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975.

Exclusions

No payment will be made under this benefit if, within the first 90 days following the later of the date the participant became insured under this benefit or the last reinstatement date of a participant’s coverage, such participant has any of the following:

a) Signs, symptoms or investigations that lead directly or indirectly to a diagnosis of any cancer (covered or excluded under this benefit), regardless of when the diagnosis is made; or

b) A diagnosis of any cancer (covered or excluded under this benefit).

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the insurer within 6 months of the date of diagnosis. If this information is not provided within this period, the insurer has the right to deny any claim for cancer or any critical illness caused by any cancer or its treatment.

No payment will be made under this benefit for the following:

a) Lesions described as benign, non-invasive, pre-malignant, of low and/or uncertain malignant potential, borderline, carcinoma in-situ, or tumours classified as Tis or Ta;

b) Malignant melanoma skin cancer that is less than or equal to 1 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;

c) Any non-melanoma skin cancer, without lymph node or distant metastasis, including but not limited to cutaneous T cell lymphoma, basal cell carcinoma, squamous cell carcinoma or Merkel cell carcinoma;

d) Prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;

e) Papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2 cm in greatest diameter and classified as T1, without lymph node or distant metastasis;

f) Chronic lymphocytic leukemia classified as Rai stage 0 without enlargement of lymph nodes, spleen or liver and with normal red blood cell and platelet counts;

g) Gastrointestinal stromal tumours (GIST) classified as AJCC stage 1;

h) Grade 1 neuroendocrine tumours (carcinoid) confined to the affected organ, treated with surgery alone and requiring no additional treatment, other than perioperative medication to oppose effects from hormonal oversecretion by the tumour; or

i) Thymomas (stage 1) confined to the thymus, without evidence of invasion into the capsule or spread beyond the thymus.

Limitation for Category 1 – Covered Conditions and Surgeries

Once a benefit has become payable for a covered condition or surgery covered under Category 1, the participant will not be insured under this benefit for any future covered conditions or surgeries specified under Category 1.

Category 2 – Covered Conditions and Surgeries

Aortic Surgery

Aortic surgery means the undergoing of surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. **Aorta** means the thoracic and abdominal aorta but not its branches.

For payment to be made under this benefit, the surgery must be determined to be medically required by a specialist.

Exclusions

No payment will be made under this benefit for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Coronary Artery Bypass Surgery

Coronary artery bypass surgery means the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s).

For payment to be made under this benefit, the surgery must be determined to be medically required by a specialist.

Exclusions

No payment will be made under this benefit for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Heart Attack

Heart attack (acute myocardial infarction) means a definite diagnosis of the death of heart muscle due to obstruction of blood flow, that results in a rise and fall of cardiac biomarkers to levels considered diagnostic of myocardial infarction, with at least one of the following:

a) Heart attack symptoms;

b) New electrocardiogram (ECG) changes consistent with a heart attack;

c) Development of new pathological Q waves on ECG following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and Coronary Angioplasty.

For payment to be made under this benefit, the diagnosis of heart attack must be made by a specialist.

Exclusions

No payment will be made under this benefit for:

a) ECG changes suggesting a prior myocardial infarction; or

b) Other acute coronary syndromes, including angina pectoris and unstable angina; or

c) Elevated cardiac biomarkers and/or symptoms that are due to medical procedures or diagnoses other than heart attack.

Heart Valve Replacement or Repair

Heart valve replacement or repair means the undergoing of surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities.

For payment to be made under this benefit, the surgery must be determined to be medically required by a specialist.

Exclusions

No payment will be made under this benefit for angioplasty, inter-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Limitation for Category 2 – Covered Conditions and Surgeries

Once a benefit has become payable for a covered condition or surgery covered under Category 2, the participant will not be insured under this benefit for any future covered conditions or surgeries specified under Category 2.

Notwithstanding the above, once a benefit has become payable for a stroke, the participant will not be insured under this benefit for any future covered conditions or surgeries specified under Category 2 or Category 3.

Category 3 – Covered Conditions and Surgeries

Bacterial Meningitis

Bacterial meningitis means a definite diagnosis of meningitis, confirmed by cerebrospinal fluid showing the presence of pathogenic bacteria. The presence of pathogenic bacteria must be confirmed by culture or other generally medically accepted microbiological testing. The bacterial meningitis must result in objective neurological deficits persisting for at least 90 days from the date of diagnosis.

For payment to be made under this benefit, the diagnosis of bacterial meningitis must be made by a specialist.

For the purposes of this benefit, neurological deficits must be detectable by the specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

Exclusions

No payment will be made under this benefit for viral meningitis.

Benign Brain Tumour

Benign brain tumour means a definite diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The participant must have undergone surgery or radiation treatment, or the tumour must have caused irreversible objective neurological deficits.

These deficits must be corroborated by diagnostic imaging showing changes that are consistent in character, location and timing with the neurological deficits.

For payment to be made under this benefit, the diagnosis of benign brain tumour must be made by a specialist.

For the purposes of this benefit, neurological deficits must be detectable by the specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

Exclusions

No payment will be made under this benefit if, within the first 90 days following the later of the date the participant became insured under this benefit or the last reinstatement date of a participant's coverage, such participant has any of the following:

a) Signs, symptoms or investigations that lead directly or indirectly to a diagnosis of any benign brain tumour (covered or excluded under this benefit), regardless of when the diagnosis is made; or

b) A diagnosis of any benign brain tumour (covered or excluded under this benefit).

Medical Information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the insurer within 6 months of the date of diagnosis. If this information is not provided within this period, the insurer has the right to deny any claim for benign brain tumour or any critical illness caused by any benign brain tumour or its treatment.

No payment will be made under this benefit for pituitary adenomas less than 10 mm, vascular malformations, cholesteatomas or infectious or inflammatory tumours.

Coma

Coma means a definite diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, and for which period the Glasgow Coma score must be 4 or less.

For payment to be made under this benefit, the diagnosis of coma must be made by a specialist.

Exclusions

No payment will be made under this benefit for:

a) A medically induced coma; or

b) A coma which results directly from alcohol or drug use; or

c) A diagnosis of brain death.

Dementia, including Alzheimer's Disease

Dementia, including Alzheimer's disease means a definite diagnosis of dementia, which must be characterized by a progressive deterioration of memory and at least one of the following areas of cognitive function:

a) Aphasia (a disorder of speech);

b) Apraxia (difficulty performing familiar tasks);

c) Agnosia (difficulty recognizing objects);

d) Disturbance in executive functioning (e.g. inability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behavior), which is affecting daily life.

The participant must exhibit:

a) Dementia of at least moderate severity, which must be evidenced by a Mini Mental State Exam of 20/30 or less, or equivalent score on another generally medically accepted test or tests of cognitive function; and

b) Evidence of progressive worsening in cognitive and daily functioning either by serial cognitive tests or by history over at least a 6 month period.

For payment to be made under this benefit, the diagnosis of dementia, including Alzheimer's disease must be made by a specialist.

For the purposes of this benefit, reference to the Mini Mental State Exam is to Folstein MF, Folstein SE, McHugh PR, J Psychiatry Res. 1975;12(3):189.

Exclusions

No payment will be made under this benefit for affective or schizophrenic disorders, or delirium.

Loss of Independent Existence

Loss of independent existence means a definite diagnosis of the total inability, due to disease or injury, to perform independently, with or without the aid of assistive devices, at least 3 of the following 6 activities of daily living for a continuous period of at least 90 days with no reasonable chance of recovery.

For payment to be made under this benefit, the diagnosis of loss of independent existence must be made by a physician and supported by an independent home care assessment made by an occupational therapist or equivalent.

Activities of daily living are:

a) **Bathing:** the ability to wash oneself in a bathtub, shower or by sponge bath;

b) **Dressing:** the ability to put on and remove necessary clothing, braces, artificial limbs or other surgical appliances;

c) **Toileting:** the ability to get on and off the toilet and maintain personal hygiene;

d) **Bladder and bowel continence:** the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that hygiene is maintained;

e) **Transferring:** the ability to move in and out of a bed, chair or wheelchair;

f) **Feeding:** the ability to consume food or drink that already has been prepared and made available.

No additional survival period is required once the conditions described above are satisfied.

Loss of Speech

Loss of speech means a definite diagnosis of the total and irreversible loss of the ability to speak as a result of physical injury or disease, for a period of at least 180 days.

For payment to be made under this benefit, the diagnosis of loss of speech must be made by a specialist.

Exclusions

No payment will be made under this benefit for all psychiatric related causes.

Motor Neuron Disease

Motor neuron disease means a definite diagnosis of one of the following: amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy, and limited to these conditions.

For payment to be made under this benefit, the diagnosis of motor neuron disease must be made by a specialist.

Multiple Sclerosis

Multiple sclerosis means a definite diagnosis of at least one of the following occurring after the later of the date the participant became insured under this benefit, or the date of the last reinstatement of a participant's coverage:

a) Two or more separate clinical attacks, confirmed by at least one magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination; or

b) A single attack, with objective neurological deficits lasting more than 6 months, confirmed by MRI of the nervous system, showing multiple lesions of demyelination; or

c) A single attack, confirmed by repeated MRI of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart.

For payment to be made under this benefit, the diagnosis of multiple sclerosis must be made by a specialist.

For the purposes of this benefit, neurological deficits must be detectable by a specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

Exclusions

No payment will be made under this benefit if, within the first year following the later of the date the participant became insured under this benefit or the last reinstatement date of a participant's coverage, such participant has any of the following:

a) Signs, symptoms or investigations that lead directly or indirectly to a diagnosis of multiple sclerosis (covered or excluded under this benefit), regardless of when the diagnosis is made; or

b) A diagnosis of multiple sclerosis (covered or excluded under this benefit).

Medical Information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the insurer within 6 months of the date of diagnosis. If this information is not provided within this period, the insurer has the right to deny any claim for multiple sclerosis or any critical illness caused by multiple sclerosis or its treatment.

No payment will be made under this benefit for:

a) Solitary sclerosis; or

b) Clinically isolated syndrome; or

c) Radiologically isolated syndrome; or

d) Neuromyelitis optica spectrum disorders; or

e) Suspected multiple sclerosis of probable multiple sclerosis.

Paralysis

Paralysis means a definite diagnosis of the total loss of muscle function of two or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event.

For payment to be made under this benefit, the diagnosis of paralysis must be made by a specialist.

Parkinson's disease and Specified Atypical Parkinsonian Disorders

Parkinson's disease and specified atypical parkinsonian disorders means a definite diagnosis of either a) Parkinson's disease or b) specified atypical parkinsonian disorders, as defined below:

a) Parkinson's disease means a definite diagnosis of primary Parkinson's disease, a permanent neurological condition which must be characterized by bradykinesia (slowness of movement) and at least one of the following: muscular rigidity or rest tremor. The participant must exhibit objective signs of progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's disease.

b) Specified atypical parkinsonian disorders means a definite diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.

For payment to be made under this benefit, the diagnosis of Parkinson's disease or a specified atypical parkinsonian disorder must be made by a Neurologist.

Exclusions

No payment will be made under this benefit if, within the first year following the later of the date the participant became insured under this benefit or the last reinstatement date of a participant's coverage, such participant has any of the following:

a) Signs, symptoms or investigations that lead directly or indirectly to a diagnosis of Parkinson's disease, a specified atypical parkinsonian disorder or any other type of parkinsonism, regardless of when the diagnosis is made; or

b) A diagnosis of Parkinson's disease, a specified atypical parkinsonian disorder or any other type of parkinsonism.

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the insurer within 6 months of the date of diagnosis. If this information is not provided within this period, the insurer has the right to deny any claim for Parkinson's disease or specified atypical parkinsonian disorders or its treatment.

No payment will be made under this benefit for any other type of parkinsonism.

Stroke

Stroke (cerebrovascular accident resulting in persistent neurological deficits) means a definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism, with:

a) Acute onset of new neurological symptoms, and

b) New objective neurological deficits on clinical examination,

persisting for more than 30 days following the date of diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging testing showing changes that are consistent in character, location and timing with the new neurological deficits.

For payment to be made under this benefit, the diagnosis of stroke must be made by a specialist.

For the purposes of this benefit, neurological deficits must be detectable by a specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia, (difficulty with speech) dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

Exclusions

No payment will be made under this benefit for:

a) Transient Ischaemic Attacks; or

b) Intracerebral vascular events due to trauma; or

c) Ischaemic disorders of the vestibular system; or

d) Death of tissue of the optic nerve or retina without total loss of vision of that eye; or

e) Lacunar infarcts which do not meet the definition of stroke as described above.

Limitation for Category 3 – Covered Conditions and Surgeries

Once a benefit has become payable for a covered condition or surgery covered under Category 3, the participant will not be insured under this benefit for any future covered conditions or surgeries specified under Category 3.

Notwithstanding the above, once a benefit has become payable for a stroke, the participant will not be insured under this benefit for any future covered conditions or surgeries specified under Category 2 or Category 3.

Category 4 – Covered Conditions and Surgeries

Aplastic Anemia

Aplastic anemia means a definite diagnosis of a chronic persistent bone marrow failure, confirmed by biopsy, which results in anemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following:

a) Marrow stimulating agents; or

b) Immunosuppressive agents; or

c) Bone marrow transplantation.

For payment to be made under this benefit, the diagnosis of aplastic anemia must be made by a specialist.

Kidney Failure

Kidney failure means a definite diagnosis of chronic irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation is initiated.

For payment to be made under this benefit, the diagnosis of kidney failure must be made by a specialist.

Major Organ Failure on Waiting List

Major organ failure on waiting list means a definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically required. To qualify under major organ failure on waiting list, the participant must become enrolled as the recipient in a recognized transplant center in Canada or the United States that performs the required form of transplant surgery. For the purposes of the survival period, the date of diagnosis is the date of the participant's enrollment in the transplant centre.

For payment to be made under this benefit, the diagnosis of the major organ failure must be made by a specialist.

Major Organ Transplant

Major organ transplant means a definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically required. To qualify under major organ transplant, the participant must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities.

For payment to be made under this benefit, the diagnosis of the major organ failure must be made by a specialist.

Limitation for Category 4 – Covered Conditions and Surgeries

Once a benefit has become payable for a covered condition or surgery covered under Category 4, the participant will not be insured under this benefit for any future covered conditions or surgeries specified under Category 4.

Category 5 – Covered Conditions and Surgeries

Blindness

Blindness means a definite diagnosis of the total and irreversible loss of vision in both eyes, evidenced by:

a) The corrected visual acuity being 20/200 or less in both eyes; or

b) The field of vision being less than 20 degrees in both eyes.

For payment to be made under this benefit, the diagnosis of blindness must be made by a specialist.

Limitation for Category 5 – Covered Conditions and Surgeries

Once a benefit has become payable for a covered condition or surgery covered under Category 5, the participant will not be insured under this benefit for any future covered conditions or surgeries specified under Category 5.

Category 6 – Covered Conditions and Surgeries

Deafness

Deafness means a definite diagnosis of the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz.

For payment to be made under this benefit, the diagnosis of deafness must be made by a specialist.

Limitation for Category 6 – Covered Conditions and Surgeries

Once a benefit has become payable for a covered condition or surgery covered under Category 6, the participant will not be insured under this benefit for any future covered conditions or surgeries specified under Category 6.

Category 7 – Covered Conditions and Surgeries

Severe Burns

Severe burns means a definite diagnosis of third-degree burns over at least 20% of the body surface.

For payment to be made under this benefit, the diagnosis of severe burns must be made by a specialist.

Limitation for Category 7 – Covered Conditions and Surgeries

Once a benefit has become payable for a covered condition or surgery covered under Category 7, the participant will not be insured under this benefit for any future covered conditions or surgeries specified under Category 7.

Category 8 – Covered Conditions and Surgeries

Loss of Limbs

Loss of limbs means a definite diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation.

For payment to be made under this benefit, the diagnosis of loss of limbs must be made by a specialist.

Limitation for Category 8 – Covered Conditions and Surgeries

Once a benefit has become payable for a covered condition or surgery covered under Category 8, the participant will not be insured under this benefit for any future covered conditions or surgeries specified under Category 8.

Category 9 – Covered Conditions and Surgeries

Occupational HIV Infection

Occupational HIV infection means a definite diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the participant's normal occupation, which exposed the person to HIV contaminated body fluids.

The accidental injury leading to the infection must have occurred after the later of the date the participant became insured under this benefit or the last reinstatement date of a participant's coverage.

Payment under this Covered Condition or surgery requires satisfaction of all of the following:

a) The accidental injury must be reported to the insurer within 14 days of the accidental injury; and

b) A serum HIV test must be taken within 14 days of the accidental injury and the result must be negative; and

c) A serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive; and

d) All HIV tests must be performed by a duly licensed laboratory in Canada or the United States; and

e) The accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States workplace guidelines.

For payment to be made under this benefit, the diagnosis of occupational HIV infection must be made by a specialist.

Exclusions

No payment will be made under this benefit if:

a) The participant has elected not to take any available licensed vaccine offering protection against HIV; or

b) A licensed cure for HIV infection has become available prior to the accidental injury; or

c) HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use.

Limitation for Category 9 – Covered Conditions and Surgeries

Once a benefit has become payable for a covered condition or surgery covered under Category 9, the participant will not be insured under this benefit for any future covered conditions or surgeries specified under Category 9.

Category 10 – Covered Conditions and Surgeries

Coronary Angioplasty

Coronary angioplasty means the undergoing of an interventional procedure to unblock or widen a coronary artery that supplies blood to the heart to allow an uninterrupted flow of blood.

For payment to be made under this benefit, the procedure must be determined to be medically required by a specialist.

The benefit payable for a coronary angioplasty will be 10% of the sum insured as indicated in the Summary of Benefits.

Early Stage Cancer

Early stage cancer refers to one of the following conditions:

a) Malignant melanoma skin cancer that is less than or equal to 1 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis; or

b) Prostate cancer classified as T1a or T1b, without lymph node or distant metastasis; or

c) Papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2 cm in greatest diameter and classified as T1, without lymph node or distant metastasis; or

d) Chronic lymphocytic leukemia classified as Rai stage 0; or

e) Gastrointestinal stromal tumours (GIST) classified as AJCC Stage 1; or

f) Ductal carcinoma in situ of the breast; or

g) Grade 1 neuroendocrine tumours (carcinoid) confined to the affected organ, treated with surgery alone and requiring no additional treatment, other than perioperative medication to oppose effects from hormonal oversecretion by the tumour.

For payment to be made under this benefit, the diagnosis of an early stage cancer must be made by a specialist.

The benefit payable for an early stage cancer will be 10% of the sum insured as indicated in the Summary of Benefits.

Limitation for Category 10 – Covered Conditions and Surgeries

Once a benefit has become payable for a covered condition or surgery covered under Category 10, the participant will not be insured under this benefit for any future covered conditions or surgeries specified under Category 10.

PRE-EXISTING CONDITION EXCLUSION

As used in this provision, **Pre-existing condition** means a covered condition or surgery:

a) Which was sustained or contracted; or

b) For the signs and symptoms of which the participant was under treatment by a physician; or

c) For the signs and symptoms of which a physician had undertaken an investigation or review of; or

d) For which the participant was taking medication as prescribed by a physician,

during the 24 months prior to the date the participant became insured under this benefit.

No payment will be made under this benefit for a covered condition or surgery:

a) That resulted either directly or indirectly from, or was in any manner or degree associated with or occasioned by a pre-existing condition; and

b) Which occurred during the first 24 months after the date the participant became insured under this benefit.

Notwithstanding the above, with respect to a participant who had his insurance reinstated under this benefit as described in the Reinstatement of Insurance provision, if the insurance provided to the participant was not in force for the full period of 24 months at the termination date of insurance, the participant will continue to satisfy the remainder of the pre-existing condition from the reinstatement date.

Exception to Pre-existing Condition

However, if the participant's insurance under this benefit is replacing a critical illness benefit under a previous group policy, the Pre-existing Condition provision will not apply for a condition or surgery which had been provided for under the critical illness benefit of the previous group policy and a benefit will be payable due to such condition or surgery provided:

a) The participant had been insured under the critical illness benefit under the previous group policy immediately prior to the date the benefit terminated under such policy; and

b) The participant became insured under this benefit immediately following the date the critical illness benefit terminated under the previous group policy; and

c) The participant had satisfied the pre-existing condition exclusion period that was specified under the critical illness benefit of the previous group policy or he has satisfied the pre-existing condition exclusion period under this benefit, giving consideration towards continuous time insured under this benefit and the critical illness benefit under the previous group policy.

The benefit that will be payable to the participant for whom the pre-existing condition exclusion has been waived due to the preceding paragraph, will be determined in accordance with the critical illness benefit under the group policy, but in no case will it exceed the critical illness benefit that would have been payable under the previous group policy.

The Pre-existing Condition provision will apply to any condition or surgery which had not been provided for under the critical illness benefit of the previous group policy with respect to a participant whose benefit under the group policy is replacing a critical illness benefit that had been provided under a previous group policy.

This pre-existing condition exclusion will not apply to any coverage issued with evidence of insurability provided and approved for this benefit.

EXCLUSIONS

No payment will be made under this benefit if the covered condition or surgery resulted directly or indirectly from any of the following causes:

a) Suicide, attempted suicide or self-inflicted injury, regardless of any impairment, illness, or state of mind.

b) Committing or attempting to commit a criminal offense or provoking an assault.

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

d) Use of drugs, poisonous substances, intoxicants or narcotics, other than as prescribed and administered by or in accordance with the instructions of a legally licensed physician.

e) Abuse of alcohol.

f) The operation of a motor vehicle, if the participant at the time of the accident had a blood alcohol concentration rate in excess of the limit permitted by law.

g) Flight in an aircraft, except as riding as a passenger and not as a pilot, operator or member of the crew, in or on any aircraft provided (i) the flight was a regularly scheduled flight, (ii) the aircraft has a current and valid certificate of air worthiness and is piloted by a person who holds a current and valid pilot's license of a rate authorizing him to pilot the aircraft and (iii) the aircraft is not owned, operated, chartered or licensed by the policyholder or the participant's employer.

h) Participation, amateur or professional, in any of the following activities:

i) Underwater activities, including but not limited to, scuba diving and scuba diving; or

ii) Hang-gliding; or

iii) Parachuting; or

iv) Motor vehicle race or speed competition on land and/or water; or

v) Boxing; or

vi) Bungee jumping; or

vii) BASE jumping; or

viii) Cliff diving; or

ix) Mountain climbing.

LIMITATIONS

a) Cancer

A participant will not be entitled to a covered condition or surgery benefit for cancer if, within the first 90 days following the date the participant became insured under this benefit, the participant has a diagnosis of cancer or any signs, symptoms or investigations that lead to a diagnosis of cancer, regardless of when the diagnosis is actually made.

In the event of any such diagnosis of cancer:

i) The covered condition or surgery benefit will not be payable; and

ii) Cancer will no longer be considered a covered condition or surgery for the participant.

b) Benign Brain Tumour

A participant will not be entitled to a covered condition or surgery benefit for benign brain tumour if, within the first 90 days following the date the participant became insured under this benefit, the participant has a diagnosis of benign brain tumour or any signs, symptoms or investigations that lead to a diagnosis of benign brain tumour, regardless of when the diagnosis is actually made.

In the event of any such diagnosis of benign brain tumour:

i) The covered condition or surgery benefit will not be payable; and

ii) Benign brain tumour and any other covered condition or surgery within the category 3 of covered conditions and surgeries will no longer be considered a covered condition or surgery for the participant.

c) Early Stage Cancer

A participant is not entitled to a covered condition or surgery benefit for early stage cancer if, within 90 days following the date the participant became insured under this benefit, the participant has a diagnosis of an early stage cancer or has any signs, symptoms or investigations that lead to a diagnosis of early stage cancer, regardless of when the diagnosis is made.

In the event of any such diagnosis of early stage cancer, the covered condition and surgery benefit will not be payable. Notwithstanding the foregoing, this benefit will remain in force, subject to the continued payment of the required premiums and other terms and conditions of the group policy, but early stage cancer will no longer be considered a covered condition or surgery for the participant.

EFFECT OF TERMINATION OF INSURANCE ON CLAIMS

Termination of this benefit or the termination of the participant's insurance will not prejudice any claim in connection with a covered condition or surgery provided that:

a) The date of diagnosis is before the earlier of the termination date of this benefit or the termination date of the participant's insurance.

b) The existence of the covered condition or surgery is reported to the insurer within 30 days of the earlier of the termination date of this benefit or the termination date of the participant's insurance.

c) For bacterial meningitis, the documented 90 day period of neurological deficit must have commenced, but need not be completed, before the earlier of the termination date of this benefit or the termination date of the participant's insurance.

d) For coma, the continuous 96 hour minimum period of unconsciousness must have commenced, but need not be completed, before the earlier of the termination date of this benefit or the termination date of the participant's insurance.

e) For loss of independent existence, the continuous 90 day period of incapacity must have commenced, but need not be completed, before the earlier of the termination date of this benefit or the termination date of the participant's insurance.

f) For loss of speech, the 180 day period of total and irreversible loss of speech must have commenced, but need not be completed, before the earlier of the termination date of this benefit or the termination date of the participant's insurance.

g) For major organ failure on waiting list, the date the participant is enrolled as a recipient in a recognized transplant centre must have occurred before the earlier of the termination date of this benefit or the termination date of the participant's insurance.

h) For multiple sclerosis, the 6 month period of episodes of well-defined neurological abnormalities must have commenced, but need not be completed, before the earlier of the termination date of this benefit or the termination date of the participant's insurance.

i) For occupational HIV infection, the 14 day period during which a serum HIV test must be taken, must have commenced, but need not be completed, before the earlier of the termination date of this benefit or the termination date of the participant's insurance.

j) For paralysis, the 90 day period of total loss of muscle function must have commenced, but need not be completed, before the earlier of the termination date of this benefit or the termination date of the participant's insurance.

k) For stroke, the 30 day period of paralysis or other measurable objective neurological deficit must have commenced, but need not be completed, before the earlier of the termination date of this benefit or the termination date of the participant's insurance.

SPOUSE'S OPTIONAL CRITICAL ILLNESS INSURANCE

A participant may obtain an amount of optional critical illness insurance on his spouse if he so requests it in writing to the insurer and furnishes evidence of insurability satisfactory to the insurer, and the insurer provides approval of evidence of insurability.

The sum insured that will be applicable to the spouse will be the amount of insurance requested as provided for in the Summary of Benefits.

If the spouse suffers any of the conditions or undergoes any of the surgeries which are described in the Covered Conditions and Surgeries provision of the Participant's Optional Critical Illness Insurance benefit, the insurer undertakes to pay the sum insured, subject to the terms and conditions of this benefit and the group policy.

Payment will be made to the participant.

ADDITIONAL PROVISIONS

Any provisions of the Participant's Optional Critical Illness Insurance benefit which are not inconsistent with the provisions of this benefit form part of this benefit.

CHILDREN'S OPTIONAL CRITICAL ILLNESS INSURANCE

A participant may obtain an amount of optional critical illness insurance on his children if he so requests it in writing to the insurer and furnishes evidence of insurability satisfactory to the insurer, as required in the Summary of Benefits.

The sum insured that will be applicable to the children will be the amount of insurance requested as provided for in the Summary of Benefits.

If a child suffers any of the conditions or undergoes any of the surgeries which are described in the Covered Conditions and Surgeries provision of this benefit, the insurer undertakes to pay the sum insured, subject to the terms and conditions of this benefit and the group policy.

Payment will be made to the participant.

CONDITIONS

Payment will be made for the covered condition or surgery provided:

a) The condition was diagnosed or the surgery took place while the child was insured under this benefit; and

b) The date of diagnosis of the covered condition or surgery must be later than:

   i) The date the child became insured under this benefit; or

   ii) The latest reinstatement date of the child's coverage; and

c) The child survived for at least 30 days after the date the condition was diagnosed or the surgery took place, unless otherwise indicated under this benefit.

In the case of cancer recurrences or metastases, no payment will be made for any recurrence or metastases of a cancer if that cancer was originally diagnosed prior to the date the child became insured under this benefit, regardless of the date of the recurrence or metastases.

Notwithstanding the foregoing, if a natural child of the participant, born on or after the effective date of this benefit,

a) Is diagnosed by a specialist, while in the womb, with a covered condition or surgery, excluding cancer and benign brain tumour, and such child survives for 30 days following the effective date of this benefit of such

child, the insurer will pay the child covered condition or surgery benefit to the participant, or

b) Is diagnosed by a specialist, while in the womb, with cancer or benign brain tumour, the terms a) and b) of the Limitations provision of this benefit will apply respectively.

Once payment has been made for a child due to a covered condition or surgery, the child's coverage under this benefit will terminate.

DEFINITIONS

As used in this benefit:

Date of diagnosis means the date on which a specialist diagnoses the child with one of the covered conditions or surgeries.

Diagnosis means the certified diagnosis of the child with a covered condition or surgery by a specialist.

Irreversible means a condition cannot be improved by medical or surgical treatment at the time of diagnosis. Notwithstanding the foregoing, a condition is considered irreversible if, in the opinion of the child's physician, medical or surgical treatment to improve the condition would present a risk to the child's health which would outweigh the expected benefits of such treatment.

Life support means the child is under the regular care of a licensed physician for nutritional, respiratory and/or cardiovascular support when irreversible cessation of all functions of the brain has occurred.

Specialist means a physician licensed to practice medicine who:

a) Has been trained in the specific area of medicine relevant to the covered condition or surgery for which a benefit is being claimed; and

b) Has been certified by a specialty examining board; and

c) Is currently practicing in his area of specialty in Canada or the United States.

Specialist includes, but is not limited to, cardiologist, neurologist, nephrologist, oncologist, ophthalmologist, burn specialist and internist. The specialist must not be the participant, a relative or business associate of the participant.

In the absence or unavailability of a specialist, and as approved by the insurer, a covered condition or surgery may be diagnosed by a qualified medical practitioner practicing in Canada or the United States.

Surgery means medically required surgery performed on the written advice of a specialist. The surgery must be performed by a physician in Canada or the United States.

Survival period means 30 consecutive days immediately following the date of diagnosis of a covered condition or the date of a surgery, as applicable, unless a longer period is specified in the definition of the applicable covered condition or surgery. The survival period with respect to a diagnosis of major organ transplant means 30 consecutive days immediately following the child's transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow. The survival period does not include the number of days of life support. The child must be alive at the end of the survival period and must not have experienced irreversible cessation of all functions of the brain. For those covered conditions or surgeries which have a qualifying period, for example 90 days for bacterial meningitis and paralysis, the survival period runs concurrently with that covered condition or surgery's qualifying period.

COVERED CONDITIONS AND SURGERIES

Aortic Surgery

Aortic surgery means the undergoing of surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. **Aorta** means the thoracic and abdominal aorta but not its branches.

For payment to be made under this benefit, the surgery must be determined to be medically required by a specialist.

Exclusions

No payment will be made under this benefit for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Aplastic Anemia

Aplastic anemia means a definite diagnosis of a chronic persistent bone marrow failure, confirmed by biopsy, which results in anemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following:

a) Marrow stimulating agents; or

b) Immunosuppressive agents; or

c) Bone marrow transplantation.

For payment to be made under this benefit, the diagnosis of aplastic anemia must be made by a specialist.

Bacterial Meningitis

Bacterial meningitis means a definite diagnosis of meningitis, confirmed by cerebrospinal fluid showing the presence of pathogenic bacteria. The presence of pathogenic bacteria must be confirmed by culture or other generally medically accepted microbiological testing. The bacterial meningitis must result in objective neurological deficits persisting for at least 90 days from the date of diagnosis.

For payment to be made under this benefit, the diagnosis of bacterial meningitis must be made by a specialist.

For the purposes of this benefit, neurological deficits must be detectable by the specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance,

lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

Exclusions

No payment will be made under this benefit for viral meningitis.

Benign Brain Tumour

Benign brain tumour means a definite diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The child must have undergone surgery or radiation treatment, or the tumour must have caused irreversible objective neurological deficits.

These deficits must be corroborated by diagnostic imaging showing changes that are consistent in character, location and timing with the neurological deficits.

For payment to be made under this benefit, the diagnosis of benign brain tumour must be made by a specialist.

For the purposes of this benefit, neurological deficits must be detectable by the specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

Exclusions

No payment will be made under this benefit if, within the first 90 days following the later of the date the child became insured under this benefit or the last reinstatement date of a child's coverage, such child has any of the following:

a) Signs, symptoms or investigations that lead directly or indirectly to a diagnosis of any benign brain tumour (covered or excluded under this benefit), regardless of when the diagnosis is made; or

b) A diagnosis of any benign brain tumour (covered or excluded under this benefit).

Medical Information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the insurer within 6 months of the date of diagnosis. If this information is not provided within this period, the insurer has the right to deny any claim for benign brain tumour or any critical illness caused by any benign brain tumour or its treatment.

No payment will be made under this benefit for pituitary adenomas less than 10 mm, vascular malformations, cholesteatomas or infectious or inflammatory tumours.

Blindness

Blindness means a definite diagnosis of the total and irreversible loss of vision in both eyes, evidenced by:

a) The corrected visual acuity being 20/200 or less in both eyes; or

b) The field of vision being less than 20 degrees in both eyes.

For payment to be made under this benefit, the diagnosis of blindness must be made by a specialist.

Cancer

Cancer means a definite diagnosis of a malignant tumour, which must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Types of cancer include carcinoma, melanoma, leukemia, lymphoma, and sarcoma.

For payment to be made under this benefit, the diagnosis of cancer must be made by a specialist and must be confirmed by a pathology report.

For purposes of this benefit,

a) **T1a or T1b prostate cancer** means a clinically inapparent tumour that was not palpable on digital rectal examination and was incidentally found in resected prostatic tissue.

b) The term **Gastrointestinal stromal tumours (GIST) classified as AJCC Stage 1** means:

   i) Gastric and omental GISTs that are less than or equal to 10 cm in greatest dimension with five or fewer mitoses per 5 mm^2, or 50 per HPF; or

   ii) Small intestinal, esophageal, colorectal, mesenteric and peritoneal GISTs that are less than or equal to 5 cm in greatest dimension with 5 or fewer mitoses per 5 mm^2, or 50 per HPF;

c) The terms "Tis, Ta, T1a, T1b, T1 and AJCC Stage 1" are to be applied as defined in the American Joint Committee on Cancer (AJCC) Cancer Staging Manual, 8th Edition, 2018.

d) The term Rai stage 0 as defined in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975.

Exclusions

No payment will be made under this benefit if, within the first 90 days following the later of the date the child became insured under this benefit or the last reinstatement date of a child's coverage, such child has any of the following:

a) Signs, symptoms or investigations that lead directly or indirectly to a diagnosis of any cancer (covered or excluded under this benefit), regardless of when the diagnosis is made; or

b) A diagnosis of any cancer (covered or excluded under this benefit).

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the insurer within 6 months of the date of diagnosis. If this information is not provided within this period, the insurer has the right to deny any claim for cancer or any critical illness caused by any cancer or its treatment.

No payment will be made under this benefit for the following:

a) Lesions described as benign, non-invasive, pre-malignant, of low and/or uncertain malignant potential, borderline, carcinoma in-situ, or tumours classified as Tis or Ta;

b) Malignant melanoma skin cancer that is less than or equal to 1 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;

c) Any non-melanoma skin cancer, without lymph node or distant metastasis, including but not limited to cutaneous T cell lymphoma, basal cell carcinoma, squamous cell carcinoma or Merkel cell carcinoma;

d) Prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;

e) Papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2 cm in greatest diameter and classified as T1, without lymph node or distant metastasis;

f) Chronic lymphocytic leukemia classified as Rai stage 0 without enlargement of lymph nodes, spleen or liver and with normal red blood cell and platelet counts;

g) Gastrointestinal stromal tumours (GIST) classified as AJCC Stage 1;

h) Grade 1 neuroendocrine tumours (carcinoid) confined to the affected organ, treated with surgery alone and requiring no additional treatment, other than perioperative medication to oppose effects from hormonal oversecretion by the tumour; or

i) Thymomas (stage 1) confined to the thymus, without evidence of invasion into the capsule or spread beyond the thymus.

Cerebral Palsy

Cerebral palsy means a non-progressive neurological defect characterized by spasticity and the child's inability to co-ordinate his movements.

For payment to be made under this benefit, the diagnosis of cerebral palsy must be made by a specialist.

Coma

Coma means a definite diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, and for which period the Glasgow Coma score must be 4 or less.

For payment to be made under this benefit, the diagnosis of coma must be made by a specialist.

Exclusions

No payment will be made under this benefit for:

a) A medically induced coma; or

b) A coma which results directly from alcohol or drug use; or

c) A diagnosis of brain death.

Congenital Heart Disease

Congenital heart disease means a diagnosis of one of the following heart conditions following a 30 day survival period from diagnosis or birth, whichever comes later:

a) Atresia of any heart valve;

b) Coarctation of the aorta;

c) Double Inlet Ventricle;

d) Double Outlet Left Ventricle;

e) Ebstein's Anomaly;

f) Eisenmenger Syndrome;

g) Hypoplastic Left Heart Syndrome;

h) Hypoplastic Right Ventricle;

i) Single Ventricle;

j) Tetralogy of Fallot;

k) Total Anomalous Pulmonary Venous Connection;

l) Transposition of the Great Vessels;

m) Truncus Arteriosus.

For payment to be made under this benefit, the diagnosis must be made by a qualified pediatric cardiologist and supported by appropriate cardiac imaging.

Congenital heart disease also means an open-heart surgery performed for the correction of the following heart conditions following a 30 day survival period from surgery:

a) Pulmonary Stenosis;

b) Aortic Stenosis;

c) Discrete Subvalvular Aortic Stenosis;

d) Ventricular Septal Defect;

e) Atrial Septal Defect.

For payment to be made under this benefit, the surgery must be recommended by a qualified pediatric cardiologist and performed by a cardiac surgeon in Canada or the United States.

Exclusions

No benefit will be payable for trans-catheter procedures such as, but not limited to, balloon valvuloplasty or percutaneous atrial septal defect closure, or any other congenital cardiac conditions not referred to under this covered condition or surgery.

Coronary Artery Bypass Surgery

Coronary artery bypass surgery means the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s).

For payment to be made under this benefit, the surgery must be determined to be medically required by a specialist.

Exclusions

No payment will be made under this benefit for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Cystic Fibrosis

Cystic fibrosis means a definitive diagnosis of cystic fibrosis with evidence of chronic lung disease and pancreatic insufficiency.

For payment to be made under this benefit, the diagnosis of cystic fibrosis must be made by a specialist.

Deafness

Deafness means a definite diagnosis of the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz.

For payment to be made under this benefit, the diagnosis of deafness must be made by a specialist.

Dementia, including Alzheimer's Disease

Dementia, including Alzheimer's disease means a definite diagnosis of dementia, which must be characterized by a progressive deterioration of memory and at least one of the following areas of cognitive function:

a) Aphasia (a disorder of speech);

b) Apraxia (difficulty performing familiar tasks);

c) Agnosia (difficulty recognizing objects);

d) Disturbance in executive functioning (e.g. inability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behavior), which is affecting daily life.

The child must exhibit:

a) Dementia of at least moderate severity, which must be evidenced by a Mini Mental State Exam of 20/30 or less, or equivalent score on another generally medically accepted test or tests of cognitive function; and

b) Evidence of progressive worsening in cognitive and daily functioning either by serial cognitive tests or by history over at least a 6 month period.

For payment to be made under this benefit, the diagnosis of dementia, including Alzheimer's disease must be made by a specialist.

For the purposes of this benefit, reference to the Mini Mental State Exam is to Folstein MF, Folstein SE, McHugh PR, J Psychiatry Res. 1975;12(3):189.

Exclusions

No payment will be made under this benefit for affective or schizophrenic disorders, or delirium.

Down's Syndrome

Down's syndrome means a definitive diagnosis of Down's syndrome supported by chromosomal evidence of Trisomy 21.

For payment to be made under this benefit, the diagnosis of Down's syndrome must be made by a specialist.

Heart Attack

Heart attack (acute myocardial infarction) means a definite diagnosis of the death of heart muscle due to obstruction of blood flow, that results in a rise and fall of cardiac biomarkers to levels considered diagnostic of myocardial infarction, with at least one of the following:

a) Heart attack symptoms;

b) New electrocardiogram (ECG) changes consistent with a heart attack;

c) Development of new pathological Q waves on ECG following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

For payment to be made under this benefit, the diagnosis of heart attack must be made by a specialist.

Exclusions

No payment will be made under this benefit for:

a) ECG changes suggesting a prior myocardial infarction; or

b) Other acute coronary syndromes, including angina pectoris and unstable angina; or

c) Elevated cardiac biomarkers and/or symptoms that are due to medical procedures or diagnoses other than heart attack.

Heart Valve Replacement or Repair

Heart valve replacement or repair means the undergoing of surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities.

For payment to be made under this benefit, the surgery must be determined to be medically required by a specialist.

Exclusions

No payment will be made under this benefit for angioplasty, inter-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

Kidney Failure

Kidney failure means a definite diagnosis of chronic irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation is initiated.

For payment to be made under this benefit, the diagnosis of kidney failure must be made by a specialist.

Loss of Independent Existence

Loss of independent existence means a definite diagnosis of the total inability, due to disease or injury, to perform independently, with or without the aid of assistive devices, at least 3 of the following 6 activities of daily living for a continuous period of at least 90 days with no reasonable chance of recovery.

For payment to be made under this benefit, the diagnosis of loss of independent existence must be made by a physician and supported by an independent home care assessment made by an occupational therapist or equivalent.

Activities of daily living are:

a) **Bathing:** the ability to wash oneself in a bathtub, shower or by sponge bath;

b) **Dressing:** the ability to put on and remove necessary clothing, braces, artificial limbs or other surgical appliances;

c) **Toileting:** the ability to get on and off the toilet and maintain personal hygiene;

d) **Bladder and bowel continence:** the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that hygiene is maintained;

e) **Transferring:** the ability to move in and out of a bed, chair or wheelchair;

f) **Feeding:** the ability to consume food or drink that already has been prepared and made available.

No additional survival period is required once the conditions described above are satisfied.

Loss of Limbs

Loss of limbs means a definite diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation.

For payment to be made under this benefit, the diagnosis of loss of limbs must be made by a specialist.

Loss of Speech

Loss of speech means a definite diagnosis of the total and irreversible loss of the ability to speak as a result of physical injury or disease, for a period of at least 180 days.

For payment to be made under this benefit, the diagnosis of loss of speech must be made by a specialist.

Exclusions

No payment will be made under this benefit for all psychiatric related causes.

Major Organ Failure on Waiting List

Major organ failure on waiting list means a definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically required. To qualify under major organ failure on waiting list, the child must become enrolled as the recipient in a recognized transplant center in Canada or the United States that performs the required form of transplant surgery. For the purposes of the survival period, the date of diagnosis is the date of the child's enrollment in the transplant centre.

For payment to be made under this benefit, the diagnosis of the major organ failure must be made by a specialist.

Major Organ Transplant

Major organ transplant means a definite diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically required. To qualify under major organ transplant, the child must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities.

For payment to be made under this benefit, the diagnosis of the major organ failure must be made by a specialist.

Motor Neuron Disease

Motor neuron disease means a definite diagnosis of one of the following: amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy, and limited to these conditions.

For payment to be made under this benefit, the diagnosis of motor neuron disease must be made by a specialist.

Multiple Sclerosis

Multiple sclerosis means a definite diagnosis of at least one of the following occurring after the later of the date the child became insured under this benefit or the date of the last reinstatement of a child's coverage:

a) Two or more separate clinical attacks, confirmed by at least one magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination; or

b) A single attack, with objective neurological deficits lasting more than 6 months, confirmed by MRI of the nervous system, showing multiple lesions of demyelination; or

c) A single attack, confirmed by repeated MRI of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart.

For payment to be made under this benefit, the diagnosis of multiple sclerosis must be made by a specialist.

For the purposes of this benefit, neurological deficits must be detectable by a specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia (difficulty with speech), dysphagia (difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

Exclusions

No payment will be made under this benefit if, within the first year following the later of the date the child became insured under this benefit or the last reinstatement date of a child's coverage, such child has any of the following:

a) Signs, symptoms or investigations that lead directly or indirectly to a diagnosis of multiple sclerosis (covered or excluded under this benefit), regardless of when the diagnosis is made; or

b) A diagnosis of multiple sclerosis (covered or excluded under this benefit).

Medical Information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the insurer within 6 months of the date of diagnosis. If this information is not provided within this period, the insurer has the right to deny any claim for multiple sclerosis or any critical illness caused by multiple sclerosis or its treatment.

No payment will be made under this benefit for:

a) Solitary sclerosis; or

b) Clinically isolated syndrome; or

c) Radiologically isolated syndrome; or

d) Neuromyelitis optica spectrum disorders; or

e) Suspected multiple sclerosis of probable multiple sclerosis.

Muscular Dystrophy

Muscular dystrophy means a definitive diagnosis of muscular dystrophy, characterized by well defined neurological abnormalities, confirmed by electromyography and muscle biopsy.

For payment to be made under this benefit, the diagnosis of muscular dystrophy must be made by a specialist.

Occupational HIV Infection

Occupational HIV infection means a definite diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the child's normal occupation, which exposed the person to HIV contaminated body fluids.

The accidental injury leading to the infection must have occurred after the later of the date the child became insured under this benefit, or the last reinstatement date of a child's coverage.

Payment under this covered condition or surgery requires satisfaction of all of the following:

a) The accidental injury must be reported to the insurer within 14 days of the accidental injury; and

b) A serum HIV test must be taken within 14 days of the accidental injury and the result must be negative; and

c) A serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive; and

d) All HIV tests must be performed by a duly licensed laboratory in Canada or the United States; and

e) The accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States workplace guidelines.

For payment to be made under this benefit, the diagnosis of occupational HIV infection must be made by a specialist.

Exclusions

No payment will be made under this benefit if:

a) The child has elected not to take any available licensed vaccine offering protection against HIV; or

b) A licensed cure for HIV infection has become available prior to the accidental injury; or

c) HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use.

Paralysis

Paralysis means a definite diagnosis of the total loss of muscle function of two or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event.

For payment to be made under this benefit, the diagnosis of paralysis must be made by a specialist.

Parkinson's Disease and Specified Atypical Parkinsonian Disorders

Parkinson's disease and specified atypical parkinsonian disorders means a definite diagnosis of either a) Parkinson's disease or b) specified atypical parkinsonian disorders, as defined below:

a) Parkinson's disease means a definite diagnosis of primary Parkinson's disease, a permanent neurological condition which must be characterized by bradykinesia (slowness of movement) and at least one of the following: muscular rigidity or rest tremor. The child must exhibit objective signs of progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's disease.

b) specified atypical parkinsonian disorders means a definite diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.

For payment to be made under this benefit, the diagnosis of Parkinson's disease or a specified atypical parkinsonian disorder must be made by a neurologist.

Exclusions

No payment will be made under this benefit if, within the first year following the later of the date the child became insured under this benefit or the last reinstatement date of a child's coverage, such child has any of the following:

a) Signs, symptoms or investigations that lead directly or indirectly to a diagnosis of Parkinson's disease, a specified atypical parkinsonian disorder or any other type of parkinsonism, regardless of when the diagnosis is made; or

b) A diagnosis of Parkinson's disease, a specified atypical parkinsonian disorder or any other type of parkinsonism.

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to the insurer within 6 months of the date of diagnosis. If this information is not provided within this period, the insurer has the right to deny any claim for Parkinson's disease or specified atypical parkinsonian disorders or its treatment.

No payment will be made under this benefit for any other type of parkinsonism.

Severe Burns

Severe burns means a definite diagnosis of third-degree burns over at least 20% of the body surface.

For payment to be made under this benefit, the diagnosis of severe burns must be made by a specialist.

Stroke

Stroke (cerebrovascular accident resulting in persistent neurological deficits) means a definite diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism, with:

a) Acute onset of new neurological symptoms, and

b) New objective neurological deficits on clinical examination,

persisting for more than 30 days following the date of diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging testing showing changes that are consistent in character, location and timing with the new neurological deficits.

For payment to be made under this benefit, the diagnosis of stroke must be made by a specialist.

For the purposes of this benefit, neurological deficits must be detectable by a specialist and may include, but are not restricted to, measurable loss of hearing, measurable loss of vision, measurable changes in neuro-cognitive function, objective loss of sensation, paralysis, localized weakness, dysarthria (difficulty with pronunciation), dysphasia, (difficulty with speech) dysphagia

(difficulty swallowing), impaired gait (difficulty walking), difficulty with balance, lack of coordination, or new-onset seizures undergoing treatment. Headache or fatigue will not be considered a neurological deficit.

Exclusions

No payment will be made under this benefit for:

a) Transient Ischaemic Attacks; or

b) Intracerebral vascular events due to trauma; or

c) Ischaemic disorders of the vestibular system; or

d) Death of tissue of the optic nerve or retina without total loss of vision of that eye; or

e) Lacunar infarcts which do not meet the definition of stroke as described above.

Type 1 Diabetes

Type 1 diabetes means a diagnosis of type 1 mellitus, characterized by absolute insulin deficiency and continuous dependence on exogenous insulin for survival.

For payment to be made under this benefit, the diagnosis of Type 1 diabetes must be made by a qualified pediatrician or endocrinologist licenced and practicing in Canada or the United States and there must be evidence of dependence on insulin for a minimum of 3 months.

PRE-EXISTING CONDITION EXCLUSION

As used in this provision, **Pre-existing condition** means a covered condition or surgery:

a) Which was sustained or contracted; or

b) For the signs and symptoms of which the child was under treatment by a physician; or

c) For the signs and symptoms of which a physician had undertaken an investigation or review of; or

d) For which the child was taking medication as prescribed by a physician,

during the 24 months prior to the date the child became insured under this benefit.

No payment will be made under this benefit for a covered condition or surgery:

a) That resulted either directly or indirectly from, or was in any manner or degree associated with or occasioned by a pre-existing condition; and

b) Which occurred during the first 24 months after the date the child became insured under this benefit.

Notwithstanding the above, with respect to a child who had his insurance reinstated under this benefit as described in the Reinstatement of Insurance provision, if the insurance provided to the child was not in force for the full period of 24 months at the termination date of insurance, the child will continue to satisfy the remainder of the pre-existing condition from the reinstatement date.

This exclusion is not applicable to a child born on or after the effective date of this benefit.

Exception to Pre-existing Condition

However, if the child's insurance under this benefit is replacing a critical illness benefit under a previous group policy, the Pre-existing Condition provision will not apply for a condition or surgery which had been provided for under the critical illness benefit of the previous group policy and a benefit will be payable due to such condition or surgery provided:

a) The child had been insured under the critical illness benefit under the previous group policy immediately prior to the date the benefit terminated under such policy; and

b) The child became insured under this benefit immediately following the date the critical illness benefit terminated under the previous group policy; and

c) The child had satisfied the pre-existing condition exclusion period that was specified under the critical illness benefit of the previous group policy or he has satisfied the pre-existing condition exclusion period under this benefit, giving consideration towards continuous time insured

under this benefit and the critical illness benefit under the previous group policy.

The benefit that will be payable to the participant with respect to a child for whom the pre-existing condition exclusion has been waived due to the preceding paragraph, will be determined in accordance with the critical illness benefit under the group policy, but in no case will it exceed the critical illness benefit that would have been payable under the previous group policy.

The Pre-existing Condition provision will apply to any condition or surgery which had not been provided for under the critical illness benefit of the previous group policy with respect to a child whose benefit under the group policy is replacing a critical illness benefit that had been provided under a previous group policy.

This pre-existing condition exclusion will not apply to any coverage issued with evidence of insurability provided and approved for this benefit.

EXCLUSIONS

No payment will be made under this benefit if the covered condition or surgery resulted directly or indirectly from any of the following causes:

a) Suicide, attempted suicide or self-inflicted injury, regardless of any impairment, Illness, or state of mind.

b) Committing or attempting to commit a criminal offense or provoking an assault.

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

d) Use of drugs, poisonous substances, intoxicants or narcotics, other than as prescribed and administered by or in accordance with the instructions of a legally licensed physician.

e) Abuse of alcohol.

f) The operation of a motor vehicle, if the child at the time of the accident had a blood alcohol concentration rate in excess of the limit permitted by law.

g) Flight in an aircraft, except as riding as a passenger and not as a pilot, operator or member of the crew, in or on any aircraft provided (i) the flight was a regularly scheduled flight, (ii) the aircraft has a current and valid certificate of air worthiness and is piloted by a person who holds a current and valid pilot's license of a rate authorizing him to pilot the aircraft and (iii) the aircraft is not owned, operated, chartered or licensed by the Policyholder or the participant's Employer.

h) Participation, amateur or professional, in any of the following activities:

   i) Underwater activities, including but not limited to, scuba diving and scuba diving; or

   ii) Hang-gliding; or

   iii) Parachuting; or

   iv) Motor vehicle race or speed competition on land and/or water; or

   v) Boxing; or

   vi) Bungee jumping; or

   vii) BASE jumping; or

   viii) Cliff diving; or

   ix) Mountain climbing.

LIMITATIONS

a) Cancer

   A child will not be entitled to a covered condition or surgery benefit for cancer if, within the first 90 days following the date the child became insured under this benefit, the child has a diagnosis of cancer or any signs, symptoms or investigations that lead to a diagnosis of cancer, regardless of when the diagnosis is actually made.

   In addition, a child who is a natural child of a participant born on or after the effective date of this benefit is not entitled to a covered condition or surgery benefit for cancer and the child's insurance under this benefit will be void if cancer was diagnosed while such child was in the womb.

In the event that such child is the only insured child of the participant, then applicable premiums paid for this benefit will be refunded.

b) Benign Brain Tumour

A child will not be entitled to a covered condition or surgery benefit for benign brain tumour if, within the first 90 days following the date the child became insured under this benefit, the child has a diagnosis of benign brain tumour or any signs, symptoms or investigations that lead to a diagnosis of benign brain tumour, regardless of when the diagnosis is actually made.

In addition, a child who is a natural child of a participant born on or after the effective date of this benefit is not entitled to a covered condition or surgery benefit for benign brain tumour and the child's insurance under this benefit will be void if benign brain tumour was diagnosed while such child was in the womb.

In the event that such child is the only insured child of the participant, then applicable premiums paid for this benefit will be refunded.

c) All covered conditions and surgeries excluding cancer and benign brain tumour

A child who is a natural child of the participant born in the 10 month period immediately following the effective date of this benefit will not be entitled to a child covered condition or surgery benefit if, within 30 days of birth, such child has any of the following:

i) A diagnosis of a covered condition or surgery; or

ii) The child's parents or physician notice or become aware of any sign, symptom, condition or medical problem that leads to a diagnosis of a covered condition or surgery at any time in the future.

In the event of any such diagnosis with respect to such child of a covered condition or surgery other than cancer and benign brain tumour, this benefit will remain in force, but the applicable diagnosed covered condition or surgery will no longer be considered a covered condition or surgery for such child.

EFFECT OF TERMINATION OF INSURANCE ON CLAIMS

Termination of this benefit or the termination of the child's insurance will not prejudice any claim in connection with a covered condition or surgery provided that:

a) The date of diagnosis is before the earlier of the termination date of this benefit or the termination date of the child's insurance.

b) The existence of the covered condition or surgery is reported to the insurer within 30 days of the earlier of the termination date of this benefit or the termination date of the child's insurance.

c) For bacterial meningitis, the documented 90 day period of neurological deficit must have commenced, but need not be completed, before the earlier of the termination date of this benefit or the termination date of the child's insurance.

d) For coma, the continuous 96 hour minimum period of unconsciousness must have commenced, but need not be completed, before the earlier of the termination date of this benefit or the termination date of the child's insurance.

e) For congenital heart disease, the 30 day survival period from the later of the date of diagnosis or birth must have commenced, but need not be completed, before the earlier of the termination date of this benefit or the termination date of the child's insurance;

f) For loss of independent existence, the continuous 90 day period of incapacity must have commenced, but need not be completed, before the earlier of the termination date of this benefit or the termination date of the child's insurance.

g) For loss of speech, the 180 day period of total and irreversible Loss of Speech must have commenced, but need not be completed, before the earlier of the termination date of this benefit or the termination date of the child's insurance.

h) For major organ failure on waiting list, the date the child is enrolled as a recipient in a recognized transplant centre must have occurred before the earlier of the termination date of this benefit or the termination date of the child's insurance.

i) For multiple sclerosis, the 6 month period of episodes of well-defined neurological abnormalities must have commenced, but need not be completed, before the earlier of the termination date of this benefit or the termination date of the child's insurance.

j) For occupational HIV infection, the 14 day period during which a serum HIV test must be taken, must have commenced, but need not be completed, before the earlier of the termination date of this benefit or the termination date of the child's insurance.

k) For paralysis, the 90 day period of total loss of muscle function must have commenced, but need not be completed, before the earlier of the termination date of this benefit or the termination date of the child's insurance.

l) For stroke, the 30 day period of paralysis or other measurable objective neurological deficit must have commenced, but need not be completed, before the earlier of the termination date of this benefit or the termination date of the child's insurance.

m) For Type 1 diabetes, the minimum 3 month period of dependence on insulin must have commenced, but need not be completed, before the earlier of the termination date of this benefit or the termination date of the child's insurance.

If a participant becomes disabled while insured under this benefit and while he or she is actively at work, the insurer will undertake to pay the participant the amount of the monthly indemnity benefit specified herein for each month or part of a month during which such disability lasts, subject to the terms and conditions of this benefit and the group policy.

PARTICULARS

Beginning of Benefit Payments

Payment of the monthly indemnity benefit begins following completion of the elimination period specified in the Summary of Benefits.

Amount of Benefit Payments

The amount of the monthly indemnity 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

The monthly indemnity payable under this benefit will be reduced, after the application of the monthly maximum indicated in the Summary of Benefits, by:

a) any remuneration received from the employer;

b) the net initial monthly amount of any disability benefit payable in relation to the disability in question by the employer's pension plan;

c) the amount payable or which would have been payable had the participant made a satisfactory application under Québec* or Canada Pension Plan, excluding benefits payable on behalf of dependent children.

Moreover, when the aforementioned benefits and the gross initial monthly amount of any disability benefits that are payable or which would have been payable had you made a satisfactory application under:

a) a workers' compensation act;

b) a provincial automobile insurance law;

c) a provincial crime victims compensation act;

d) any other provincial labour legislation of your province of residence

e) the Quebec Pension Plan before July 1st, 2023**

exceed the OVERALL MAXIMUM, as defined in the Summary of Benefits, the amount of the disability benefit payable by the insurer is then adjusted so as to not exceed the maximum.

* For the participant to whom Quebec Pension Plan Disability benefits are payable, or would have been payable, for any period starting prior to January 1, 2024, the insurer will reduce or continue to reduce, for the entire duration of the disability, the monthly indemnity benefit:

i) by the same amount of disability benefit as originally approved by the Quebec Pension Plan for the period beginning before January 1, 2024, or

ii) by the same amount of disability benefit which would have been payable to the participant for the period beginning before January 1, 2024, had a satisfactory application been made under the Quebec Pension Plan

** For the participant to whom Quebec Pension Plan Disability benefits are payable, or would have been payable, for any period starting prior to July 1st, 2023, the insurer will continue to take into consideration the same amount as defined in i) and ii) for the calculation of the amount exceeding the OVERALL MAXIMUM, as defined in the Summary of Benefits, for the entire duration of the disability.

Future cost of living adjustments made to amounts received from any of the above-mentioned sources will not bring about further reductions.

Termination of Benefit Payments

The monthly indemnity ceases on the earliest of the following dates:

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

b) The date on which the participant ceases to be disabled. However, if the date of the cessation of the disability corresponds to the period between the end of a school year and the beginning of the following school year,

benefits will continue to be paid until the beginning of the following school year;

c) The date on which the participant reaches the age of 65;

d) The date on which the participant retires or reach the normal retirement age under the employer's pension plan, but never beyond the normal retirement age indicated in the Summary of Benefits of this plan;

e) The date of the participant's death;

f) The date on which the participant fails to submit to an examination by the physician designated by the insurer within 31 days of written request by the latter;

g) The date on which the participant fails to provide any evidence of disability required by the insurer within 31 days of written request by the latter;

h) The date on which the participant refuses to participate in a rehabilitation program or to engage in rehabilitation employment which the insurer and its consulting physicians deem reasonably appropriate.

i) The date on which the participant is incarcerated after committing a criminal offence for which he was found guilty.

SUCCESSIVE PERIODS OF DISABILITY

If the participant returns to active work and again becomes disabled while the coverage is in force, within the period equivalent to a disability period as described in the GENERAL PROVISIONS, and if such disability results from the same cause as the previous disability or from related causes, this is considered to be a continuation of the previous disability.

However, if the participant returns to active work and again becomes disabled while the coverage is in force, due to an illness or accidental injury totally unrelated to the previous cause of disability, the disability is considered to be a new disability and a new elimination period will apply.

EXCLUSIONS AND LIMITATIONS

a) The benefit specified herein does not cover any disability:

   i) during which the participant is not under the regular and continuous care of a physician or a specialist, except in the case of a stationary state recognized by a physician or a specialist, to the insurer's satisfaction;

   ii) resulting from committing or attempting to commit a criminal act, active participation in a riot or insurrection, or intentionally self-inflicted injuries, whether the participant is conscious or not of his or her actions;

   iii) resulting from esthetic treatments;

   iv) resulting from alcoholism or drug addiction, unless the participant is receiving medical treatment or care in view of rehabilitation, to the insurer's satisfaction;

   v) resulting directly or indirectly from a war (whether war be declared or not), or a civil war;

   vi) during which the participant is entitled to indemnities or benefits, related or not to his or her disability, under the Employment Insurance Act;

   vii) during which the participant is performing a gainful occupation, unless it is a job tryout or a part-time job, or to participate in a modified work program or rehabilitation employment, as recommended by the insurer;

   viii) resulting from a flight or attempted flight on board an airplane or other aircraft if the participant is part of the crew or performs any function relating to the flight, or participates in the flight as a parachutist.

b) If the participant is out of Canada and the United States for a period exceeding 90 consecutive days, the participant will no longer be entitled to the indemnity under the present benefit and such entitlement will be restored only upon his or her return, subject to all other provisions of the present benefit.

c) The insurance provided herewith does not cover any disability resulting from an illness or accidental injury which occurs during a strike, lock-out

or temporary layoff, if the participant benefit is not kept in force during the strike, lock-out or temporary layoff.

However, if the participant benefit is kept in force, the elimination period of the disability income benefit begins on the date the participant would have returned to work.

WAIVER OF PREMIUMS

If premiums are waived under the article *Waiver of Premiums* of the participant's life insurance benefit, the participant is also entitled to waiver of premiums for the present benefit, under the same conditions.

Moreover, if the participant is not covered under the LIFE INSURANCE BENEFIT, the participant is entitled to waiver of premiums for the present benefit, subject however to all other provisions described under *Waiver of Premiums* of the LIFE INSURANCE BENEFIT.

WORK RE-ENTRY

If a disabled participant participates in

a) a trial work, part-time work or modified work program, which has been approved by the insurer, or

b) a rehabilitation program, which has been approved by the insurer,

with the intent of returning to his own or any other occupation, and at such time he is incapable of earning at least 80% of his indexed gross monthly salary payable at the beginning of benefit payments due to the illness or injury which caused his disability, he will still be considered by the insurer to be disabled.

The insurer reserves the right to require that a disabled participant engage in a rehabilitation program or a trial work, part-time work or modified work program which has been recommended by the insurer to assist him in returning to gainful employment, if the insurer determines that the program is appropriate to the participant based on his disability, and his level of education, training or experience. If the participant does not co-operate or participate in the program, the participant will no longer be eligible to receive a monthly indemnity benefit.

If the disabled participant receives an income as a result of his participation in the rehabilitation program, trial work, part-time work or modified work program, the amount of the monthly indemnity benefit payable to him under the terms of this benefit will not be reduced unless the total of the monthly indemnity benefit he is receiving under this benefit, the income received from his participation in the program and the sources listed in the Reduction of Benefit Payments provision exceeds

a) 100% of his gross monthly salary payable at the beginning of benefit payments, if the monthly indemnity benefit is taxable to him, or

b) 100% of his net monthly salary payable at the beginning of benefit payments, if the monthly indemnity benefit is non-taxable to him. (For the purposes of this calculation, the income for the program shall be net.)

If the total of the monthly income he is receiving exceeds 100% of the salary, the amount of monthly indemnity benefit payable to him under the terms of this benefit will be reduced so that his total monthly income does not exceed 100% of such salary.

The insurer will pay the expenses incurred by the participant, other than usual employment expenses, which are associated with the approved trial work, part-time work or modified work program or rehabilitation program, provided the expenses were approved, in writing, by the insurer prior to being incurred.

INDEXATION

The initial amount of the indemnity provided herein is adjusted on the first day of January of each year to the cost of living index determined on October 31 of the previous year, in accordance with the terms and conditions with respect to cost of living adjustments used by the Québec Pension Plan, without, however, exceeding the MAXIMUM ANNUAL INDEXATION RATE in the Summary of Benefits. The first adjustment is made on the first day of January following the start of the indemnity payments.

SUPPLEMENTAL HEALTH INSURANCE

The insurer undertakes to reimburse customary and reasonable health care expenses incurred due to accidental injury, illness or pregnancy, subject to the terms and conditions hereinafter specified.

DEFINITIONS

As used in this benefit:

Coinsurance payment: The coinsurance payment is the portion of the cost of the covered expenses that must be paid by the insured person until the maximum contribution is reached.

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

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

Hospital: An institution which

a) is legally licensed by the appropriate government body;

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

c) provides at all times the services of physicians and registered nurses.

Maximum contribution: The maximum contribution is the total amount paid by the insured person beyond which the cost of the covered expenses which are eligible as per the list under the Basic Prescription Drug Insurance Plan of Quebec is covered 100% by the insurer.

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

Medically required: Certified by a physician as required to treat a condition which is detrimental to the patient's health.

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 and is usually less expensive.

Orthesis or Orthopedic Device: A device applied to a limb or part of the body in order to correct a functional disability.

Rehabilitation institution or convalescent home: An institution or health unit which

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

b) is intended for the care of bedridden patients.

Nursing homes, homes for the aged, rest homes, chronic care institution, residential and long-term care centres and drug and alcohol treatment centres are excluded.

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

Therapeutic or Medical Appliances: Appliances currently used according to the manufacturer's standards and recognized as specifically for the immediate treatment of a pathological condition following an illness or an accident, such as appliances for the control of pain, extended physiotherapy and the administration of medication, respiratory assistance and diagnostic devices, excluding orthopedic appliances, stethoscopes and sphygmomanometers.

PRESCRIPTION DRUG INSURANCE

(Applicable to Quebec Residents Only)

The insurer undertakes to reimburse the expense of prescription drugs which are listed under the Basic Prescription Drug Insurance Plan of Quebec, for each insured person who is a resident of Quebec and who is registered with the *Régie de l'assurance maladie du Québec* (hereafter referred to as the "RAMQ"), regardless of the insured person's state of health.

Coverage under this benefit is mandatory for all participants, retirees and their dependents who are eligible to be insured under the group policy, subject to the provisions of the Act respecting prescription drug insurance.

The coverage provided under this benefit is in accordance with the relevant provisions of the Act respecting prescription drug insurance and the Summary of Benefits.

Any modification to the Act respecting prescription drug insurance which relates to the Basic Prescription Drug Insurance Plan of Quebec will automatically result in the modification of the relevant provisions of this benefit and the group policy.

Special provision for insured persons age 65 and over

The insured person's choice to be covered by the RAMQ for the Basic Prescription Drug Insurance Plan of Quebec is irrevocable.

For the purpose of the group policy, insured persons age 65 and over will be presumed to be covered with the RAMQ for the Basic Prescription Drug Insurance Plan of Quebec. In addition, dependents of a participant who is 65 years of age or over will be presumed to be covered with the RAMQ for the Basic Prescription Drug Insurance Plan of Quebec, regardless of age. However, dependents age 65 and over of a participant less than age 65 remain covered with the insurer under the present benefit.

The insurer reserves the right to modify the rates applicable to this benefit for any insured person age 65 and over, who is eligible for insurance under the group policy and who has chosen to be insured under this benefit.

Notwithstanding any stipulation to the contrary in the group policy, this benefit does not provide any termination with regard to the participant's age.

Covered expenses

The following expenses are covered, provided they are incurred in Quebec after the insured person became insured under this benefit:

a) The services of a pharmacist to fill or renew a prescription for a drug which is included on the list of the RAMQ or specified by government regulation;

b) Drugs which are included on the list of the RAMQ and which are provided by a pharmacist on a prescription of a healthcare provider who is legally licensed to prescribe drugs;

c) Any drug specified by government regulation, when prescribed for the conditions and the therapeutic indications as set out in the regulation.

This benefit does not include the cost of pharmaceutical services and drugs that an insured person may obtain or to which the person is otherwise entitled, pursuant to any government plan or act, other than the Act respecting prescription drug insurance in Quebec.

Dispensing Quantity 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.

HOSPITALIZATION IN THE PROVINCE OF RESIDENCE

Room and board charges made by a hospital in the 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 insured person is confined to the hospital on an in-patient basis;

b) the level of accommodation was specifically requested by the insured person; and

c) the insured person was hospitalized for acute care and not chronic or convalescent care.

EMERGENCY MEDICAL EXPENSES INCURRED OUTSIDE THE PROVINCE OF RESIDENCE

Expenses for the services and supplies listed herein will be covered, up to the maximum specified in the Summary of Benefits, when they are incurred as a result of a medical emergency which occurs during an insured person's absence from his province of residence provided:

a) the medical emergency occurs during the first 90 days of the insured person's absence from his province of residence, or if the absence is due to his attendance at an accredited educational institution on a full-time basis, the medical emergency occurs during the school year for which he is enrolled at the institution; and

b) the insured person's absence was due to business, a vacation or full-time attendance at an accredited educational institution; and

c) the provision of the services and supplies could not have been delayed until the insured person had returned to his province of residence without endangering his health.

The following services and supplies which are received as a result of a medical emergency will be covered:

a) Services of a physician;

b) Accommodation in a hospital up to the level specified for the Hospitalization in the Province of Residence benefit;

c) Medical services, appliances and supplies furnished during a hospital confinement;

d) Diagnostic, medical imaging and laboratory services;

e) Paramedical services provided during a hospital confinement;

f) Hospital out-patient services and supplies;

g) Drugs;

h) Medical appliances and supplies provided out of hospital;

i) Professional ambulance service to transport the insured person to the nearest hospital equipped to provide the required medical treatment.

For paramedical services, drugs and medical appliances, only those drugs, appliances and services which would have been covered in the insured person's province of residence will be covered when they are received outside of his province of residence in a medical emergency.

Limitations For Emergency Medical Expenses Incurred Outside The Province Of Residence

If the insured person should become hospitalized outside of his province of residence due to a medical emergency, the insured person will be required to contact the insurer's Medical Assistance Service provider as soon as the person is reasonably able to do so after the commencement of his hospitalization. Failure to do so may result in the insurer limiting or denying the insured person's claim resulting from the medical emergency.

In addition, if during a medical emergency, the insurer determines that the insured person can be repatriated to his province of residence without endangering his health and the insured person refuses to be repatriated, the insurer will not be responsible for any further expenses incurred by the insured person due to the medical emergency.

No coverage will be provided under this benefit for any expenses that are incurred for a medical emergency if:

a) The insured person's medical condition was not stable before the absence from his province of residence began; and

b) The medical emergency results directly or indirectly from that medical condition.

The insurer determines, at its sole discretion, what stable means. In this assessment, the insurer may take into consideration medical factors, such as but not limited to the following:

a) Medical status;

b) Medical treatment, examination, consultation or hospitalization;

c) Increase or worsening of any symptom or health problem;

d) Change in medical treatment or in medication;

e) Medical treatment or examination planned or for which results are pending for any symptom or health problem;

within a period of 90 days prior to that absence.

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

a) The following expenses are covered, but only if they were incurred after the effective date of the insurance:

   i) Services rendered at the insured person's home by a registered nurse or certified nursing assistant provided:

      - the services were prescribed by a physician and pre-approved by the insurer;
      - the services are medically required;
      - the services fall within the scope of services provided by a registered nurse or certified nursing assistant; and
      - the registered nurse or certified nursing assistant is unrelated to the insured person and does not normally reside with him or her.

   ii) 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 insured person precludes the use of any other means of transportation. The ambulance service is limited to the most adequate and least expensive transportation;

   iii) Oxygen and rental of equipment necessary for its administration;

   iv) Transportation expenses, with the exception of ambulance service, for insured persons who have to undergo medical treatment that cannot be performed in their region, up to the maximums indicated in the Summary of Benefits;

   v) Drugs (including drugs related to obesity) which are dispensed by a pharmacist 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 medication to treat asthma, diabetes, high cholesterol or high blood pressure, provided they are prescribed by a healthcare provider who is legally licensed to prescribe such drugs and dispensed by a pharmacist.

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

Preventive immunization vaccines.

For Quebec residents, this medical expense is supplementary to the Prescription Drug Insurance provision.

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.

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

The insurer reserves the right to exclude coverage of any drug where it has determined, at its sole discretion, that coverage of the drug causes or may cause a material change in the risk

insured under the group policy or a material change in risk for the insurer in general.

Mandatory Generic

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 insured person provides proof, satisfactory to the insurer, that due to a valid medical reason as verified by his attending physician, that he must take the original drug, the insurer will make payment 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.

vi) Purchase of artificial limbs and eyes, or external prostheses, if the loss occurred while insured;

vii) Rental or purchase of a manual wheelchairs or electric wheelchairs when the insured person is incapable of operating a manual wheelchair due to a medical condition;

viii) Rental or purchase of a manually operated hospital beds or electrically operated hospital beds when the insured person is incapable of operating a manually operated hospital bed due to a medical condition, including bed rails and trapeze bars;

ix) Rental or purchase of any respiratory assistance devices;

x) Purchase or rental of diabetic administration equipment, therapeutic appliances and maintenance, adjustment and replacement expenses for these appliances, up to the maximum amount indicated in the Summary of Benefits.

Monitoring devices such as dextrometers, stethoscopes, sphygmomanometers or other devices of similar nature are not covered, unless specified in the present benefit;

xi) Purchase of breast prostheses, up to the maximum specified in the Summary of Benefits;

xii) Purchase of medium or high compression support hose (more than 20 mm/Hg) due to a venous or lymphatic system deficiency, up to the maximum amount indicated in the Summary of Benefits;

xiii) Room and board charges made in a facility licensed to provide rehabilitative or convalescent care provided:

i) the insured person is under the regular supervision of a physician or registered nurse;

ii) the confinement was recommended by a physician;

iii) the confinement is for rehabilitative or convalescent care.

However, there will be no coverage if the rehabilitative or convalescent care is for drug or alcohol abuse or addiction.

xiv) Cost of orthopedic shoes and deep shoes for which the medical necessity of was determined by a health practitioner operating within the scope of his license and which have been custom made, modified or custom molded for the insured person by a certified specialist in orthopedic footwear;

xv) Cost of foot orthoses for which the medical necessity of was determined by a health practitioner operating within the scope of his license and which have been specifically designed and constructed for the insured person by a certified specialist in foot orthoses. Off the shelf foot orthoses which have not been specifically designed and constructed for the insured person will not be eligible for coverage;

xvi) Cost of laboratory analyses, electrocardiograms, electro-encephalograms, nuchal scans, prenatal screening tests, radiation treatments, gastro-intestinal diagnostic programs and x-rays, performed in a commercial establishment or a private clinic, up to the maximum indicated in the Summary of Benefits;

xvii) Rental or purchase of braces with rigid support; back supports; shoulder harnesses; head halters and cervical collars;

xviii) Purchase or rental of crutches, as previously approved by the insurer, and purchase of hernial belts, corsets, splints and casts;

xix) Glasses, contact lenses or intraocular lenses following cataract surgery, up to the maximum indicated in the Summary of Benefits;

xx) Purchase of wigs required following chemotherapy or following total loss from alopecia totalis, up to the maximum indicated in the Summary of Benefits;

xxi) Fees for sclerosing injections that are medically required, up to the maximum indicated in the Summary of Benefits;

xxii) Purchase of diabetic monitoring equipment other than the insulin supplies such as needles, syringes, lancets and diagnostic testing materials;

xxiii) The daily cost of room and board in a recognized clinic, located in Canada or the United States, specializing in rehabilitation for alcoholism and other drug addiction where the patient actually receives curative treatment, up to the maximums indicated in the Summary of Benefits. The clinic must be run by a physician and under the constant supervision of a registered nurse. This benefit applies only to the participant;

xxiv) Purchase of blood and blood plasma.

b) Dental care given out of hospital by a dentist which is required as a result of accidental injury to whole, healthy, natural teeth, provided

i) the accidental injury occurs while the insured person is covered under this benefit;

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

iii) the charges do not exceed the amount shown for the treatment in the current provincial fee schedule for general practitioners in the participant's province of residence; and

iv) the care is received within 6 months of the date of the accidental injury.

Any charges for dental care which is not related to the accidental injury will not be covered.

c) Fees for the care 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.

X-ray fees of a chiropractor, osteopath, podiatrist (chiropodist) and acupuncturist, up to the maximum indicated in the Summary of Benefits.

d) 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 audiologist.

If the total cost of the expenses to be incurred is estimated to be more than $1,000, authorization must be obtained from the insurer prior to incurring such costs.

e) Cannabis for medical purposes, provided the cannabis is:

i) Prescribed by a physician; and

ii) Medically required; and

iii) Obtained in compliance with all the requirements of the Access to Cannabis for Medical Purpose Regulations; and

iv) Purchased after being pre-authorized by the insurer. To request pre-authorization, 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 it.

f) The eye examinations expenses are reimbursable, if mentioned in the Summary of Benefits, when prescribed by an ophthalmologist or an optometrist.

g) The following expenses are reimbursable, if mentioned in the Summary of Benefits, when prescribed by an ophthalmologist or an optometrist:

Eyeglasses (frame and corrective lenses), excluding sunglasses or safety glasses, or contact lenses, at the option of the insured person, up to the maximums specified in the Summary of Benefits;

Contact lenses, when medically required, up to the maximum specified in the Summary of Benefits, if applicable, provided that:

i) these lenses have been prescribed for a keratoconus (conical cornea) or as a result of surgery;

ii) satisfactory correction of vision cannot be obtained with eyeglasses;

iii) the lenses are purchased within 12 months following the surgery.

EXCLUSIONS AND REDUCTIONS

a) This benefit does not cover:

i) Expenses which are or would normally be payable or reimbursable under a workers' compensation act, if a claim had been submitted;

ii) Expenses 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;

iii) Expenses resulting from injury or illness caused by civil unrest, insurrection or war, whether war be declared or not, participation in a riot or active service in the armed forces of any country;

iv) Expenses for an illness or injury resulting from the commission of or attempted commission of a criminal offence or provoking of an assault;

v) Surgery or treatment which is not medically required, and which is given for cosmetic purposes or for any reason other than curative;

vi) 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;

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

viii) 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;

ix) Care and services rendered free of charge or which would be free of charge were it not for insurance coverage or which are not chargeable to the insured person;

x) 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;

xi) Eye examination, except if specifically mentioned as being covered under this benefit;

xii) Purchase or rental of any comfort or massage apparatus, and of domestic accessories that are not exclusively for medical purposes, such as whirlpool baths, air purifiers, humidifiers, air conditioners and other similar devices;

xiii) Purchase of food or nutritional supplements;

xiv) The following products or drugs are not covered:

  i) products for esthetic or cosmetic care;

  ii) "natural" products;

  iii) artificial insemination products;

xv) Expenses for preventive immunization vaccines or the administration of serums, vaccines and injectable medications, except if mention is made that these expenses are covered under this benefit;

xvi) Expenses for contraceptives (other than oral), except if mention is made that these expenses are covered under this benefit;

xvii) Expenses 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;

xviii) Expenses for any contribution to the cost of drugs and pharmaceutical services which must be paid by the insured person under the Basic Prescription Drug Insurance Plan of Quebec;

xix) Services, supplies, tests or care required by a third party or received collectively;

xx) Expenses for any drugs which are considered lifestyle drugs such as, but not limited to, drugs for the treatment erectile dysfunction;

xxi) Care or treatments related to fertility or infertility;

xxii) Expenses for any drugs which are excluded from coverage by the insurer under the Dispensing Limitations provision of this benefit;

xxiii) Expenses 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;

xxiv) Expenses for any care or treatment received outside the province of residence 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;

xxv) Expenses 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; or

v) in the opinion of the insurer, does not meet the insurer's standards relevant to his professional conduct or practice; or

vi) 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.

b) 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.

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 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) 24 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 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.

CONVERSION PRIVILEGE

A participant whose coverage under the group policy is cancelled due to termination of:

a) his employment; or

b) his group membership,

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

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

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

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

WAIVER OF PREMIUMS

If premiums are waived under the article *Waiver of Premiums* of the participant's life insurance benefit, the participant is also entitled to waiver of premiums for the present benefit, under the same conditions.

Moreover, if the participant is not covered under the LIFE INSURANCE BENEFIT, the participant is entitled to waiver of premiums for the present benefit, subject however to all other provisions described under *Waiver of Premiums* of the LIFE INSURANCE BENEFIT.

Waiver of premiums of the present benefit terminates automatically on the date of termination of the present benefit

SUPPLEMENTAL HEALTH INSURANCE – EMERGENCY OUT OF PROVINCE ASSISTANCE

The services listed herein will be provided in connection with a medical emergency or personal emergency which occurs while the insured person is absent from his province of residence provided:

a) the insured person is covered by the Supplemental Health Insurance benefit at the time of the emergency;

b) the medical emergency or personal emergency occurs during the first 90 days of the insured person's absence from his province of residence, or if the absence is due to his attendance at an accredited educational institution on a full-time basis, the emergency occurs during the school year for which he is enrolled at the institution; and

c) the insured person's absence was due to business, a vacation or full-time attendance at an accredited educational institution; and

d) in case of a medical emergency, the emergency is covered under the Emergency Medical Expenses Incurred Outside the Province of Residence section of the Supplemental Health Insurance benefit.

The services will be provided by the insurer's Medical Assistance Service provider. The insured person will be required to contact the Medical Assistance Service provider to request the services in an emergency.

DEFINITION

As used in this benefit:

Member of the immediate family: The insured person's spouse, father, mother, child, brother or sister.

MEDICAL EMERGENCY ASSISTANCE SERVICES

The following services will be provided during a medical emergency:

a) 24 Hour Telephone Access

- The Medical Assistance Service provider will provide a 24 hour hotline, 365 days a year, staffed by multilingual co-ordinators to

connect the insured person to a network of specialists who will handle the emergency.

b) Medical Care

The Medical Assistance Service provider will:

- If the insured person is unable to locate a physician or hospital, provide a referral to a physician or an appropriate hospital;
- Upon request of the insured person, organize consultations with general practitioners or specialists in order to obtain the best medical care available in the area;
- Provide assistance with admittance to a hospital;
- Confirm to doctors and hospitals that the insured person's group policy will cover the insured person's medical expenses.

c) Medical Transportation

The Medical Assistance Service provider will:

- Arrange and pay for the transportation or transfer of the insured person by appropriate means to a hospital as recommended by the attending physician, and which the Medical Assistance Service provider agrees to;
- Arrange and pay for the return of the insured person to his residence or to a hospital near his residence after initial medical care has been provided, by an appropriate means of transportation, provided the return is medically necessary and permissible based on his medical condition. The Medical Assistance Service provider will arrange for the insured person's return using the most appropriate means of transportation: air ambulance, helicopter, commercial airline, train or ambulance.

d) Payment of Medical Expenses and Cash Advance

- The Medical Assistance Service provider will make the necessary arrangements to pay medical expenses which are covered under the Emergency Medical Expenses Incurred Outside of Province section of the Supplemental Health Insurance benefit;
- When necessary in order for the insured person to obtain needed medical treatment, the Medical Assistance Service provider will advance up to $10,000 (Canadian), after consultation with the insurer.

e) Return of Deceased

- Should the insured person die, the Medical Assistance Service provider will make all arrangements and pay all expenses associated with returning the body of the deceased person to the place of burial in his province of residence, up to a maximum of $3,000. Funeral expenses will not be covered.

f) Return of Dependent Children

- The Medical Assistance Service provider will organize the return of the insured person's dependent children under age 16 who are left unattended due to the hospitalization of the insured person. In addition, the Medical Assistance Service provider will arrange and pay for economy transportation for the children, with an escort if necessary, to their usual place of residence. If the return tickets are still valid, only the additional cost incurred for the return transportation, after deducting the value of the tickets, will be paid.

g) Return of an Insured Person or a Member of the Insured Person's Immediate Family

- The Medical Assistance Service provider will organize the return of the insured person and/or a member of the insured person's immediate family who has lost the use of his return ticket due to the insured person's hospitalization or death. The Medical Assistance Service provider will arrange and pay for economy transportation to return the insured person and/or member of the immediate family to his usual place of residence. If the return tickets are still valid, only the additional cost incurred for the return transportation, after deducting the value of the tickets, will be paid.

h) Visit from a Member of the Immediate Family

- The Medical Assistance Service provider will arrange and pay for round-trip economy class transportation for a member of the immediate family to visit the insured person if the person is hospitalized for at least 7 consecutive days and the attending physician feels that the visit would be beneficial to him.

i) Expenses for Commercial Accommodation and Meals

- When a return is delayed due to the hospitalization of an insured person for a period of more than 24 hours or because of an insured person's death, the expenses for commercial accommodation and meals incurred due to the delay by the insured person, by a member of the immediate family accompanying the insured person or visiting the insured person in accordance with h) will be reimbursed, subject to a daily maximum of $150 per person, and an overall maximum of $1,500.

  Receipts must be provided before reimbursement will be made by the Medical Assistance Service provider.

j) Vehicle Return

- The Medical Assistance Service provider will pay up to $1,000 to return the insured person's vehicle, either private or rental, to the insured person's residence or the nearest appropriate vehicle rental location.

k) Emergency Drugs

- Should an insured person require drugs for the treatment of a medical condition and such drugs are not available locally, the Medical Assistance Service provider will co-ordinate a search for the drugs and once located arrange for the delivery of the drugs. The insured person will be responsible for the cost of the drugs unless they are covered under the Supplemental Health Insurance benefit.

PERSONAL EMERGENCY TRAVEL ASSISTANCE SERVICES

The following services will be provided during a personal emergency:

a) Telephone Interpretation Service

- The Medical Assistance Service provider will provide the insured person with telephone interpretation services in most foreign languages.

b) Messages

- The Medical Assistance Service provider will relay a message, upon request, from the insured person to his home, office or elsewhere, or hold messages for the insured person or the members of his immediate family for up to 15 days.

c) Legal Assistance

- The Medical Assistance Service provider will assist the insured person in finding local legal aid when required, and will also help the insured person obtain a cash advance from his credit cards, family and friends, in order to pay for any bail or legal fees.

d) Travel Information

- The Medical Assistance Service provider will provide the insured person with travel information related to transportation, vaccinations and precautionary measures before, during and after the insured person's trip.

e) Lost Baggage or Travel Documents

- If the insured person loses or has his travel documents and/or baggage stolen, the Medical Assistance Service provider will help him contact the appropriate authorities.

EXCLUSIONS

The medical emergency assistance services provided under this benefit will be subject to the exclusions that are applicable to the Emergency Medical Expenses Incurred Outside the Province of Residence section of the Supplemental Health Insurance benefit.

LIABILITY

The Medical Assistance Service provider and insurer will not be held responsible for the provider's failure to provide medical assistance or for delays caused by strikes, civil wars, wars, invasions, intervention by enemy powers, hostilities (whether war is declared or not), rebellions, insurrections, acts of terrorism, military operations or coups, riots or uprisings, radioactive fallout, or any other situation beyond its control.

The doctors, hospitals, clinics, lawyers and other authorized practitioners or institutions to which the Medical Assistance Service provider directs insured persons are independent contractors and act on their own behalf and are not employees, agents or subordinates of the Medical Assistance Service provider or the insurer.

The Medical Assistance Service provider and the insurer are not responsible and assume no liability for the negligence or other acts or omissions by the doctors, hospitals, clinics, lawyers or other authorized practitioners or institutions to which the insured person is directed by the Medical Assistance Service provider.

REIMBURSEMENT

If a cash advance was made to cover a charge that had been made or a charge was paid, and the participant submits to the insurer such charge as a covered expense under the Supplemental Health Insurance benefit at a later date, the insurer will only reimburse the participant an amount, less that which was previously advanced or paid for such expense, subject to the deductible and reimbursement level that is applicable to the expense.

If a cash advance to cover an expense had been made or an expense had been paid and (i) such expense is not a covered expense under the Emergency Medical Expenses Incurred Outside the Province of Residence section of the Supplemental Health Insurance benefit or (ii) the amount advanced or paid was in excess of the insurer's responsibility under the group policy, the participant will be responsible for reimbursing the insurer the cash advancement or the excess amount, whichever is applicable, within 90 days of the insured person returning to his province of residence. Should the participant fail to pay back the cash advance or excess amount, the insurer will have the right to reduce future health claims or any other claims by the participant or his dependents under the group policy by the amount owing.

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.

PROTECTING PERSONAL INFORMATION

Industrial Alliance Insurance and Financial Services Inc. (hereafter "the Company") 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 Company recognizes and respects a person's right to privacy concerning his or her personal information.

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

Access to the file will be limited to the Company 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 Company, 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 Company has medical information about the participant which was not obtained directly from the participant, the Company 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 Company, 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

ANNEX - VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Policy No. 100004461 issued by Special Markets Solutions, a division of Industrial Alliance Insurance and Financial Services Inc.

If you elect to participate, you are covered for injuries sustained as the result of any accident anywhere in the world - 24 hours per day - on or off the job, for the Principal Sum amount you have selected. You may select any Principal Sum of insurance from a minimum of $25,000.00 to a maximum of $350,000.00 in units of $25,000.00.

You may also elect to insure your family. If you do not have children, your spouse will be insured for 60% of the amount you have selected for yourself. If you and your spouse have children, your spouse will be insured for 50% of the amount you have selected and each child (regardless of the number) will be insured for 10% of the amount you have selected for yourself. If you do not have a spouse, each child will be insured for 20% of the benefit you have selected for yourself subject to a maximum of $50,000.00 and to a maximum of $75,000.00 with respect to the Child Enhancement Benefit.

Accidental Death, Dismemberment and Specific Loss Indemnity

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

	% of Principal Sum
Life	100%
Both Hands or Both Feet or Entire Sight of Both Eyes	100%
One Hand and One Foot or One Hand and Entire Sight of One Eye	100%
One Foot and Entire Sight of One Eye or Speech and Hearing in both Ears	100%
One Arm or One Leg	75%
One Hand or One Foot or Entire Sight of One Eye or Speech or Hearing in both Ears	66 2/3%
Thumb and Index Finger of Either Hand or Four Fingers of Either Hand	33 1/3%
Hearing in One Ear	33 1/3%
All Toes of One Foot	25%
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%

ANNEX - VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Child Enhancement Benefit

With the exception of loss of life, all amounts provided under the Accidental Death, Dismemberment and Specific Loss Indemnity are doubled with respect to insured dependent children, subject to a maximum of $75,000.00.

Common Disaster Benefit ($700,000)

In the event of the accidental death of both the participant and his/her insured spouse, and provided benefits for such loss becomes payable in accordance with the policy as a result of the same accident, and both deaths occur within 90 days after the date of the accident, the Principal Sum applicable to the participant's insured spouse will be increased to the amount of the participant's Principal Sum. In no event will the amount payable under this part exceed $700,000.00.

Repatriation Benefit ($15,000)

If 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.

Spousal Retraining Benefit ($15,000)

If injury results in the loss of life of a participant, the Company will reimburse the spouse for the actual expenses 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.

Education Benefit ($10,000)

If injury results in loss of life of a participant, the Company will pay 5% of the principal sum to any dependent child who, on the date of the accident, was enrolled as a full-time student in any institution of higher learning beyond the secondary school level (not to exceed four years). If, at the time of loss, there are no dependent children eligible for the Education Benefit, the Company shall pay an additional amount of $2,500.00 to the designated beneficiary.

Day Care Benefit ($5,000)

If injury results in the loss of life of a participant, 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 four years) for each dependent child who is under 13 years of age and enrolled in a legally licensed day care centre on the date of the accident, or within the 12 months following.

Seat Belt Benefit

If 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 participant, insured spouse, or insured dependent child was driving or riding in a vehicle and wearing a properly fastened seat belt.

Hospital Indemnity Expense ($2,500)

A daily benefit, subject to the above-mentioned monthly maximum, will be payable when a participant, insured spouse, or insured dependent child 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 of the policy and begins while insurance is in force.

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.

Family Transportation Benefit ($15,000)

If injury results in confinement as an inpatient in a hospital, and such injury results in a loss being payable under the Accidental Death, Dismemberment and Specific Loss Indemnity, and the hospital is located at least 150 km from the participant's, insured spouse's, or insured dependent child's residence, 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 participant, insured spouse, or insured dependent child.

If transportation occurs in a vehicle or device other than one operated under a license for the conveyance of passengers for hire, then reimbursement of transportation expenses will be limited to a maximum of $0.35 per kilometre travelled.

Rehabilitation Benefit ($15,000)

If injury requires that the participant undergo special training in order to be qualified to engage in a special occupation in which the participant would not have engaged except for such injury, the Company will pay the reasonable and necessary expense incurred for such training. Provided such injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity.

Home Alteration and Vehicle Modification Benefit ($15,000)

If injury requires the use of a wheelchair to be ambulatory, the Company will pay the cost of alterations to the participant's, insured spouse's, or insured dependent child's principal residence and/or the cost of modification to one motor vehicle utilized by the participant, insured spouse, or insured dependent child. Provided such injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity.

Waiver of Premium

In the event a participant becomes totally disabled and the Waiver of Premium Benefit 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.

Conversion Option

Upon termination of active employment with the Policyholder, a participant may convert his/her insurance only (and not that of his/her insured spouse or insured dependent children) to an individual accident insurance plan, with no evidence of insurability, for an amount of principal sum equal to or lower 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.

ANNEX - VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

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.

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.

Termination of Insurance of an Insured

Coverage will immediately terminate on the earliest of:

A. For the participant: (a) the policy termination date; (b) the premium due date if the Policyholder fails to pay the participant's premium, except as a result of an inadvertent error; (c) the premium due date coinciding with or immediately following the date a participant attains age 75; (d) the premium due date next following the date a participant is ineligible for coverage.

B. For the insured spouse and/or insured dependent child: (a) the date such person becomes ineligible for coverage; and (b) the date the participant's insurance is terminated.

When Does This Insurance Not Apply?

- 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".

ANNEX - VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Beneficiary

Indemnity payable in the event of the loss of life of a Participant is payable to the beneficiary or beneficiaries designated in writing by the Participant on his enrollment card on file with the Policyholder, or if there is no such beneficiary designation with respect to the Participant, such indemnity is payable to the estate of the Participant. All other indemnities payable, including those payable for the insured Spouse and/or insured Dependent Children, are payable to the Participant, with the exception of indemnities payable under the following parts:

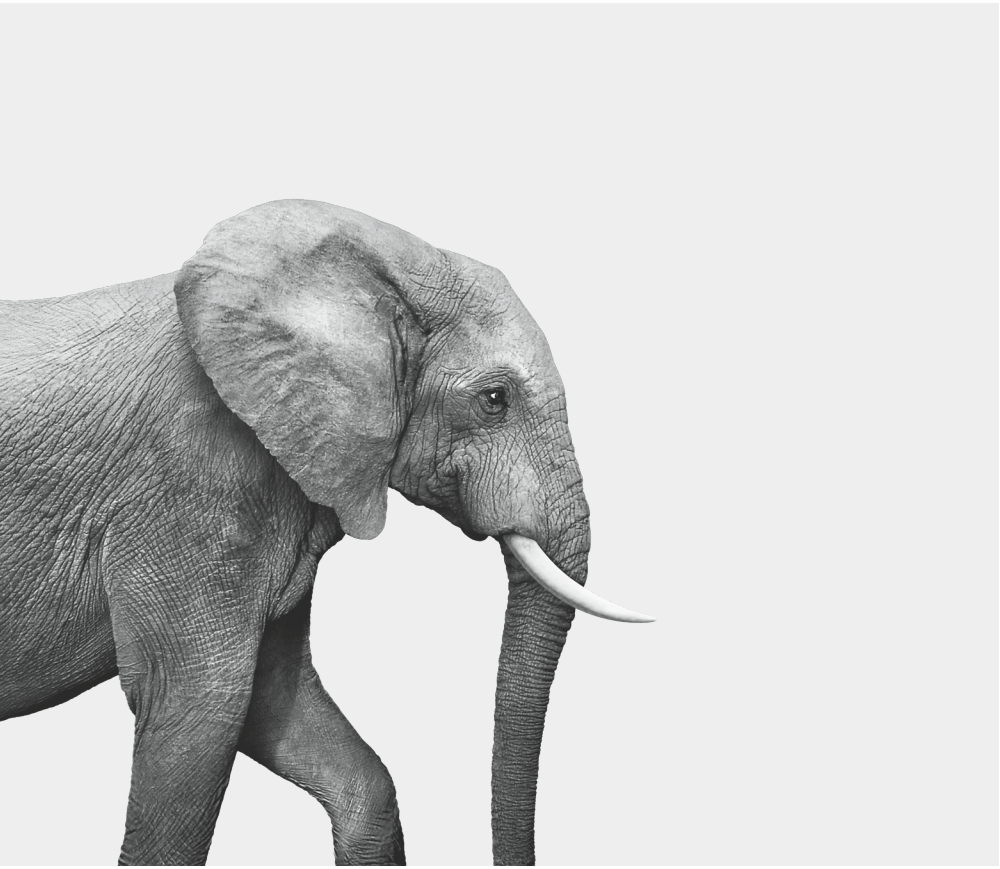
Day Care Benefit
Education Benefit
Family Transportation Benefit
Repatriation Benefit
Spousal Retraining Benefit

In the situation where the policy replaces an existing policy issued to the Policyholder, the beneficiary designation recorded under the replaced policy will be deemed to be valid and of full force and effect 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. This 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 Special Markets Solutions, a division of Industrial Alliance Insurance and Financial Services Inc., not this summary.

NOTES



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