

CHUBB

Critical Illness Program

For the employees of:
Mitel Networks Corporation

Policy Number:
CI10231801

Underwritten by:
Chubb Life Insurance Company of Canada

Effective Date:
10/01/16

This brochure has been prepared in connection with a group plan underwritten by Chubb Life Insurance Company of Canada (“Chubb Life”). For ease of reference it contains a brief description only and does not mention every provision of the contract issued. Please remember that rights and obligations are determined in accordance with the contract and not this brochure. For the exact provisions applicable, please consult your Employer.

ELIGIBILITY

You will be eligible for coverage if you are an active, permanent, full-time employee of the Policyholder working a minimum of 20 hours per week, under age 65.

Coverage can also be purchased by your spouse (legally married or a person who co-habits with you and has been represented as your domestic partner for a period of 1 year or longer in the community in which you reside and continues to be so represented) under age 65 or unmarried dependent children, including step, foster or legally adopted children who are under age 21, or under age 25, if the child is a full-time student and dependent on you or your spouse for financial support, or over age 21 if the child is dependent by reason of mental or physical infirmity and incapable of self-sustaining employment and dependent upon you or your spouse for financial support.

INSURED CONDITIONS

- Alzheimer's Disease
- Aorta Surgery
- Benign Brain Tumour
- Blindness
- Cancer
- Cancer Recurrence
- Coma
- Coronary Artery Bypass Surgery
- Deafness
- Dismemberment
- Heart Attack
- Heart Valve Replacement
- Loss of Independence
- Loss of Speech
- Major Organ Failure
- Major Organ Transplant
- Motor Neuron Disease
- Multiple Sclerosis
- Occupational HIV Infection
- Paralysis
- Parkinson's Disease
- Severe Burns
- Stroke

ADDITIONAL BENEFITS

- Ductal Carcinoma in situ (DCIS) Benefit
- Early Stage Prostate Cancer (T1a or T1b) Treatment
- Second Event Benefit

BENEFITS & COVERAGE

Optional Guaranteed Issue Plan

You and your spouse are eligible for \$10,000 to \$100,000 in units of \$5,000 of coverage with NO MEDICAL EVIDENCE. A pre-existing condition limitation provision is applied.

What Is a Pre-Existing Condition Limitation?

This means that we won't pay for a critical condition diagnosed in the first 2 years of coverage, if that diagnosis was directly or indirectly caused by an injury or

sickness you've received treatment, advice or a diagnosis on, in the 2 years just prior to your effective date of coverage.

Child Benefits:

You may also purchase coverage for your children in the amount of \$5,000 or \$30,000 in units of \$5,000 (in conjunction with enrollment of an employee and/or spouse). This covers all eligible dependent children you have.

COST OF INSURANCE FOR OPTIONAL COVERAGE

Premium payments will be administered through payroll deduction

Monthly Rates

Age Band	\$5,000/month Male		\$5,000/month Female	
	Non-smoker	Smoker	Non-smoker	Smoker
	Under 35	\$0.57	\$0.67	\$0.59
34 to 44	\$2.33	\$2.75	\$2.10	\$2.47
45 to 54	\$6.31	\$7.43	\$5.20	\$6.13
55 to 65	\$18.80	\$22.14	\$10.45	\$12.31

Monthly Rates for Children

Monthly Rate for \$5,000
\$0.75

BENEFIT PAYMENT

If an Insured is diagnosed with or meets the definition of an Insured Condition or a Partial Payment Benefit condition, after the effective date or latest reinstatement date of coverage, and survives a period of 30 days following the date of diagnosis, or such longer period of time set out in the description of the insured condition or Partial Payment Benefit condition, the insurer will pay the applicable benefit.

PARTIAL BENEFITS

Subject to the terms, conditions and other provisions of the policy, the insurer will pay the Partial Payment Benefit as set out below.

Please note that Partial Payment Benefits are not deemed to be Insured Conditions, nor do they fall under the category of Insured Conditions for the purposes of the Second Event Benefit.

Payment of a Partial Payment Benefit does not reduce eligible payment of a principal sum payment. Each Partial Payment Benefit is payable only once.

Ductal Carcinoma In Situ (DCIS)

“DCIS” means the diagnosis by a Physician, of the presence of Ductal Carcinoma In Situ of the breast, as confirmed by biopsy. A Physician certified as an oncologist must confirm the diagnosis in writing.

The insurer will pay 20% of the Principal Sum up to a maximum of \$20,000 if the insured is diagnosed with DCIS and survives 30 days thereafter.

Early Stage Prostate Cancer Treatment

“Early Stage Prostate Cancer (T1a or T1b Treatment” means the diagnosis by a Physician certified as an oncologist of Early Stage Prostate Cancer with one of the following recommended treatments: Prostate Surgery, Radiation Therapy, Chemotherapy, or Hormone Therapy

The insurer will pay 20% of the Principal Sum up to a maximum of \$20,000 if the Insured undergoes Early Stage Prostate Cancer (T1a or T1b) Treatment and the Insured survives 30 days thereafter.

No Partial Payment Benefit will be payable unless the Physician has recommended at least one of the above treatments.

Second Event Benefit

If an Insured Person is diagnosed with either of the following Category of Conditions:

- a. Cancer, or
- b. Cardiovascular Condition (defined as Heart Attack, Stroke, Coronary Artery Bypass, undergoes Aorta Surgery or Heart Valve Replacement)

for which the Principal Sum has been paid and an Insured is thereafter considered (by the treating physician) fully recovered and not actively receiving treatment and has returned to work for a period of at least 90 days and is then diagnosed with another Insured Condition, the Second Event benefit payable will be equal to the Principal Sum.

The Second Event Benefit is subject to the Insured surviving 30 days after the diagnosis of such Insured Condition. An insured spouse is considered eligible for a Second Event 90 days after the required treatment has finished and they have survived 30 days after the diagnosis of such Insured Condition, except as provided for under Cancer Recurrence.

In order to be considered an eligible Second Event condition the first event and the second event cannot fall into the same Category of Conditions, except as provided for under Cancer Recurrence.

The Second Event Benefit is payable only once. Payment of the Second Event Benefit will represent full and final discharge of all claims under the Second Event Benefit. Following Payment of the Second Event Benefit, coverage under the policy will terminate.

DEFINITIONS OF INSURED CONDITIONS

Alzheimer's Disease: means the diagnosis of Alzheimer's Disease, which is a progressive degenerative disease of the brain. The diagnosis must be supported by medical evidence that the Insured Person exhibits the loss of intellectual capacity resulting in impairment of their memory and judgment, which results in a significant reduction in their mental and social functioning, such that they require permanent daily personal supervision for the activities of daily living. All other dementing organic brain disorders and psychiatric illnesses are excluded from this insured condition definition. A physician who is certified as either a neurologist or a psychiatrist must confirm diagnosis in writing.

Aorta Surgery: means surgery to the aorta that is medically required to treat disease of the aorta and that involves the excision and surgical replacement of the diseased aorta with a graft. The Aortic Surgery must be performed on the prior written advice of a physician certified as a cardiovascular surgeon. Aorta includes the thoracic and abdominal aorta but does not include any of the branches of the aorta.

Benign Brain Tumour: means a benign neoplasm in the brain or meninges with histologic confirmation. Cysts, granulomas, malformations of intracranial arteries or veins, and tumours or lesions of the pituitary are specifically excluded. The diagnosis must be confirmed neuro-radiologically by a specialist trained in the interpretation of radiological investigations.

Blindness: means the total and irrecoverable loss of sight in both eyes due to injury or sickness. Corrected visual acuity must be 20/200 or less in both eyes and the field of vision must be less than 20 degrees in both eyes. A physician certified in ophthalmology, must clinically confirm the diagnosis in writing.

Cancer: means a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and invasion of tissue. This includes Leukemia, Hodgkin's Disease and invasive melanoma but does not include:

- Carcinoma in situ
- Kaposi's Sarcoma (or other AIDS related cancers) and cancer in the presence of human immunodeficiency virus (HIV).
- Skin cancer or melanoma that is not invasive and has not exceeded .75 millimeters in depth.
- Prostate cancer diagnosed as T1 N0M0 or equivalent staging.
- A recurrence or metastasis of a cancer which was originally diagnosed prior to the effective date of coverage, except as provided for under Cancer Recurrence.

A physician certified as an oncologist must confirm diagnosis in writing.

Cancer Recurrence means, if the insured person has already been diagnosed with Cancer and, while insured, a new diagnosis of Cancer is made, a benefit will be paid, subject to all the policy terms and provisions, if the following conditions have been met:

- More than 60 months have passed since the previous cancer diagnosis; and
- No Treatment relating directly or indirectly to cancer has been received within that 60 month period (treatment does not include preventive medications and follow up visits to the doctor).

Coma: means you have been in a state of unconsciousness for a continuous period of at least 96 hours, during which external stimulation produced no more than primitive avoidance reflexes. A physician who is certified as a neurologist must confirm diagnosis in writing.

Coronary Artery Bypass Surgery: means surgery performed by a physician who is certified as a cardiovascular surgeon to correct narrowing or blockage of one or more coronary arteries with bypass grafts. Non-surgical techniques such as balloon angioplasty, laser relief of an obstruction, or other intra-arterial techniques will not be considered to be a covered Critical Illness.

Deafness: means the diagnosis of permanent loss of hearing in both of your ears, with an auditory threshold of more than 90 decibels in each ear. A physician, who is certified as an otolaryngologist must confirm diagnosis in writing.

Dismemberment: 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. The diagnosis of Loss of Limbs must be made by a Specialist.

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

- a. heart attack symptoms; or
- b. new electrocardiogram (ECG) changes consistent with a heart attack; or
- c. development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

The diagnosis of Heart Attack must be made by a Specialist.

Exclusions: No benefit will be payable under this condition for:

- a. elevated biochemical cardiac markers with a:
 - i. Troponin Level of less than 1
 - ii. CK-Mb Level of less than 4, or
- b. ECG changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as described above.

Heart Valve Replacement: means undergoing surgery to replace any heart valve with either a natural or mechanical valve. The surgery must be determined to be medically necessary by a Specialist. **Exclusion:** No benefit will be payable under this condition for heart valve repair.

Loss of Speech: means the definite diagnosis of the total and irreversible loss of the ability to speak as the result of physical injury or disease, for a period of at least 180 days. The diagnosis of Loss of Speech must be made by a Specialist.

Loss of Independence: means the definitive diagnosis by a physician of either:

- Being totally and permanently unable to perform, by oneself, at least 2 of the 6 activities of daily living or,
- Cognitive impairment.

A mental or nervous disorder without a demonstrable organic cause is not covered. Loss of Independence must persist for a continuous period of 90 days from the date of the diagnosis with no reasonable chance of recovery as diagnosed by a physician.

Major Organ Failure: means the irreversible failure of the entire heart, entire liver, entire pancreas (pancreatic islet cell transplants are excluded) both lungs, both kidneys or bone marrow, in which the affected organ is unresponsive to any treatment and for which the Insured Person is medically required to become enrolled in a recognized Canadian transplant program to become the recipient of a heart, a liver, a pancreas, a lung, or a kidney or to receive a bone marrow 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 necessary. To qualify under Major Organ Transplant, the Insured Person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities. The diagnosis of the major organ failure must be made by a Specialist.

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
- Pseudo bulbar palsy

The diagnosis of Motor Neuron Disease must be made by a Specialist.

Multiple Sclerosis: means the unequivocal written diagnosis by a physician who is certified as a neurologist confirming at least one of the following:

- two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination; or
- well-defined neurological abnormalities lasting more than 6 months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination; or
- a single attack, confirmed by repeated MRI imaging of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart.

Occupational HIV Infection: means a definite diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Insured Person'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 effective date of the policy, the effective date of last reinstatement of the policy, or the Insured Person's effective date of coverage.

Payment under this condition requires satisfaction of all of the following:

- a. The accidental injury must be reported to the insurer within 14 days of the accidental injury;
- b. A serum HIV test must be taken within 14 days of the accidental injury and the result must be negative;
- c. A serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;
- d. All HIV tests must be performed by a duly licensed laboratory in Canada or the United States of America;
- e. The accidental injury must be reported, investigated and documented in accordance with current Canadian or United States of America workplace guidelines.
- f. The diagnosis of Occupational HIV Infection must be made by a Specialist.

Exclusions: No benefit will be payable under this condition if:

- The Insured Person has elected not to take any available licensed vaccine offering protection against HIV; or,

- A licensed cure for HIV infection is available prior to the accidental injury; or,
- HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use.

Paralysis: means the total and irrecoverable loss of function of two (2) or more limbs through neurological damage due to injury or sickness, provided such loss of function continually lasts for 180 consecutive days and such loss of function is thereafter determined on evidence satisfactory to the insurer to be permanent. A physician certified as a neurologist must confirm diagnosis in writing.

Parkinson's Disease: means unequivocal diagnosis of primary idiopathic Parkinson's Disease resulting in the inability to perform 3 of the 6 activities of daily living without assistance. Diagnosis should show signs of progressive impairment and must be confirmed in writing by a physician who is certified as a neurologist.

Severe Burns: means the Insured Person has third degree burns covering at least 20% of the surface area of their body. A physician who is certified as a plastic surgeon must confirm diagnosis of this condition in writing.

Stroke: means that the Insured Person has suffered a cerebrovascular incident, excluding transient ischemic attack (TIA), producing infarction of brain tissue due to thrombosis, hemorrhage from an intracranial vessel or embolization caused by an extracranial source. There must be evidence of permanent neurological deficit persisting for 30 consecutive days, supported by evidence that the deficit is resulting from the stroke, confirmed in writing by a physician who is certified as a neurologist.

CONTINUANCE OF COVERAGE

In the case of a Primary Insured who is (1) laid-off on a temporary basis, (2) temporarily absent from work due to short-term disability, or (3) on leave of absence, coverage shall be extended for a period of 12 months following the beginning of any such event subject to payment of premiums.

In the case of a Primary Insured who is on maternity or parental leave coverage shall be extended for a period of up to 18 months following the beginning of any such event subject to payment of premiums.

If an Insured assumes other occupational duties during the leave or lay-off period, no benefits shall be payable for a loss occurring during the performance of such other occupation.

WAIVER OF PREMIUM

If you are under age 65 and become totally disabled* while you are insured under this plan and satisfactory evidence of your total disability is provided to Chubb Life on an annual basis, payment of premium will be waived until the earlier of the following occurs:

- a. you return to active employment with your employer;
- b. you attain age 65;
- c. the master policy underwritten by Chubb Life is terminated.

Once you return to active employment with your employer, your coverage will continue only upon the commencement of premium payments.

*You will be considered totally disabled if you are unable to engage in any business or occupation and perform in any work for compensation or profit and your disability has existed continuously for a period of at least 12 months or is in accordance with the waiver of premium requirements under the Policyholder's Group Life Insurance Policy.

CONVERSION

On the date of termination of employment or during the 31 day period following termination of employment, an Insured may convert his or her coverage under this policy to an individual insurance policy of the insurer. The individual policy will be effective either as of the date that the insurer receives the application or on the date that coverage under the group policy ceases, whichever occurs later. The premium will be the same as an Insured would ordinarily pay when applying for an individual policy at that time. The amount of Critical Illness insurance benefit converted to shall not exceed that amount issued during employment up to an all policies combined maximum of \$25,000 maximum without medical evidence. The individual policy will cover the same conditions as those available under the group policy currently in force.

LIMITATIONS AND EXCLUSIONS

The plan does not provide benefits for any of the specified coverages caused directly or indirectly by or resulting from intentionally self-inflicted injury, suicide or any attempt thereat, while sane or insane; declared or undeclared war or any act thereof; injury or sickness, other than one of the specified insured conditions, even though such injury or sickness may have been complicated by one of the specified coverages; a complication of Human Immunodeficiency Virus (HIV) infection or any variance thereof including AIDS and AIDS Related Complex; the use, existence or escape of nuclear weapons, material or ionizing radiation from or contamination by radioactivity from any nuclear fuel or waste from the combustion of nuclear fuel; the commission or attempted commission by the Insured Person of any act which if adjudicated by a court would be an illegal act under the laws of the jurisdiction where the act was committed; misuse

of medication or the abuse of drugs or intoxicants; or a pre-existing medical condition except where coverage has been in effect for a period of 24 months following your or your covered dependent's effective date of coverage.

90 Day DCIS, Early Stage Prostate Cancer (T1a or T1b) Treatment and Cancer Exclusion

The insurer will not pay the Critical Illness Benefit for a diagnosis of DCIS, Early Stage Prostate Cancer (T1a or T1b) Treatment, and Cancer 90 days from the effective date, or latest reinstatement date of coverage.

In the event of a diagnosis within this 90 day DCIS, Early Stage Prostate Cancer (T1a or T1b) Treatment and Cancer exclusion period, coverage under this policy for the Insured will remain in force but DCIS, Early Stage Prostate Cancer (T1a or T1b) Treatment and Cancer will be a Pre-Existing Condition and the Critical Illness Benefit will not be payable. This 90 day DCIS, Early Stage Prostate Cancer (T1a or T1b) Treatment and Cancer Exclusion does not apply to a diagnosis of another Insured Condition or a subsequent diagnosis of an unrelated Cancer.

HOW TO CLAIM

You may obtain the required forms from your Plan Administrator.

Notice of claim must be given to the insurer within 30 days from the date of the accident, the beginning of the disability or after the survival period, and subsequent proof of claim must be submitted to the insurer within 90 days from the date of the accident or after survival period.

Failure to give notice of claim or furnish proof of claim within the time prescribed in the policy condition will not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible and if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed. In no event, will the insurer accept notice of claim beyond one year.

GENERAL PROVISIONS

Beneficiary

You or your covered spouse have the right to name a beneficiary when applying for insurance.

It is understood that the beneficiary designation made under the Policyholder's Group Life Insurance Policy shall be recognized as the beneficiary under this policy, unless a further designation has been made that specifically identifies the policy. Failing such designation, all benefits will be paid to the estate of the insured employee.

All other indemnities of the policy will be payable to the insured employee. An insured person can change his beneficiary at any time, where permitted by law. The insurer assumes no responsibility for the validity of such designation or change of beneficiary.

The beneficiary designation made by the insured person (if any) under the replaced policy has been retained. The insured person should review the existing designation to ensure it reflects his/her current intention.

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

Legal Actions

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, Limitations Act, 2002 or other applicable legislation in the Insured's province of residence.

Change of Insurer

An insured person under a former policy may not be excluded from the new policy or be denied benefits solely because of a pre-existing condition limitation that was not applicable or that did not exist in the former policy, or because the person is not at work on the date of coming into force of the new policy.

The insured person and any claimant under the policy has the right, as determined by law applicable in the insured person's province of residence, to obtain a copy of his/her application, any written evidence of insurability (as applicable) and the Policy, on request, subject to certain access limitations.

CHUBB

Chubb Life is part of the Chubb group of insurance companies, with operations in 54 countries. Chubb provides commercial and personal property and casualty insurance, personal accident and supplemental health insurance, reinsurance and life insurance to a diverse group of clients.

Chubb Limited, the parent company of Chubb Life, is listed on the New York Stock Exchange (NYSE: CB) and is a component of the S&P 500 index.