Class(es) 12
Full-time Employees of IHS MARKIT CANADA ULC who reside in Quebec

GROUP PLAN

Planholder: **IHS MARKIT CANADA ULC**

Plan No.: **27345**

Plan Effective Date: **April 1, 2021**

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

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

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

In addition, the Planholder reserves the right to change the contribution requirements for the coverages, including coverages for retirees, provided under the group plan at any time with respect to active Members (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 Member 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.

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

* MEMBER'S LIFE INSURANCE
* MEMBER'S OPTIONAL LIFE INSURANCE
* DEPENDENTS' LIFE INSURANCE
* SPOUSE'S OPTIONAL LIFE INSURANCE
* MEMBER'S OPTIONAL CRITICAL ILLNESS INSURANCE
* SPOUSE'S OPTIONAL CRITICAL ILLNESS INSURANCE
* CHILDREN'S OPTIONAL CRITICAL ILLNESS INSURANCE
* MEMBER'S ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE
* LONG-TERM DISABILITY INSURANCE

Appointment as Administrator

Industrial Alliance Insurance and Financial Services (hereinafter called the "insurer or Administrator") has been appointed by the Planholder to administer the following benefits provided under its Self-Insured Benefit Plan (hereinafter called the "group plan"),

* QUEBEC PRESCRIPTION DRUGS
* SUPPLEMENTAL HEALTH
* SUPPLEMENTAL HEALTH – EMERGENCY OUT OF PROVINCE ASSISTANCE
* DENTAL CARE

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SUMMARY OF BENEFITS

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

Members are covered under the following class(es):

Class(es)

12 - Full-time Employees of IHS MARKIT CANADA ULC who reside in Quebec

GENERAL PROVISIONS

ELIGIBILITY DATE

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

Class(es): 12

a) The effective date of the plan, if he is then an Employee;

or

b) On the Employee's first Working Day with the Employer.

ELIGIBILITY PERIOD

Class(es): 12

As per the Eligibility Date above.

PARTICIPANT'S LIFE INSURANCE

Class(es)	Sum Insured
12	2 times the Annual Earnings, the result being rounded to the next higher $1,000, if not already a multiple thereof. Maximum: $500,000 Minimum: $20,000

Reductions, Exclusions and Limitations:

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

Termination:

The insurance under this benefit terminates on the earliest of: the Member's 70th birthday; or his date of retirement; or such other earlier date indicated in this benefit or in the General Provisions of the group plan.

PARTICIPANT'S OPTIONAL LIFE INSURANCE

Classes	Sum Insured
12	Units of $10,000 Maximum $300,000

Reductions, Exclusions and Limitations:

All amounts of optional life insurance require evidence of health and are subject to the insurer receiving the required evidence of health and providing Approval of Evidence of Health in accordance with all of the terms and conditions of this benefit or in the General Provisions of the group plan.

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

Termination:

The insurance under this benefit terminates on the earliest of: the Member's 70th birthday; or his date of retirement; or such other earlier date indicated in this benefit or in the General Provisions of the group plan.

DEPENDENTS' LIFE INSURANCE

Class(es)		Sum Insured
12	Spouse:	$10,000
	Each Child upon a live birth:	$5,000

Reductions, Exclusions and Limitations:

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

Termination:

For each covered Dependent, the insurance under this benefit terminates on the earliest of: the Member's 70th birthday; or the Member's date of retirement; or such other earlier date indicated in this benefit or in the General Provisions of the group plan.

SPOUSE'S OPTIONAL LIFE INSURANCE

Class(es)		Sum Insured
12	Spouse:	Units of $10,000 Maximum: $300,000

Reductions, Exclusions and Limitations:

All amounts of optional life insurance require evidence of health and are subject to the insurer receiving the required evidence of health and providing Approval of Evidence of Health in accordance with all of the terms and conditions of this benefit or in the General Provisions of the group plan.

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

Termination:

For each covered Dependent, the insurance under this benefit terminates on the earliest of: the covered Dependent's 70th birthday; or the Member's date of retirement; or or such other earlier date indicated in this benefit or in the General Provisions of the group plan.

MEMBER'S OPTIONAL CRITICAL ILLNESS INSURANCE

Class(es)	Sum Insured
12	Units of $10,000 Maximum: $200,000

Reductions, Exclusions and Limitations:

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.

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

Termination:

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

SPOUSE'S OPTIONAL CRITICAL ILLNESS INSURANCE

Class(es)	Sum Insured
12	Units of $10,000 Maximum: $200,000

Reductions, Exclusions and Limitations:

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.

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

Termination:

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

CHILDREN'S OPTIONAL CRITICAL ILLNESS INSURANCE

Class(es)	Sum Insured
12	Units of $5,000 Maximum: $20,000

Reductions, Exclusions and Limitations:

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.

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

Termination:

For each insured Child, the insurance under this benefit terminates on the earliest of: the Member's 65th birthday; or the Member's date of retirement; or such other earlier date indicated in this benefit or in the General Provisions of the group policy.

PARTICIPANT'S ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Class(es)	Sum Insured
12	An amount equal to the Member's amount of life insurance.

Reduction, Exclusions and Limitations:

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

Termination:

The insurance under this benefit terminates on the earliest of: the Member's 70th birthday; or his date of retirement; or such other earlier date indicated in this benefit or in the General Provisions of the group plan.

LONG-TERM DISABILITY INSURANCE

Class(es)	**Monthly Indemnity**
12	60% of the first $2,750 of the Monthly Earnings, plus 55% of the following $3,750, plus 45% of the excess, the result being rounded to the next higher dollar, if not already a multiple thereof. Monthly maximum: $9,000 without Evidence of Health or $12,000 with Evidence of Health However, the overall maximum must not exceed 85% of the Pre-Total Disability Net Monthly Earnings.
Reductions, Exclusions and Limitations:	This benefit and any amounts payable thereunder are subject to any reductions, exclusions and limitations indicated in this benefit or in the General Provisions of the group plan.
Elimination Period:	**Class(es): 12** 26 consecutive weeks
Maximum Benefit Payment Period:	**Class(es): 12** To the Member's 65th birthday.

Class(es): 12

Benefit Payments are non-taxable.

LONG-TERM DISABILITY INSURANCE (cont'd)

Termination:

Class(es): 12

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

QUEBEC PRESCRIPTION DRUGS

(Addendum to Supplemental Health Coverage Applicable to Quebec Residents Only)

(eligible drugs as per the list of the *Régie de l'assurance maladie du Québec*)

Maximum Contribution for the Member and Spouse during the Calendar Year:

As stated under the *Act respecting prescription drug insurance* (R.S.Q., chapter A-29.01).

The Member's Maximum Contribution will include any amounts paid as a Deductible and/or Coinsurance for a Dependent Child.

Deductible:

As stated under the Supplemental Health benefit, subject to any maximum stated under the *Act respecting prescription drug insurance*.

Reimbursement by the Planholder:

As stated under the Supplemental Health benefit. However, if the level of Reimbursement is less than that provided by the *Act respecting prescription drug insurance*, the Reimbursement level will be as per the minimum Reimbursement level allowed.

Once the Maximum Contribution has been satisfied by the Member 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.

QUEBEC PRESCRIPTION DRUGS (cont'd)

Reductions, Exclusions and Limitations:

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

Termination:

The coverage under this benefit terminates on the earliest of: the Member's 65th birthday; or his date of retirement; or such other earlier date indicated in this benefit or in the General Provisions of the group plan, subject to the Special Provision for Covered Persons Age 65 and Over provision under this benefit.

SUPPLEMENTAL HEALTH - BRONZE OPTION

(This option is applicable only to those Members and their Dependents, if any, who elected to be insured under this option in accordance with the terms of the group plan.)

HOSPITALIZATION IN THE PROVINCE OF RESIDENCE

Class(es): 12

Deductible:	Reimbursement:	Daily maximum:
None	70%	Semi-private room rate
		Maximum per Covered Person: Unlimited

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

Class(es): 12

Deductible:	Reimbursement:	Maximum per Covered Person:
None	100%	$5,000,000 per lifetime for Members under age 70 and their Dependents. $1,000,000 per lifetime for Members age 70 and over and their Dependents.

OUT OF CANADA REFERRAL COVERAGE

Class(es): 12

Deductible:	Reimbursement:	Maximum per Covered Person:
None	50%	$50,000 per lifetime

SUPPLEMENTAL HEALTH - BRONZE OPTION (cont'd)

DRUGS

Class(es): 12

Deductible:	$3.60 for each prescription item or refill of a prescription item
Reimbursement:	80% to an out of pocket maximum of $4,500 per Insured Person per Calendar Year and 100% thereafter
Maximum :	Unlimited

ALL OTHER MEDICAL EXPENSES INCURRED IN CANADA

Class(es): 12

Deductible:	None
Reimbursement:	70%
Maximum:	Unlimited

Reductions, Exclusions and Limitations:

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

Termination:

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

SUPPLEMENTAL HEALTH - BRONZE OPTION (cont'd)

Medical Expenses

Covered Expenses	Maximums Per Covered Person
All covered expenses included under the Medical Expenses Incurred in Canada section of the Supplemental Health Insurance benefit, other than those listed below	Unlimited.
Preventive immunization vaccines	**Class(es): 12** Unlimited.
Drugs for the treatment of infertility	**Class(es): 12** $2,500 per lifetime.
Smoking cessation drugs	**Class(es): 12** $500 per lifetime.
Anti-addiction drugs	**Class(es): 12** Unlimited.
Contraceptive patches and contraceptive rings	**Class(es) : 12** Unlimited.
Intrauterine devices and diaphragms	**Class(es) : 12** Unlimited.
Sclerosing injections	**Class(es) : 12** $40 per Day.

SUPPLEMENTAL HEALTH - BRONZE OPTION(cont'd)

Medical Expenses (cont'd)

Covered Expenses	Maximums Per Covered Person
Injectable drugs and vitamins	**Class(es) : 12** Unlimited.
Over-the-counter muscle relaxants	**Class(es) : 12** Unlimited.
Fees for nursing care	**Class(es) : 12** $10,000 per Calendar Year.
Licensed ambulance service	**Class(es) : 12** Unlimited.
Room and board in a facility licensed to provide rehabilitative or convalescent care	**Class(es) : 12** $20 per Day; maximum of 180 Days per disability for all periods of confinement due to the same cause.
Room and board charges made by a chronic care Hospital	**Class(es) : 12** The difference in the cost of a ward and a private room, up to a maximum of $360 per Calendar Year.
Diagnostic laboratory tests	**Class(es) : 12** Unlimited.

SUPPLEMENTAL HEALTH - BRONZE OPTION(cont'd)

Medical Expenses (cont'd)

Covered Expenses	Maximums Per Covered Person
Medical imaging services	**Class(es) : 12** $1,000 per Calendar Year.
Medical appliances and supplies	**Class(es) : 12** Unlimited.
Oxygen, trusses and blood and plasma transfusions	**Class(es) : 12** Unlimited.
Radiotherapy and coagulotherapy	**Class(es) : 12** Unlimited.
Artificial prostheses	**Class(es) : 12** Unlimited.
Diabetic monitoring equipment (dextrometers, glucometers, reflectometers)	**Class(es) : 12** $700 per lifetime.
Continuous glucose monitors	**Class(es) : 12** $4,000 per Calendar Year.
Diabetic administrative equipment (insulin pumps)	**Class(es) : 12** Unlimited.
Breast prostheses	**Class(es) : 12** $200 per Calendar Year.

SUPPLEMENTAL HEALTH - BRONZE OPTION(cont'd)

Medical Expenses (cont'd)

Covered Expenses	Maximums Per Covered Person
Surgical brassieres	**Class(es) : 12** Maximum of 6 surgical brassieres per Calendar Year.
Medical elastic stockings	**Class(es) : 12** Maximum of 6 pairs per Calendar Year.
Orthopedic shoes (modified off the shelf custom made or custom molded)	**Class(es) : 12** $400 per Calendar Year.
Foot orthoses (custom made)	**Class(es) : 12** $400 per period of 24 consecutive months.
Contact lenses or intraocular lenses following cataract surgery	**Class(es) : 12** 1 lens per eye up to a maximum of $5,000 per lifetime.
Wigs (required as a result of Chemotherapy)	**Class(es) : 12** $300 per Calendar Year.
Speech aids	**Class(es) : 12** $1,000 per lifetime.

SUPPLEMENTAL HEALTH - BRONZE OPTION(cont'd)

Medical Expenses (cont'd)

Covered Expenses	Maximums Per Covered Person
Stump socks	**Class(es) : 12** Maximum of 6 pairs per Calendar Year.
Dental care as a result of accidental injury	**Class(es) : 12** Unlimited.
Hearing aids or any related devices	**Class(es) : 12** $500 per period of 36 consecutive months.
Eye examinations	**Class(es) : 12** $100 per period of 24 consecutive months.
Class(es): 12	
Fees for the following paramedical practitioners: Acupuncturist, Chiropractor [1], Massage Therapist, Naturopath, Osteopath [1], Physiotherapist and Speech Therapist	Maximum of $200 per Calendar Year for each practitioner. [1] Including 1 x-ray(s) for each practitioner.

SUPPLEMENTAL HEALTH - BRONZE OPTION(cont'd)

Medical Expenses (cont'd)

Covered Expenses	Maximums Per Covered Person
Fees for the following paramedical practitioners: Chiropodist (Applicable in Ontario and Saskatchewan only) [1] and Podiatrist [1]	Combined maximum of $200 per Calendar Year. [1] Including 1 x-ray(s) for all practitioners.
Overall combined maximum of $400 per Calendar Year for the above practitioners	
Fees for the following paramedical practitioners: Psychologist, Psychotherapist and Social Worker	Combined maximum of $1,000 per Calendar Year.

SUPPLEMENTAL HEALTH - SILVER OPTION

(This option is applicable only to those Members and their Dependents, if any, who elected to be insured under this option in accordance with the terms of the group plan.)

HOSPITALIZATION IN THE PROVINCE OF RESIDENCE

Class(es): 12

Deductible:	Reimbursement:	Daily maximum:
None	85%	Semi-private room rate
		Maximum per Covered Person: Unlimited

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

Class(es): 12

Deductible:	Reimbursement:	Maximum per Covered Person:
None	100%	$5,000,000 per lifetime for Members under age 70 and their Dependents.
		$1,000,000 per lifetime for Members age 70 and over and their Dependents.

OUT OF CANADA REFERRAL COVERAGE

Class(es): 12

Deductible:	Reimbursement:	Maximum per Covered Person:
None	50%	$50,000 per lifetime

SUPPLEMENTAL HEALTH - SILVER OPTION (cont'd)

DRUGS

Class(es): 12

Deductible:	$3.60 for each prescription item or refill of a prescription item
Reimbursement:	80% to an out of pocket maximum of $2,250 per Insured Person per Calendar Year and 100% thereafter
Maximum :	Unlimited

ALL OTHER MEDICAL EXPENSES INCURRED IN CANADA

Class(es): 12

Deductible:	None
Reimbursement:	85%
Maximum:	Unlimited

Reductions, Exclusions and Limitations:

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

Termination:

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

SUPPLEMENTAL HEALTH - SILVER OPTION (cont'd)

Medical Expenses

Covered Expenses	Maximums Per Covered Person
All covered expenses included under the Medical Expenses Incurred in Canada section of the Supplemental Health Insurance benefit, other than those listed below	Unlimited.
Preventive immunization vaccines	**Class(es): 12** Unlimited.
Drugs for the treatment of infertility	**Class(es): 12** $2,500 per lifetime.
Smoking cessation drugs	**Class(es): 12** $500 per lifetime.
Anti-addiction drugs	**Class(es): 12** Unlimited.
Contraceptive patches and contraceptive rings	**Class(es) : 12** Unlimited.
Intrauterine devices and diaphragms	**Class(es) : 12** Unlimited.
Sclerosing injections	**Class(es) : 12** $40 per Day.

SUPPLEMENTAL HEALTH - SILVER OPTION (cont'd)

Medical Expenses (cont'd)

Covered Expenses	Maximums Per Covered Person
Injectable drugs and vitamins	**Class(es) : 12** Unlimited.
Over-the-counter muscle relaxants	**Class(es) : 12** Unlimited.
Fees for nursing care	**Class(es) : 12** $10,000 per Calendar Year.
Licensed ambulance service	**Class(es) : 12** Unlimited.
Room and board in a facility licensed to provide rehabilitative or convalescent care	**Class(es) : 12** $20 per Day; maximum of 180 Days per disability for all periods of confinement due to the same cause.
Room and board charges made by a chronic care Hospital	**Class(es) : 12** The difference in the cost of a ward and a private room, up to a maximum of $360 per Calendar Year.
Diagnostic laboratory tests	**Class(es) : 12** Unlimited.

SUPPLEMENTAL HEALTH - SILVER OPTION (cont'd)

Medical Expenses (cont'd)

Covered Expenses	Maximums Per Covered Person
Medical imaging services	**Class(es) : 12** $1,000 per Calendar Year.
Medical appliances and supplies	**Class(es) : 12** Unlimited.
Oxygen, trusses and blood and plasma transfusions	**Class(es) : 12** Unlimited.
Radiotherapy and coagulotherapy	**Class(es) : 12** Unlimited.
Artificial prostheses	**Class(es) : 12** Unlimited.
Diabetic monitoring equipment (dextrometers, glucometers, reflectometers)	**Class(es) : 12** $700 per lifetime.
Continuous glucose monitors	**Class(es) : 12** $4,000 per Calendar Year.
Diabetic administrative equipment (insulin pumps)	**Class(es) : 12** Unlimited.
Breast prostheses	**Class(es) : 12** $200 per Calendar Year.

SUPPLEMENTAL HEALTH - SILVER OPTION (cont'd)

Medical Expenses (cont'd)

Covered Expenses	Maximums Per Covered Person
Surgical brassieres	**Class(es) : 12** Maximum of 6 surgical brassieres per Calendar Year.
Medical elastic stockings	**Class(es) : 12** Maximum of 6 pairs per Calendar Year.
Orthopedic shoes (modified off the shelf custom made or custom molded)	**Class(es) : 12** $400 per Calendar Year.
Foot orthoses (custom made)	**Class(es) : 12** $400 per period of 24 consecutive months.
Contact lenses or intraocular lenses following cataract surgery	**Class(es) : 12** 1 lens per eye up to a maximum of $5,000 per lifetime.
Wigs (required as a result of Chemotherapy)	**Class(es) : 12** $300 per Calendar Year.
Speech aids	**Class(es) : 12** $1,000 per lifetime.

SUPPLEMENTAL HEALTH - SILVER OPTION (cont'd)

Medical Expenses (cont'd)

Covered Expenses	Maximums Per Covered Person
Stump socks	**Class(es) : 12** Maximum of 6 pairs per Calendar Year.
Dental care as a result of accidental injury	**Class(es) : 12** Unlimited.
Hearing aids or any related devices	**Class(es) : 12** $500 per period of 36 consecutive months.
Eye examinations	**Class(es) : 12** $100 per period of 24 consecutive months.
Eyeglasses (including sunglasses and safety glasses), contact lenses or corrective laser surgery	
• Children under age 14	**Class(es) : 12** $150 per period of 12 consecutive months.
• Adults	**Class(es) : 12** $150 per period of 24 consecutive months.

SUPPLEMENTAL HEALTH - SILVER OPTION (cont'd)

Medical Expenses (cont'd)

Covered Expenses	Maximums Per Covered Person
Class(es): 12	
Fees for the following paramedical practitioners: Acupuncturist, Chiropractor [1], Massage Therapist, Naturopath, Osteopath [1], Physiotherapist and Speech Therapist	Maximum of $450 per Calendar Year for each practitioner. [1] Including 1 x-ray(s) for each practitioner.
Fees for the following paramedical practitioners: Chiropodist (Applicable in Ontario and Saskatchewan only) [1] and Podiatrist [1]	Combined maximum of $450 per Calendar Year. [1] Including 1 x-ray(s) for all practitioners.
Overall combined maximum of $900 per Calendar Year for the above practitioners	
Fees for the following paramedical practitioners: Psychologist, Psychotherapist and Social Worker	Combined maximum of $1,000 per Calendar Year.

SUPPLEMENTAL HEALTH - GOLD OPTION

(This option is applicable only to those Members and their Dependents, if any, who elected to be insured under this option in accordance with the terms of the group plan.)

HOSPITALIZATION IN THE PROVINCE OF RESIDENCE

Class(es): 12

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

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

Class(es): 12

Deductible:	Reimbursement:	Maximum per Covered Person:
None	100%	$5,000,000 per lifetime for Members under age 70 and their Dependents.
		$1,000,000 per lifetime for Members age 70 and over and their Dependents.

OUT OF CANADA REFERRAL COVERAGE

Class(es): 12

Deductible:	Reimbursement:	Maximum per Covered Person:
None	50%	$50,000 per lifetime

SUPPLEMENTAL HEALTH - GOLD OPTION (cont'd)

DRUGS

Class(es): 12

Deductible:	$3.60 for each prescription item or refill of a prescription item
Reimbursement:	80% to an out of pocket maximum of $2,250 per Insured Person per Calendar Year and 100% thereafter
Maximum :	Unlimited

ALL OTHER MEDICAL EXPENSES INCURRED IN CANADA

Class(es): 12

Deductible:	None
Reimbursement:	100%
Maximum:	Unlimited

Reductions, Exclusions and Limitations:

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

Termination:

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

SUPPLEMENTAL HEALTH - GOLD OPTION (cont'd)

Medical Expenses

Covered Expenses	Maximums Per Covered Person
All covered expenses included under the Medical Expenses Incurred in Canada section of the Supplemental Health Insurance benefit, other than those listed below	Unlimited.
Preventive immunization vaccines	**Class(es): 12** Unlimited.
Drugs for the treatment of infertility	**Class(es): 12** $2,500 per lifetime.
Smoking cessation drugs	**Class(es): 12** $500 per lifetime.
Anti-addiction drugs	**Class(es): 12** Unlimited.
Contraceptive patches and contraceptive rings	**Class(es) : 12** Unlimited.
Intrauterine devices and diaphragms	**Class(es) : 12** Unlimited.
Sclerosing injections	**Class(es) : 12** $40 per Day.

SUPPLEMENTAL HEALTH - GOLD OPTION (cont'd)

Medical Expenses (cont'd)

Covered Expenses	Maximums Per Covered Person
Injectable drugs and vitamins	**Class(es) : 12** Unlimited.
Over-the-counter muscle relaxants	**Class(es) : 12** Unlimited.
Fees for nursing care	**Class(es) : 12** $10,000 per Calendar Year.
Licensed ambulance service	**Class(es) : 12** Unlimited.
Room and board in a facility licensed to provide rehabilitative or convalescent care	**Class(es) : 12** $20 per Day; maximum of 180 Days per disability for all periods of confinement due to the same cause.
Room and board charges made by a chronic care Hospital	**Class(es) : 12** The difference in the cost of a ward and a private room, up to a maximum of $360 per Calendar Year.
Diagnostic laboratory tests	**Class(es) : 12** Unlimited.

SUPPLEMENTAL HEALTH - GOLD OPTION (cont'd)

Medical Expenses (cont'd)

Covered Expenses	Maximums Per Covered Person
Medical imaging services	**Class(es) : 12** $1,000 per Calendar Year.
Medical appliances and supplies	**Class(es) : 12** Unlimited.
Oxygen, trusses and blood and plasma transfusions	**Class(es) : 12** Unlimited.
Radiotherapy and coagulotherapy	**Class(es) : 12** Unlimited.
Artificial prostheses	**Class(es) : 12** Unlimited.
Diabetic monitoring equipment (dextrometers, glucometers, reflectometers)	**Class(es) : 12** $700 per lifetime.
Continuous glucose monitors	**Class(es) : 12** $4,000 per Calendar Year.
Diabetic administrative equipment (insulin pumps)	**Class(es) : 12** Unlimited.
Breast prostheses	**Class(es) : 12** $200 per Calendar Year.

SUPPLEMENTAL HEALTH - GOLD OPTION (cont'd)

Medical Expenses (cont'd)

Covered Expenses	Maximums Per Covered Person
Surgical brassieres	**Class(es) : 12** Maximum of 6 surgical brassieres per Calendar Year.
Medical elastic stockings	**Class(es) : 12** Maximum of 6 pairs per Calendar Year.
Orthopedic shoes (modified off the shelf custom made or custom molded)	**Class(es) : 12** $400 per Calendar Year.
Foot orthoses (custom made)	**Class(es) : 12** $400 per period of 24 consecutive months.
Contact lenses or intraocular lenses following cataract surgery	**Class(es) : 12** 1 lens per eye up to a maximum of $5,000 per lifetime.
Wigs (required as a result of Chemotherapy)	**Class(es) : 12** $300 per Calendar Year.
Speech aids	**Class(es) : 12** $1,000 per lifetime.

SUPPLEMENTAL HEALTH - GOLD OPTION (cont'd)

Medical Expenses (cont'd)

Covered Expenses	Maximums Per Covered Person
Stump socks	**Class(es) : 12** Maximum of 6 pairs per Calendar Year.
Dental care as a result of accidental injury	**Class(es) : 12** Unlimited.
Hearing aids or any related devices	**Class(es) : 12** $500 per period of 36 consecutive months.
Eye examinations	**Class(es) : 12** $100 per period of 24 consecutive months.
Eyeglasses (including sunglasses and safety glasses), contact lenses or corrective laser surgery	
• Children under age 14	**Class(es) : 12** $300 per period of 12 consecutive months.
• Adults	**Class(es) : 12** $300 per period of 24 consecutive months.

SUPPLEMENTAL HEALTH - GOLD OPTION (cont'd)

Medical Expenses (cont'd)

Covered Expenses	Maximums Per Covered Person
Class(es): 12	
Fees for the following paramedical practitioners: Acupuncturist, Chiropractor [1], Massage Therapist, Naturopath, Osteopath [1], Physiotherapist and Speech Therapist	Maximum of $700 per Calendar Year for each practitioner. [1] Including 1 x-ray(s) for each practitioner.
Fees for the following paramedical practitioners: Chiropodist (Applicable in Ontario and Saskatchewan only) [1] and Podiatrist [1]	Combined maximum of $700 per Calendar Year. [1] Including 1 x-ray(s) for all practitioners.
Overall combined maximum of $1,400 per Calendar Year for the above practitioners	
Fees for the following paramedical practitioners: Psychologist, Psychotherapist and Social Worker	Combined maximum of $1,000 per Calendar Year.

DENTAL CARE – BRONZE OPTION

(This option is applicable only to those Members and their Dependents, if any, who elected to be insured under this option in accordance with the terms of the group plan.)

Class(es)		
12	Deductible:	None
	Reimbursement:	
	– Preventive treatments:	80%
	– Basic treatments:	70%
	Maximum per Covered Person:	
	– Preventive and Basic treatments:	$1,000 per Calendar Year
	– Temporomandibular joint dysfunction (TMJ):	$1,000 per lifetime

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

Reductions, Exclusions and Limitations:

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

Termination:

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

DENTAL CARE - SILVER OPTION

(This option is applicable only to those Members and their Dependents, if any, who elected to be insured under this option in accordance with the terms of the group plan.)

Class(es)

12

Deductible: None

Reimbursement:

- Preventive treatments: 85%
- Basic treatments: 85%
- Major treatments: 50%
- Orthodontic treatments: 50%

Maximum per Covered Person:

- Preventive, Basic, and Major treatments: $1,500 per Calendar Year
- Temporomandibular joint dysfunction (TMJ): $1,000 per lifetime
- Orthodontic treatments: $1,500 per lifetime

ORTHODONTIC TREATMENTS are limited to Dependent Children under 20 years of age.

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

Reductions, Exclusions and Limitations:

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

DENTAL CARE - SILVER OPTION (cont'd)

Termination:

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

DENTAL CARE - GOLD OPTION

(This option is applicable only to those Members and their Dependents, if any, who elected to be insured under this option in accordance with the terms of the group plan.)

Class(es)

12

Deductible: None

Reimbursement:

- Preventive treatments: 100%
- Basic treatments: 100%
- Major treatments: 60%
- Orthodontic treatments: 60%

Maximum per Covered Person:

- Preventive, Basic, and Major treatments: $2,500 per Calendar Year
- Temporomandibular joint dysfunction (TMJ): $1,000 per lifetime
- Orthodontic treatments: $2,500 per lifetime

ORTHODONTIC TREATMENTS are limited to Dependent Children under 20 years of age.

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

Reductions, Exclusions and Limitations:

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

DENTAL CARE - GOLD OPTION (cont'd)

Termination:

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

DEFINITIONS

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

Actively at Work means:

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

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

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

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

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

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

Covered Person means a Member or a Dependent of a Member who is covered under the group plan.

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

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

Dependent means the Member 's Spouse, or a Child of the Member or of the Spouse, who is covered under the group plan and who satisfies the following respective definitions:

a) Spouse

The person who is married to or is in a civil union with the Member, or the person designated by the Member, whom he declares publicly to be his Spouse and with whom he has been living on a permanent basis for at least 1 year.

A de facto separation of more than 3 months will result in the person no longer qualifying as the Member's Spouse for the purposes of the group plan.

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

b) Child

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

i) He is under 21 years of age; or

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

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

Earnings means:

Annual Earnings means the Member's annual remuneration as reported by the Planholder to the insurer or Administrator.

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

Weekly Earnings means the Member's Annual Earnings divided by 52.

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

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

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

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

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

Amount of Earnings to Be Used

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

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

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

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

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

Employee means a person who is actively employed by the Employer on a permanent, full-time basis for a minimum of 20 hours per week. If the Employer is a partnership or sole proprietorship, the partner or proprietor will be considered to be a Member if such person customarily works a regularly scheduled work week with the Employer on a permanent, full-time basis and for a minimum of 20 hours per week. Seasonal workers, contract workers and temporary workers are excluded from the definition of Employee.

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

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

Hospital means an institution which:

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

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

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

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

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

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

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

Member means an Employee who is covered under the group plan.

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

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

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

Travel Benefits means the following Supplemental Health benefits: Emergency Medical Expenses Incurred Outside the Province of Residence, and Emergency Out of Province Assistance, and Trip Cancellation Coverage, if included in the group plan.

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

CHANGES IN GOVERNMENT PLANS

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

Notwithstanding the preceding paragraph, the group plan will be modified to reflect any changes to the maximum insurable earnings as determined under the Employment Insurance Act. In addition, if either federal or provincial legislation mandates that the group plan provides a certain type or level of

coverage or the means of providing a certain type of coverage, the group plan will be deemed to have been amended to reflect the requirements of the legislation.

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

There will be no coverage under the group plan for any expenses related, directly or indirectly, to any medical services and/or supplies which would have been covered by a government sponsored plan or program if the Covered Person had not elected to receive the services and/or supplies on a private basis from a medical practitioner, medical facility, clinic or Hospital, whether private or public, unless the services and/or supplies are explicitly stated as being covered under the group plan.

INCONTESTABILITY

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

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

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

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

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

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

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

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

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

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

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

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

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

LAWFUL CURRENCY

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

COVERAGE ELSEWHERE

A Member who is eligible for Supplemental Health and/or Dental Care and whose Spouse is covered for comparable coverage may decline coverage under the group plan for such coverage.

The refusal of coverage under the group plan may be in respect of the Member and his Dependents or his Dependents only.

If the coverage under the Spouse's plan ceases because of termination of such plan or because eligibility for the coverage ceases, then application may be made to cover under the group plan those persons whose coverage has terminated.

The application must be made within 31 Days after termination of the coverage under the Spouse's plan and the coverage under the group plan shall be

effective on the Day following the date of termination of the coverage under the Spouse's plan.

AGENTS

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

ERRORS

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

a) Continue coverage otherwise validly terminated.

b) Increase any existing coverage.

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

d) Otherwise prejudice the Planholder in any other way.

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

a) Terminate or rescind any such associated coverage.

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

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

ELIGIBILITY

Employee

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

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

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

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

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

However, an Employee will not be eligible to become covered under the Long-Term Disability benefit if he will attain the termination age specified for this benefit in the Summary of Benefits before the end of the Elimination Period specified for this benefit.

Dependents

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

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

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

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

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

APPLICATION FOR GROUP COVERAGE

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

If the Employee fails to indicate which Option is applicable to him and to his Dependents, the Employee and his Dependents will be covered under Silver Option.

EFFECTIVE DATE OF COVERAGE

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

However:

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

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

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

TERMINATION OF COVERAGE

Member

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

a) The date the group plan is terminated; or

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

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

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

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

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

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

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

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

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

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

Dependents

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

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

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

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

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

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

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

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

CHANGES IN AMOUNT OF COVERAGE

Member

(1) With respect to any changes in the Member's amount of coverage, other than a change in his Supplemental Health/Dental Care Option:

A change which would result in a decrease in the Member's coverage will become effective on the date of the change.

A change which would result in an increase in the Member's coverage will become effective on the latest of the following dates:

a) The date of the event, or

b) The date on which the Administrator receives and provides Approval of Evidence of Health, when such evidence of health is required.

However, if the Member is not Actively at Work on the date the increase in coverage is to become effective, the increase will not become effective until the earliest date thereafter on which the Member is again Actively at Work.

(2) With respect to any changes in the Member's Supplemental Health/Dental Care Option:

A change in the Member's Supplemental Health/Dental Care Option may only take place on a Re-enrollment Date, unless such change is due to a Life Event.

A Member may change his Supplemental Health/Dental Care Option on a Re-enrollment Date by completing and signing the form supplied by, or satisfactory to, the Company. If he fails to complete such form on or prior to the Re-enrollment Date, he will not be able to change his

Supplemental Health/Dental Care Option until the next Re-enrollment Date, unless the Member experiences a Life Event.

A Member may change his Supplemental Health/Dental Care Option if he experiences a Life Event provided he completes an application for the change within 31 Days of the Life Event. The change in the Member's Supplemental Health/Dental Care Option will take effect on the latter of the date the Life Event occurred and the date the application is completed. If the application is not completed within the 31 Days, the Member will not be able to change his Supplemental Health/Dental Care Option until the next Re-Enrollment Date.

The Member may only change his Supplemental Health/Dental Care Option from the Gold Option provided he had been covered under the Gold Option for at least 2 years.

Note: Supplemental Health and Dental Care Options are tied together (i.e. if a Member elects the Bronze Option then he will be under the Bronze Option for both Supplemental Health and Dental Care).

As used above:

Re-enrollment Date means April 1, 2022, and each anniversary of April 1st thereafter.

Life Event means marriage, divorce, separation, co-habiting with an individual for the required time for the individual to be considered a spouse, birth, death of a dependent, a change in the spouse's employment status or a change in the spouse's coverage status under his group policy.

Dependents

(1) With respect to any change in the amount of a Dependent's insurance, other than a change in the Supplemental Health/Dental Care Option the Dependent is covered under

A change which would result in a decrease in the Dependent's coverage will become effective on the date of the change.

A change which would result in an increase in the Dependent's coverage will become effective on the latest of the following dates:

a) The date of the event, or

b) The date on which the Administrator receives and provides Approval of Evidence of Health, when such evidence of health is required.

However, if the Dependent is Hospitalized on the date the increase in coverage is to become effective, the increase will not become effective until the earliest date thereafter on which he is no longer Hospitalized. (This paragraph shall not apply to postpone the effective date of an increase in the coverage of a newborn Child.)

(2) With respect to a change in the Supplemental Health/Dental Care Option the Dependent is covered under

A change in the Supplemental Health/Dental Care Option which the Dependent is covered under will take effect on the date the change in the Supplemental Health/Dental Care Option with respect to the Member of whom he is a Dependent takes effect.

NOTICE AND PROOF OF CLAIM

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

- **Supplemental Health and Dental Care:**

  Notice and proof of any claim must be submitted to the insurer or Administrator within 12 months of the date of the event which gives entitlement to the benefit.

- **Life and Accidental Death and Dismemberment:**

  Notice of any claim must be submitted within 30 Days of the date of the event which gives entitlement to the benefit. Proof of claim must be submitted within 90 Days of the date of the event which gives entitlement to the benefit.

- **Critical Illness:**

  Notice of any claim must be submitted within 30 Days of the occurrence of the covered condition or surgery, unless specified otherwise under the Critical Illness Coverage benefit. Proof of claim must be submitted within 90 Days of such occurrence or surgery unless specified otherwise under the Critical Illness Coverage benefit.

- **Long-Term Disability:**

  Notice and proof of any claim must be submitted within 30 Days of the end of the Member's Elimination Period.

NOTICE AND PROOF OF CLAIM IN CASE OF TERMINATION

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

In the event of the termination of the group plan or the termination of the Member's insurance, the notice and proof of claim for any claim other than a Long-Term Disability claim, must be submitted to the insurer within 90 Days of the date of the termination of the group plan and, in the case of the termination of the Member's insurance, within 90 Days of the termination of such insurance.

Notice and proof of claim for a Long-Term Disability claim must be submitted within 180 Days of the date of the termination of the group policy and, in the case of the termination of the Member's insurance, within 90 Days of the termination of such insurance.

FRAUDULENT CLAIMS

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

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

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

APPEAL PROCESS

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

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

EXPENSES

Unless the group plan expressly states otherwise, the Member is solely responsible for all expenses and costs related directly and indirectly to submitting a claim, proof of a claim, appeals of any kind, or any other obligation the Member has under the group plan, including but not limited to submitting any application or appeal, or obtaining any medical reports, clinical records, test results, or any other information.

BENEFICIARY

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

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

All benefits, other than the Participant's Life Insurance benefit, Participant's Accidental Death and Dismemberment Insurance benefit and Participant's Optional Life Insurance benefit, will be payable only to the Member, or if the Member is deceased at the time of the payment of the benefit, to his estate, unless otherwise indicated.

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

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

INSURER'S OR PLANHOLDER'S RIGHT TO EXAMINATION, RECORDS AND INVESTIGATION

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

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

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

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

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

SUBROGATION

Where a benefit is payable under the group plan with respect to a Member or to a Dependent of a Member and if such person has a right to recover damages from an individual or organization, the insurer or Planholder will be subrogated to the rights to recovery of the Member or Dependent against such individual or organization to the extent of all benefits paid in the past and all benefits payable in the future.

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

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

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

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

Where the Member or Dependent recovers damages in a lump sum, either by way of settlement or court order, and no allocation has been made in that settlement for the benefits paid or payable by the insurer or Planholder, the insurer or Planholder shall be reimbursed, out of the gross damages recovered, the full amount of benefits that have been paid to the Member or Dependent. The insurer or Planholder shall also be entitled to be reimbursed an amount, as determined by the insurer or Planholder, which reasonably reflects the value of the future benefits payable to the Member or Dependent under the group plan. The insurer's or Planholder's recovery in this regard shall not exceed the Member 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 Member or Dependent and the third party.

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

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

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

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

The insurer or Planholder shall also have the right to seek recovery directly from the Member or Dependent, or exercise any other right or remedy it may have

under the group plan or under the law, in the event that any overpayment has resulted from the lack of reimbursement.

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

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

OVERPAYMENT

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

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

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

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

LIMITATION ON LEGAL ACTIONS

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

No action or proceeding against the insurer 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 all of the terms and conditions of the group plan.

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

MEMBER'S LIFE INSURANCE

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

DEFINITIONS

As used in this benefit:

Total Disability and Totally Disabled means that, the Member is, due to an Illness or Accident, continuously unable to perform any Gainful Employment, as determined by the insurer.

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

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

a) The availability of any Gainful Employment; and

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

However, if the Member should be covered under the Long-Term Disability Insurance benefit under the group plan, the definitions of **Total Disability** and **Totally Disabled** shall be as defined under the Long-Term Disability Insurance benefit.

Gainful Employment means any occupation, any employment or any other activity for compensation or profit, for which the Member is reasonably qualified (or may so become) by training, education or experience, and from which the Member would be able to earn at least 60% of his Indexed Pre-Total Disability Gross Monthly Earnings.

CONVERSION PRIVILEGE

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

a) His employment; or

b) His group membership; or

c) The group plan and he has been continuously covered under a life insurance benefit provided by the Planholder 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 health.

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

a) Permanent; or

b) Term to age 65; or

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

The amount that can be converted to an individual life policy will include all amounts of life insurance that the Member 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 Member; or

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

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

d) $ 200,000 ($400,000 for Members living in the Province of Quebec).

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

The individual life policy will only be issued if the insurer receives a written request to that effect, together with a deposit covering the monthly premium for a one year term policy within 31 Days of the date of the termination of the Member's life insurance, and will take effect only at the expiration of that period.

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

WAIVER OF PREMIUMS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

   iii) The date on which the Member retires or reaches the normal retirement age under the Employer's pension plan, but never beyond 65 years of age; or

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

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

   vi) The date on which the Member pleads guilty or is found guilty of an offence for which he is confined in a penitentiary, prison,

correctional facility, forensic psychiatric facility or any similar institution; or

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

f) If on the date the waiver of premiums terminates with respect to the Member, he is not eligible to be covered under the Member's Life Insurance benefit, he will be eligible to exercise the Conversion Privilege as provided for under this benefit.

REDUCTIONS

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

TERMINATION

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

MEMBER'S OPTIONAL LIFE INSURANCE

A Member may obtain an amount of optional life insurance if he so requests it in writing to the insurer and furnishes evidence of health satisfactory to the insurer and the insurer provides Approval of Evidence of Health.

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

Upon the death of the Member while covered under this benefit, the insurer undertakes to pay the beneficiary the sum insured at the time of the Member's death, subject to all of the terms and conditions of this benefit and the group plan.

NON-SMOKER STATUS

If the insurer provides reduced premium rates for non-smokers, the Member must provide a non-smoker statement on his application card to receive such rates.

Misrepresentation of Non-Smoker Status

A Member who states that he is a non-smoker on his application card or on his last evidence of health declaration, if it is more recent, when he is a smoker, will be considered to have made a misrepresentation.

If it is proven, after the Member's death, that he had made a misrepresentation, the optional life insurance benefit of the Member will become null and void and no optional life insurance will be payable under this benefit.

Proof of Status

The insurer reserves the right to request new proof of the Member's non-smoker status each time evidence of health may be required.

EXCLUSIONS

If a Member commits suicide, regardless of any impairment, Illness, or state of mind, less than 24 months after the date his insurance under this benefit commenced, no benefit will be payable by the insurer. The insurer will refund to the beneficiary the premiums paid in respect of the Member's Optional Life

Insurance and such refund will constitute a full discharge of the insurer's liability under this benefit.

The 24 month period starts anew on the date:

a) The Optional Life Insurance is reinstated; or

b) The Optional Life Insurance amount is increased at the Member's request, but only for the additional amount of insurance.

ADDITIONAL PROVISIONS

Any provisions of the Member's Life Insurance benefit which are not inconsistent with the provisions of this benefit will form part of this benefit.

REDUCTIONS

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

TERMINATION

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

DEPENDENTS' LIFE INSURANCE

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

WAIVER OF PREMIUMS

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

CONVERSION PRIVILEGE

A Member whose Spouse's life insurance under this benefit is cancelled on or prior to the earlier of his 65th birthday or his Spouse's 65th birthday, due to the termination of:

a) His employment; or

b) His group membership; or

c) The group plan and his Spouse had been continuously covered under a Dependents' Life Insurance benefit provided by the Planholder for at least 5 years.

will be able to convert all or part of his Spouse's life insurance to an individual life insurance plan without having to provide evidence of health.

A Spouse whose life insurance under this benefit is cancelled on or prior to the earlier of his 65th birthday or the 65th birthday of the Member, due to the death of the Member, will be able to convert all or part of his life insurance to an individual life insurance policy without having to provide evidence of health.

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

a) Permanent; or

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 life policy will include all amounts of life insurance and optional life insurance that the Spouse is covered for under the group plan, and any other group insurance policy issued by the insurer, and will not exceed the lesser of:

a) The amount selected by the Member or the Spouse, if applicable; or

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

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

d) $200,000 ($400,000 for Members living in the Province of Quebec).

The individual life policy will not include a disability benefit nor an accidental death and dismemberment benefit and the premiums will 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 life policy will only be issued if the insurer receives a written request to that effect, together with a deposit covering the monthly premium for a one year term policy, within 31 Days of the date of the termination of the Spouse's life 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 life insurance, the insurer shall pay an amount equal to that which could have been converted to the Member, or the Member's estate if he is no longer living, whether or not application had been made for the individual life policy.

REDUCTIONS

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

TERMINATION

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

SPOUSE'S OPTIONAL LIFE INSURANCE

A Member may obtain an amount of optional life insurance on his Spouse if he so requests it in writing to the insurer and furnishes evidence of health satisfactory to the insurer and the insurer provides Approval of Evidence of Health.

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.

Upon the death of the Spouse while covered under this benefit, the insurer undertakes to pay to the Member the sum insured at the time of death, subject to all of the terms and conditions of this benefit and the group plan.

WAIVER OF PREMIUMS

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

CONVERSION PRIVILEGE

A Member whose Spouse's optional life insurance under this benefit is cancelled on or prior to the earlier of his 65th birthday or his Spouse's 65th birthday, due to the termination of:

a) His employment;

b) His group membership; or

c) The group plan and his Spouse had been continuously covered under a Dependents' Life Insurance benefit provided by the Planholder for at least 5 years,

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

A Spouse whose optional life insurance under this benefit is cancelled on or prior to the earlier of his 65th birthday or the 65th birthday of the Member, due to the death of the Member, will be able to convert all or part of his life insurance to an individual life insurance policy without having to provide evidence of health.

SPOUSE'S OPTIONAL LIFE INSURANCE (cont'd)

The Member or Spouse, if applicable, will be able to convert the optional life insurance to one of the following types of insurance:

a) Permanent; or

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 life policy will include all amounts of life insurance and optional life insurance that the Spouse is covered for under the group plan, and any other group insurance policy issued by the insurer and will not exceed the lesser of:

a) The amount selected by the Member or the Spouse, if applicable; or

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

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

d) $200,000 ($400,000 for Members living in the Province of Quebec).

The individual life policy will not include a disability benefit nor an accidental death and dismemberment benefit and the premiums will 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 life policy will only be issued if the insurer receives a written request to that effect, together with a deposit covering the monthly premium for a one year term policy, within 31 Days of the date of the termination of the Spouse's optional life 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 life insurance, the insurer shall pay an amount equal to that which could have been converted to the Member, or the Member's estate if he is no longer living, whether or not application had been made for the individual life policy.

NON-SMOKER STATUS

If the insurer provides reduced premium rates for non-smokers, the Spouse must provide a non-smoker statement on the application card to receive such rates.

Misrepresentation of Non-Smoker Status

A Spouse who states that he is a non-smoker on the application card or on his last evidence of health declaration, if it is more recent, when he is a smoker, will be considered to have made a misrepresentation.

If it is proven, after the Spouse's death, that he had made a misrepresentation, the optional life insurance of the Spouse will become null and void and no optional life insurance will be payable under this benefit.

Proof of Status

The insurer reserves the right to request new proof of the Spouse's non-smoker status each time evidence of health may be required.

EXCLUSION

If a Dependent covered for optional life insurance commits suicide, regardless of any impairment, Illness, or state of mind, less than 24 months after the date his Optional Life Insurance commenced under this benefit no benefit will be payable by the insurer. The insurer will refund to the Member the premiums paid in respect of such person and the refund will constitute a full discharge of the insurer's liability under this benefit.

The 24 month period starts anew on the date:

a) The Optional Life Insurance is reinstated; or

b) The Optional Life Insurance amount is increased at the Member's request, but only for the additional amount of insurance.

REDUCTIONS

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

SPOUSE'S OPTIONAL LIFE INSURANCE (cont'd)

TERMINATION

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

MEMBER'S OPTIONAL CRITICAL ILLNESS INSURANCE

A Member 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 Member will be the amount of insurance requested as provided for in the Summary of Benefits.

If the Member 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 Member 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 Member is no longer living, the payment will be made to the Member'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 Member 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 Member became insured under this benefit; or

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

c) The Member 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 Member became insured under this benefit, regardless of the date of the recurrence or metastases.

Once a Member 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 Member has received payment due to a covered condition or Surgery as a result of an injury, Accident, Illness or disease, the Member 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 Member should receive a simultaneous Diagnosis of multiple covered conditions or Surgeries, the insurer undertakes to pay to the Member 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 Member with one of the covered conditions or Surgeries.

Diagnosis means the certified Diagnosis of the Member 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 Member's Physician, medical or surgical treatment to improve the condition would present a risk to the Member's health which would outweigh the expected benefits of such treatment.

Life Support means the Member 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 Member, the Spouse, a relative, or a business associate of the Member.

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 Member'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 Member 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 Member became insured under this benefit or the last reinstatement date of a Member's coverage, such Member 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 Member 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 Heat 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 Member 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 Member 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 Bacteria 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 Member 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 Member became insured under this benefit or the last

reinstatement date of a Member's coverage, such Member 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 Member 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 Member became insured under this benefit, or the date of the last reinstatement of a Member'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 Member became insured under this benefit or the last reinstatement date of a Member's coverage, such Member 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 Member 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 Parkinson's 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 Member became insured under this benefit or the last reinstatement date of a Member's coverage, such Member 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 Member 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 Member 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 Member 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 Member'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 Member 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 Member 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 Member 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 Member 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 Member 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 Member 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 Member'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 Member became insured under this benefit or the last reinstatement date of a Member'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 Member 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 Member 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 Member 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 Member 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 Member was taking medication as prescribed by a Physician,

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

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

Exception to Pre-existing Condition

However, if the Member'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 Member 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 Member became insured under this benefit immediately following the date the critical illness benefit terminated under the previous group policy; and

c) The Member 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 Member 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 Member 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 Member 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 Member'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 Member will not be entitled to a covered condition or Surgery benefit for Cancer if, within the first 90 Days following the date the Member became insured under this benefit, the Member 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 Member.

b) Benign Brain Tumour

A Member 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 Member became insured under this benefit, the Member 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:

1. The covered condition or Surgery benefit will not be payable; and

iii) 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 Member.

c) Early Stage Cancer

A Member is not entitled to a covered condition or Surgery benefit for Early Stage Cancer if, within 90 Days following the date the Member became insured under this benefit, the Member 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 Member.

REDUCTIONS

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

TERMINATION

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

MEMBER'S OPTIONAL CRITICAL ILLNESS INSURANCE (cont'd)

EFFECT OF TERMINATION OF INSURANCE ON CLAIMS

Termination of this benefit or the termination of the Member'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 Member'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 Member'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 Member'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 Member'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 Member'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 Member's insurance.

g) For Major Organ Failure on Waiting List, the date the Member 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 Member'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 Member'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 Member'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 Member's insurance.

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 Member's insurance

SPOUSE'S OPTIONAL CRITICAL ILLNESS INSURANCE

A Member 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 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 Member.

ADDITIONAL PROVISIONS

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

REDUCTIONS

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

TERMINATION

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

CHILDREN'S OPTIONAL CRITICAL ILLNESS INSURANCE

A Member 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 Member.

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:

   iii) The date the Child became insured under this benefit; or

   iv) 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 Member, 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 Member, 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 Member, a relative or business associate of the Member.

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 Bacteria 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:

c) 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

d) 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:

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

d) 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,

e) **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.

f) 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;

g) 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.

h) 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:

c) 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

d) 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:

j) 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;

k) 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;

l) 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;

m) Prostate Cancer classified as T1a or T1b, without lymph node or distant metastasis;

n) 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;

o) 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;

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

q) 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

r) 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:

d) A medically induced Coma; or

e) A Coma which results directly from alcohol or drug use; or

f) 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:

Atresia of any heart valve;

Coarctation of the Aorta;

Double Inlet Ventricle;

Double Outlet Left Ventricle;

Ebstein's Anomaly;

Eisenmenger Syndrome;

Hypoplastic Left Heart Syndrome;

Hypoplastic Right Ventricle;

Single Ventricle;

Tetralogy of Fallot;

Total Anomalous Pulmonary Venous Connection;

Transposition of the Great Vessels;

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:

Pulmonary Stenosis;

Aortic Stenosis;

Discrete Subvalvular Aortic Stenosis;

Ventricular Septal Defect;

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:

e) Aphasia (a disorder of speech);

f) Apraxia (difficulty performing familiar tasks);

g) Agnosia (difficulty recognizing objects);

h) 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:

c) 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

d) 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:

d) Heart Attack symptoms;

e) New electrocardiogram (ECG) changes consistent with a Heart Attack;

f) 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:

d) ECG changes suggesting a prior myocardial infarction; or

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

f) Elevated cardiac biomarkers and/or symptoms that are due to medical procedures or diagnoses other than Heat 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:

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

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

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

j) **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;

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

l) **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:

d) 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

e) 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

f) 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:

c) 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

d) 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:

f) Solitary sclerosis; or

g) Clinically isolated syndrome; or

h) Radiologically isolated syndrome; or

i) Neuromyelitis optica spectrum disorders; or

j) 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:

2. The accidental injury must be reported to the insurer within 14 Days of the accidental injury; and

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

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

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

j) 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:

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

A licensed cure for HIV infection has become 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

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:

> 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.
>
> Specified Atypical Parkinson's 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:

> 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
>
> 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:

Acute onset of new neurological symptoms, and

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:

Transient Ischaemic Attacks; or

Intracerebral vascular events due to trauma; or

Ischaemic disorders of the vestibular system; or

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

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:

d) 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

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

f) 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 Member 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 Member's Employer.

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

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

b) Hang-gliding; or

c) Parachuting; or

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

e) Boxing; or

f) Bungee jumping; or

g) BASE jumping; or

h) Cliff diving; or

i) Mountain climbing.

LIMITATIONS

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 Member 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 Member, then applicable premiums paid for this benefit will be refunded.

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 Member 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 Member, then applicable premiums paid for this benefit will be refunded.

1. All Covered Conditions and Surgeries excluding Cancer and Benign Brain Tumour

A Child who is a natural Child of the Member 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:

A Diagnosis of a covered condition or Surgery; or

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.

CHILDREN'S OPTIONAL CRITICAL ILLNESS INSURANCE (cont'd)

REDUCTIONS

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

TERMINATION

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

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;

CHILDREN'S OPTIONAL CRITICAL ILLNESS INSURANCE (cont'd)

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.

MEMBER'S ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

If the Member suffers a Covered Loss of a type described in the Schedule of Amounts of Insurance provision of this benefit, the insurer undertakes to pay the percentage of the sum insured specified for the Covered Loss, subject to all of the terms and conditions of this benefit and the group plan.

The sum insured under this benefit will be as indicated in the Summary of Benefits.

Payment will be made to the Member, except in the case of the Loss of the Member's life in which case payment will be made to the Member's beneficiary.

DEFINITIONS

As used in this benefit:

Hemiplegia means the total paralysis of both the upper and lower limbs of one side of the body.

Loss means:

a) With regard to a hand or foot, the complete severance through or above the wrist or ankle joint but below the elbow or knee joint.

b) With regard to an arm or leg, the complete severance through or above the elbow or knee joint.

c) With regard to a thumb, the complete loss of one entire phalanx of the thumb.

d) With regard to a finger, the complete loss of two entire phalanges of the finger.

e) With regard to a toe, the complete loss of one entire phalanx of the big toe and all phalanges of the other toes.

f) With regard to an eye, the irrecoverable loss of the entire sight thereof.

g) With regard to speech, the complete and irrecoverable loss of the ability to utter intelligible sounds.

h) With regard to hearing, the complete and irrecoverable loss of hearing.

Loss of Use means the total and irrecoverable loss of use provided the loss of use is continuous for 12 consecutive months and such loss is determined to be permanent at the end of such period.

Paraplegia means the total paralysis of both lower limbs.

Quadriplegia means the total paralysis of both the upper and lower limbs.

CONDITIONS

Benefits are payable for the Covered Loss provided all of the following conditions are met:

a) The Covered Loss results directly and solely from an Accident and independently from all other causes; and

b) The Covered Loss occurs within 365 Days of the Accident; and

c) The Accident which resulted in the Covered Loss must have occurred while the Member was insured under this benefit; and

d) The Covered Loss is not excluded under the Exclusions provision of this benefit.

SCHEDULE OF AMOUNTS OF INSURANCE

Covered Losses:	**Percentage of Sum Insured**
• **Loss or Loss of Use of**	
– life; both hands; both feet; one hand and one foot; sight of both eyes; one hand and sight of one eye; one foot and sight of one eye; hearing in both ears and speech	100%
– one arm; one leg	80%

MEMBER'S ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (cont'd)

Covered Losses:	**Percentage of Sum Insured**
• **Loss or Loss of Use of**	
– one hand; one foot; sight of one eye; speech; hearing in both ears	75%
– thumb and index finger on one hand; four fingers on one hand; hearing in one ear	40%
– all toes on one foot	33 1/3%
• **Quadriplegia, Paraplegia, or Hemiplegia**	200%

BEREAVEMENT EXPENSES

If a Member, while insured under this benefit, should sustain an accidental Loss of life and a benefit is payable under this benefit for such Loss, the insurer will reimburse the reasonable and necessary expenses actually incurred by the Spouse and Dependent Children for up to 6 sessions of grief counselling by a professional counsellor, up to a maximum of $2,500.

BRAIN DAMAGE

If a Member, while insured under this benefit, should suffer a Covered Loss for which a benefit is payable under this benefit, and as a result of such Covered Loss incurs brain damage, the insurer will pay the sum insured, less any amount paid or payable for the Covered Loss, provided:

a) The Member incurs brain damage within 120 Days from the date of the Accident; and

b) The Member is Hospitalized as a result at least 7 of the first 120 Days; and

c) A Physician determines, satisfactory to the insurer, that the Member has evidence of brain damage for at least 6 consecutive months.

DAYCARE EXPENSES

If a Member should suffer an accidental Loss of life for which a benefit is payable under this benefit, and his Dependent Child was enrolled in a Daycare Centre on the date of his death or is enrolled in a Daycare Centre within 365 Days of the date of his death, the person who is in loco parentis of such Child may apply, in a written notice deposited with the insurer, to receive a benefit to cover the reasonable and necessary expenses incurred as a result of such enrollment.

Benefit payments will be made by the insurer each year the Dependent Child is enrolled in the Daycare Centre but not beyond the year in which:

a) The Dependent Child attains his 12th birthday; or

b) 4 yearly benefit payments have been made,

whichever occurs first.

The first benefit payment will be made on the latter of the date on which the Loss of life benefit with respect to the Member becomes payable under this benefit and the date on which the insurer receives proof that the Dependent Child is enrolled in a Daycare Centre. Subsequent benefit payments will be payable for each successive year on the date the insurer receives proof of the Dependent Child's enrollment in a Daycare Centre.

The amount of each benefit payment will be equal to 5% of the sum insured, up to a maximum of $5,000.

As used above:

- **Daycare Centre** means a centre that has been licensed by the appropriate provincial government authorities to provide day care services for children.

EDUCATIONAL EXPENSES

A Dependent of a Member who suffered an accidental Loss of life for which a benefit is payable under this benefit, may apply, in a written notice deposited

with the insurer, to receive a benefit to cover the expenses incurred as a result of continuing his education as a full-time student beyond the high school level, provided:

a) On the date of the death of the Member, the Dependent is enrolled as a full-time student at an educational institution which is beyond the high school level or if the Dependent was in high school at the time of the Member's death, that he enrolls as a full-time student at an educational institute which is beyond the high school level within 365 Days of the date of the death of the Member; and

b) Proof, satisfactory to the insurer, that the Dependent is a full-time student at an educational institute which is beyond the high school level is provided to the insurer upon request.

Benefit payments will be made by the insurer each year, up to a maximum of 4 successive years, with the first payment to be made on the latter of the date on which the Loss of life benefit with respect to the Member becomes payable under this benefit and the date on which the insurer receives proof that the Dependent is enrolled as a full-time student at an educational institute which is beyond the high school level. Subsequent benefit payments will be payable for each successive school year on the date the insurer receives proof of the Dependent's continuing enrollment as a full-time student in an educational institute which is beyond the high school level. The amount of each benefit payment will be equal to 5% of the sum insured, up to a maximum of $10,000.

If, at the time of Loss, none of the Dependent Children are eligible for the Educational Expenses benefit, the insurer will provide the beneficiary with an additional amount of $2,500.

If the Spouse should receive a benefit hereunder, he will not be eligible to receive a benefit under the Occupational Training Expenses benefit.

EXPOSURE AND DISAPPEARANCE

If by reason of an Accident which is covered by this benefit, a Member is unavoidably exposed to the elements and as a result of such exposure suffers a Covered Loss for which a benefit is otherwise payable hereunder, such Covered Loss will be covered under this benefit.

If the body of a Member is not found within one year of the date of an Accident which results in the disappearance, sinking or wrecking of the conveyance in which the Member was riding at the time of the Accident and which occurs under such circumstances as would otherwise be covered hereunder, it will be presumed that the Member suffered a Loss of life, unless there is evidence to the contrary.

FAMILY TRANSPORTATION AND ACCOMMODATION EXPENSES

If a Member becomes Hospitalized while insured under this benefit and such Hospitalization is due to a Covered Loss for which a benefit is payable under this benefit, the Member may apply, in a written notice deposited with the insurer, to receive an additional benefit, up to a maximum of $20,000 to cover the expenses actually incurred by the members of his Immediate Family for transportation and hotel accommodation in visiting him, provided:

a) The accommodation and transportation expenses were incurred as a direct result of the visit to the Member; and

b) Transportation must have been by the most direct route to the Hospital; and

c) The Hospital is located at a point which is not less than 150 kilometers from the Member's normal place of residence; and

d) The Member is under the Regular Care and Attendance of a Physician or legally licensed surgeon, other than himself; and

e) The visit of the family members must be considered by the attending physician or surgeon to be beneficial to the Member; and

f) The expenses related to transportation and accommodation are deemed by the insurer to be reasonable and necessary.

If transportation to the Hospital occurs in a vehicle or other device, other than one operated under a license for the conveyance of passengers for hire, reimbursement of transportation expenses will be limited to a maximum of $0.35 per kilometer.

As used above:

- **Regular Care and Attendance** means the observation and treatment to the extent necessary under existing standards of medical practice for the condition causing the confinement.
- **Immediate Family** means a person of at least 18 years of age who is a Spouse, son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law of the Member.

If a Family Transportation and Accommodation Expenses benefit should be offered under any of the other provisions included in the group plan, it shall be provided under only one of the provisions.

FUNERAL EXPENSES

If a Member, while insured under this benefit, should sustain an accidental Loss of life and a benefit is payable under this benefit for such Loss, the insurer will reimburse the actual funeral expenses incurred, up to a maximum of $5,000.

HOME ALTERATION AND VEHICLE MODIFICATION EXPENSES

If a Member, while insured under this benefit, should suffer a Covered Loss for which a benefit is payable under this benefit, and as a result of such Covered Loss requires the use of a wheelchair to be ambulatory, the Member may apply, in a written notice deposited with the insurer, to receive an additional benefit, subject to the greater of:

a) $15,000; or

b) 10% of the sum insured, up to a maximum of $50,000,

to cover the expenses incurred for:

a) The one time cost of alterations to the Member's principal residence to make it wheelchair accessible and habitable; and

b) The one time cost of modifications necessary to a motor vehicle utilized by the Member to make it wheelchair accessible or drivable.

The benefit is payable provided that:

a) The expenses related to the alterations of the Member's residence or modifications of his motor vehicle are deemed by the insurer to be reasonable and necessary; and

b) The expenses are incurred within 365 Days of the Member's Accident which caused the Covered Loss; and

c) The home alterations are made by a person or persons experienced in such alterations and are recommended, in writing, by a recognized organization providing support and assistance to wheelchair users; and

d) The motor vehicle modifications are carried out by a person or persons who are experienced in such matters and are approved by the appropriate provincial licensing authorities.

HOSPITAL INDEMNITY EXPENSES

If a Member becomes Hospitalized while insured under this benefit and such Hospitalization is due to a Covered Loss for which a benefit is payable under this benefit, the Member may apply, in written notice deposited with the insurer, to receive a daily benefit of 1/30th of 1% of the sum insured, up to a monthly maximum of $2,500. A period of Hospitalization necessary for an injury other than for a Covered Loss for which a benefit is payable under this benefit will be covered as stated above, provided such Hospitalization is of at least a 4 Day period.

IDENTIFICATION EXPENSES

If a Member, while insured under this benefit, should sustain an accidental Loss of life and requires body identification, and a benefit is payable under this benefit for such Loss, the insurer will pay, up to a maximum of $20,000, the expenses actually incurred by a member of his Immediate Family for transportation and hotel accommodation, provided:

a) Transportation must have been by the most direct route; and

b) The body is located not less than 150 kilometres from the member of the Immediate Family's residence; and

c) The identification of the body is required by the police or a similar law enforcement agency.

If transportation occurs in a vehicle or other device, other than one operated under a license for the conveyance of passengers for hire, reimbursement of transportation expenses will be limited to a maximum of $0.35 per kilometer.

As used above:

- **Immediate Family** means a person of at least 18 years of age who is a Spouse, son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law of the Member.

OCCUPATIONAL TRAINING EXPENSES

A Spouse of a Member who suffered an accidental Loss of life for which a benefit is payable under this benefit may apply, in a written notice deposited with the insurer, to receive a benefit, up to a maximum of $20,000, to cover the expenses incurred as a result of an occupational training program which he may undertake, provided:

a) The occupational training program will result in the Spouse being qualified for active employment in an occupation for which he would not otherwise have had sufficient qualifications prior to undertaking such program; and

b) The occupational training program has been approved, in advance, by the insurer; and

c) The expenses related to the occupational training program are actually incurred within 3 years of the date of the Member's Accident; and

d) The expenses related to the occupational training program are deemed by the insurer to be reasonable and necessary. Ordinary living (e.g. room and board), travelling and clothing expenses will not be reimbursed.

If the Spouse should receive a benefit hereunder, he will not be eligible to receive a benefit under the Educational Expenses benefit.

PSYCHOLOGICAL THERAPY EXPENSES

If a Member, while insured under this benefit, should suffer a Covered Loss for which a benefit is payable under this benefit and results in the Member requiring psychological therapy, as prescribed by a Physician, the Member may apply, in a written notice deposited with the insurer, to receive an additional benefit, up to a maximum of $5,000, to cover the reasonable and necessary expenses actually incurred.

REHABILITATION EXPENSES

In the event a Member should sustain a Covered Loss for which a benefit is payable under this benefit, such Member may apply, in a written notice deposited with the insurer, to receive an additional benefit, up to a maximum of $20,000, to cover the expenses incurred as a result of a rehabilitation program which he may undertake, provided:

a) The Covered Loss resulted in the Member's inability to substantially perform all of the essential duties of his occupation; and

b) The Covered Loss requires that the Member undergo special training to be qualified to engage in a special occupation in which he would not have engaged except for such Covered Loss; and

c) The rehabilitation program has been approved, in advance, by the insurer; and

d) The expenses related to the rehabilitation program are incurred within 3 years of the date of the Accident which resulted in the Covered Loss; and

e) The expenses related to the rehabilitation program are deemed by the insurer to be reasonable and necessary. Ordinary living (e.g. room and board), travelling and clothing expenses will not be reimbursed.

If a Rehabilitation Expenses benefit should be offered under any of the other provisions included in the group plan, it shall be provided under only one of the provisions.

REPATRIATION EXPENSES

If a Member, while insured under this benefit, should sustain an accidental Loss of life while outside of his province of residence and a benefit is payable under this benefit for such Loss, the insurer will reimburse the actual expenses incurred, up to a maximum of $20,000, for:

a) The preparation of the Member's body for transportation; and

b) The transportation of the Member's body to the first resting place (including, but not limited to, a funeral home) in proximity to his normal place of residence.

The reimbursement of the expenses will be made to the individual who incurred the charges related to the preparation and transportation of the Member's body provided such individual provides proof, satisfactory to the insurer, that he incurred such charges.

If a Repatriation Expenses benefit should be offered under any of the other provisions included in the group plan, it shall be provided under only one of the provisions.

SEAT BELT

If a Member, while insured under this benefit, should suffer a Covered Loss for which a benefit is payable under this benefit and such loss should occur while he is driving or riding in a Motor Vehicle, the insurer will pay an additional amount equal to 10% of his sum insured provided that:

a) The Motor Vehicle was being used in a prudent manner at the time of the Accident; and

b) The Member was wearing a properly fastened Seat Belt at the time of the Accident. Proof, satisfactory to the insurer, that the Member was wearing

the Seat Belt at the time of the Accident must be provided to the insurer at the time of claim; and

c) The operator of the Motor Vehicle had a valid driver's license permitting such person to operate the type of Motor Vehicle being used.

As used above:

- **Motor Vehicle** means a private passenger motor vehicle.
- **Seat Belt** means the belts that form a restraint system in a passenger Motor Vehicle.

WORKPLACE MODIFICATION AND ACCOMMODATION EXPENSES

If a Member, while insured under this benefit, should suffer a Covered Loss for which a benefit is payable under this benefit and such Loss should require special adaptive equipment and/or workplace modification for a Member to return to active full-time employment, the insurer will reimburse the actual expenses incurred, up to a maximum of $5,000, provided:

a) The Policyholder agrees in writing to provide such modification and accommodation to the workplace for the purpose of making it accessible and adaptable to the needs of such Member; and

b) The Policyholder acknowledges in writing that the performance of the essential duties of such Member's occupation may be altered.

LIMITATIONS

The total amount payable for all Covered Losses resulting from any one Accident shall not exceed the Member's sum insured shown for this benefit in the Summary of Benefits, except with respect to Hemiplegia, Quadriplegia and Paraplegia.

If, as a result of any one Accident, a Member suffers more than one of the Covered Losses shown in the Schedule of Amounts of Insurance provision with respect to any one limb, payment will be made only for the one Covered Loss for which the largest amount is payable.

MEMBER'S ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE (cont'd)

AGGREGATE LIMIT OF INDEMNITY FOR ANY ONE AIR TRAVEL ACCIDENT

Notwithstanding the benefit amounts payable for each Member, the insurer's aggregate limit for all Covered Losses sustained by all Members as the result of the same air travel Accident shall not exceed $5,000,000.

In the event the aggregate limit is insufficient to pay the full amount specified for each Member, the amount of benefit payable with respect to each Member will be in the proportion that such aggregate limit bears to the total amount of benefit that would have been payable except for the aggregate limit.

EXCLUSIONS

No benefit will be payable for any Covered Loss resulting 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) Any overdose from any substance or drug of any kind, whether legal or not and whether prescribed to the Insured Person or not.

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

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

e) Service in the armed forces or reserves of any country.

f) Travel or flight in any vehicle or device for aerial navigation except when riding as a passenger and not as a pilot, operator or member of the crew, in or on any aircraft provided such aircraft (i) has a current and valid certificate of air worthiness, (ii) is piloted by a person who holds a current and valid pilot's license of a rating authorizing him to pilot the aircraft, and (iii) is not owned, operated, chartered or leased by the Policyholder or the Member's Employer.
Boarding or alighting from an aircraft will be deemed to be part of the flight.

g) The operation, care or control by the Member of any vehicle or vessel with a blood alcohol concentration in excess of the limit permitted by the law, or while under the influence of any drug whether prescribed or not, or while under the influence of any intoxicating or addictive substance.

h) The dangerous operation, care or control of any vehicle or vessel by the Member, if the Member has been convicted.

WAIVER OF PREMIUMS

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

However, the waiver of premiums will cease on the termination date of this benefit or the group plan.

REDUCTIONS

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

TERMINATION

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

LONG-TERM DISABILITY INSURANCE

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

DEFINITIONS

As used in this benefit:

Total Disability and Totally Disabled means that, during the Member's Elimination Period and the first 24 months following the Elimination Period, the Member is, due to an Illness or Accident, continuously unable to perform all the essential duties of his Regular Occupation with his own Employer and is also continuously unable to perform all those same duties of his Regular Occupation with any other employer, all of which shall be determined by the insurer.

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

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

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

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

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

Gainful Employment means any occupation, any employment or any other activity for compensation or profit, for which the Member is reasonably qualified,

or may so become, by training, education or experience, and from which the Member would be able to earn at least 60% of his Indexed Pre-Total Disability Gross Monthly Earnings.

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

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

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

PARTICULARS

Beginning of Benefit Payments

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

Amount of Benefit Payments

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

REDUCTION OF BENEFIT PAYMENTS

Satisfactory Application

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

Direct Reductions

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

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

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

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

d) Benefits payable under provincial crime victims compensation legislation; and

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

f) Payments made to the Member for statutory and common law notice as a result of his termination of employment or lay off; and

g) Any short-term disability or sick leave benefits payable to the Member by his Employer, the insurer or any other third party; and

h) Damages received from any third party that have not been already reimbursed to the insurer in accordance with the Subrogation provision under the group plan; and

i) Income benefits, including but not limited to, Earnings continued by the Employer, and any paid vacation or statutory holidays payable to the Member for the period of Total Disability.

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

Indirect Reductions

The Long-Term Disability benefit payable by the insurer will be further reduced so that the total amount of all income, compensation, profit, indemnities and benefits from All Sources, which is payable to the Member, or which would have

been payable to the Member had a Satisfactory Application been made, does not exceed:

a) 85% of the Member's Pre-Total Disability Gross Monthly Earnings, if the Long-Term Disability benefit is taxable; or

b) 85% of the Member's Pre-Total Disability Net Monthly Earnings, if the Long-Term Disability benefit is non-taxable.

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

All Sources means:

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

b) Any of the Direct Reductions listed above; and

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

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

e) Any other governmental body or government plan; and

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

Lump Sum Payments

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

Rehabilitation Program Reductions

If the Member is participating in a Rehabilitation Program approved by the insurer, the amount of the Long-Term Disability benefit payable by the insurer will be further reduced so that the total amount of all income, compensation, profit, indemnities and benefits which are payable or which would have been payable to the Member had a Satisfactory Application been made from (i) any of the All Sources; and (ii) the approved Rehabilitation Program, does not exceed

a) 100% of the Member's Pre-Total Disability Gross Monthly Earnings if the Long-Term Disability benefit is taxable; or

b) 100% of the Member's Pre-Total Disability Net Monthly Earnings if the Long-Term Disability benefit is non-taxable.

Further Reductions

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

Provisional Reductions

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

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

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

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

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

a) With respect to the Canada Pension Plan:

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

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

b) With respect to the Quebec Pension Plan:

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

ii) Signs the “Consent and Application for Remittance of Disability Benefits to an Insurer” form and any other related forms as may be requested by the insurer.

c) With respect to workers compensation benefits:

i) Applies for workers compensation benefits; and

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

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

TERMINATION OF BENEFIT PAYMENTS

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

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

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

c) The date on which the Member reaches the termination age specified in the Summary of Benefits for the Long-Term Disability benefit; or

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

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

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

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

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

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

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

SUCCESSIVE PERIODS OF TOTAL DISABILITY

During the Elimination Period

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

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

b) The Member was Actively at Work for less than 30 consecutive Days from the end of the previous Total Disability.

After the Elimination Period

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

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

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

Recurrence of the Previous Total Disability

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

The Long-Term Disability benefit payable for a recurrence of the previous Total Disability will be determined in accordance with all of the terms and conditions of the group plan based on the Member's Earnings as at the date of the previous Total Disability. Benefits for all recurrences will not be paid for a combined period longer than the maximum benefit period applicable to the previous Total Disability as shown in the Summary of Benefits.

New Total Disability

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

EXCLUSIONS

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

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

b) Self-inflicted injury unless medical evidence establishes that the injury was directly related to a mental health Illness.

c) Care, surgery or treatment which is not Medically Required.

d) Care, surgery or treatment for infertility.

e) Care, surgery or treatment for cosmetic purposes, except when such care, surgery or treatment is Medically Required as a direct result of an Illness or Accident.

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

g) The operation, care or control by the Member of any vehicle or vessel with a blood alcohol concentration in excess of the limit permitted by the law, or while under the influence of any drug, whether prescribed or not, or while under the influence of any intoxicating or addictive substance.

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

i) The dangerous operation, care or control of any vehicle or vessel by the Member, if the Member has been convicted.

j) A Pre-existing Condition, where the Total Disability begins within 12 months after the date on which the Member became covered under this benefit.

Pre-existing Condition means an Illness or Accident or the symptoms of an Illness, or symptoms arising out of an Accident, whether diagnosed or not:

i) For which the Member sought or received (or for which he was advised to seek or receive) any treatment, advice consultation, diagnostic tests, or any care or services, from any medical healthcare provider; or

ii) For which the Member was prescribed or took medication;

during the 3 months prior to the date on which the Member became covered under this benefit.

However, if the group plan is issued in replacement of a plan of a prior insurer, the Long-Term Disability benefits will be payable for a Total Disability due to a Pre-Existing Condition, provided that the Member satisfies the following requirements:

i) Was covered under the prior insurer's plan on the date it was terminated; and

ii) Became covered under this benefit on the effective date of the group plan; and

iii) Was Actively at Work on the effective date of the group plan; and

iv) Satisfies the Pre-Existing Condition exclusion period under the group plan, giving consideration towards continuous time covered under both policies, or the prior plan giving consideration towards continuous time covered under both policies.

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

LIMITATIONS

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

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

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

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

d) The Member is confined in a penitentiary, prison, correctional facility, forensic psychiatric facility or any similar institution by order of a court or review board.

e) The Member is on a leave taken in accordance with any provincial or federal legislation, including but not limited to, maternity, parental or family-related leave.

f) The Member is on any leave of absence, that was approved by the Employer.

g) The Member is on any other type of leave not already mentioned in this provision.

h) The Member is suspended with or without pay.

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

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

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

As used in this provision, Absence means:

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

As used in this provision, Conditions means:

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

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

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

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

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

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

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

a) The date the Elimination Period is satisfied; or

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

REHABILITATION PROGRAM

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

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

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

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

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

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

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

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

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

Rehabilitation Expenses

Any expenses for a Rehabilitation Program must be approved by the insurer in advance and in writing. If the insurer does approve such expenses he may limit them to a cumulative total of 3 times the Member's Long-Term Disability benefit.

Active and Continuous Participation Required

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

WAIVER OF PREMIUMS

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

SURVIVOR BENEFIT

If a Member should die while he is receiving a Long-Term Disability benefit or he was approved for and entitled to receive a Long-Term Disability benefit under this benefit, the insurer will pay a benefit to his Eligible Survivor. If there is no Eligible Survivor on the date of his death, no benefit will be payable.

The amount of the benefit to be paid to the Eligible Survivor, will be equal to 3 times the net Long-Term Disability benefit payment which was made or would have been made to the Member by the insurer immediately prior to his death.

If the benefit becomes payable to the Children of a Member, the insurer will make the payment to the Children or to the individual legally entitled to receive payment on behalf of the Children. If two or more Children are entitled to a benefit, they shall share the benefit equally.

As used above:

- **Eligible Survivor:** The Member's Spouse, or the Member's Children, if the Member has no Spouse at the time of death.
- **Spouse:** Will be as defined under the definition of Dependent of the Definitions provision.
- **Children:** Will be as defined under the definition of Dependent of the Definitions provision.

TERMINATION

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

QUEBEC PRESCRIPTION DRUGS

Addendum to Supplemental Health Insurance Applicable to Quebec Residents Only

The Administrator undertakes to reimburse the expense of prescription drugs which are listed under the Basic Prescription Drug Insurance Plan of Quebec, for each Covered 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 "Board"), regardless of the Covered Person's state of health.

Coverage under this benefit is mandatory for all Members and their Dependents who are eligible to be covered under the group plan, 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 addendum and group plan.

If a provision of the Supplemental Health coverage is, in full or in part, contrary to the Act respecting prescription drug insurance, that provision, or the part that is deemed to be contrary will be presumed to be amended to comply with the minimum requirements of the Act respecting prescription drug insurance.

DEFINITIONS

As used in this addendum:

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

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

Coinsurance Payment: The Coinsurance Payment is the portion of the cost of the covered expenses that must be paid by the Covered Person until the Maximum Contribution is reached.

Maximum Contribution: The Maximum Contribution is the total amount paid by the Covered 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 Administrator.

SPECIAL PROVISION FOR COVERED PERSONS AGE 65 AND OVER

The Covered Person's choice to be covered by the Board for the Basic Prescription Drug Insurance Plan of Quebec is irrevocable.

For the purpose of the group plan, Covered Persons who are age 65 and over will be presumed to be covered with the Board for the Basic Prescription Drug Insurance Plan of Quebec. In addition, Dependents of a Member who is 65 years of age or over will be presumed to be covered with the Board for the Basic Prescription Drug Insurance Plan of Quebec, regardless of age.

The Administrator reserves the right to modify the rates applicable to this benefit for any Covered Person age 65 and over, who is eligible for coverage under the group plan and who has chosen to be covered under this benefit.

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

COVERED EXPENSES

The following expenses are covered, provided they are incurred in Quebec after the Covered Person became covered 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 Board or specified by government regulation;

b) Drugs which are included on the list of the Board 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 a Covered 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.

REDUCTIONS

The expenses covered under the present benefit are limited to the reasonable and customary charges normally incurred in Quebec for the same expenses. These reasonable and customary charges are established by the Administrator and can be revised as needed.

EXCLUSIONS

None, except if provided by the *Act respecting prescription drug insurance* or one of its regulations.

CO-ORDINATION OF BENEFITS

The Co-ordination of benefits will be as provided for under the Co-ordination of Benefits provision of the Supplemental Health benefit.

TERMINATION

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

SUPPLEMENTAL HEALTH

Includes Prescription Drugs for Residents of Provinces Outside Quebec

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

DEFINITIONS

As used in this benefit:

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

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

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

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

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

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

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

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

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

HOSPITALIZATION IN THE PROVINCE OF RESIDENCE

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

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

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

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

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 a Covered Person's absence from his province of residence provided:

a) The Covered Person is insured under the Supplemental Health at the time of the Medical Emergency; and

b) **For Members who are under age 70, and their Dependents:**

The Medical Emergency occurs during the first 60 Days of the Covered Person's absence from his province of residence.

If, however, 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

For Members who are age 70 and over, and their Dependents:

The Medical Emergency occurs during an absence of the Covered Person from his province of residence when such absence's expected length was 30 Days or less.

If, however, 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.

Moreover, if the absence was expected to be 30 Days or less but is extended due to unforeseen circumstances, coverage will be provided only for a Medical Emergency which occurs during the first 30 Days of the absence.

If the absence is expected to exceed 30 Days, there is no coverage under this benefit during the entire absence; and

c) The Covered Person's absence was due to business, a vacation or full-time attendance at an accredited educational institution; and

d) The services and supplies had to be provided before the Covered Person could return 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 of benefit specified in the Hospitalization in the Province of Residence provision;

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

d) Diagnostic, medical imaging and laboratory services;

e) Paramedical services provided during a Hospitalization;

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 Covered 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 Covered 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 Covered Person should become Hospitalized outside his province of residence due to a Medical Emergency, the Covered Person will be required to contact the Administrator'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 Administrator limiting or denying the Covered Person's claim resulting from the Medical Emergency.

In addition, if during a Medical Emergency, the Administrator determines that the Covered Person can be repatriated to his province of residence without endangering his health and the Covered Person refuses to be repatriated, the Administrator will not be responsible for any further expenses incurred by the Covered 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 Covered 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 Administrator determines what stable means. In this assessment, the Administrator will 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.

OUT OF CANADA REFERRAL COVERAGE

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 Covered Person being referred outside of Canada for medical treatment provided:

a) The treatment could not have been provided within Canada;

b) The treatment is determined to be Medically Required as certified in writing by at least two Physicians practicing in the Covered Person's province of residence, one of whom regularly attends the Covered Person, the other whom specializes in the field of medicine applicable to the medical condition being treated and neither of whom is the Covered Person himself or a member of his family;

c) The treatment must be accepted as normal treatment for the medical condition and must not be considered experimental;

d) A benefit for the treatment will be payable under the provincial health plan of the Covered Person's province of residence. This must be confirmed, in writing, by the Covered Person with the administrators of such plan prior to the services being performed;

e) Approval for the treatment is received from the Administrator, in writing, prior to the treatment being performed;

The following services and supplies which are related to the medical treatment being received as a result of the referral 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;

d) Diagnostic, medical imaging and laboratory services;

e) Paramedical services;

f) Hospital out-patient services and supplies;

g) Drugs;

h) Professional ambulance service to transport the Covered Person to the Hospital where the medical treatment is to be provided.

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

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

a) Drugs which are dispensed by a pharmacist and which 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 law 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.

Sclerosing injections.

Colostomy and ileostomy supplies.

Contraceptive patches and contraceptive rings.

Intrauterine devices and diaphragms.

Injectable drugs and vitamins.

Over-the-counter muscle relaxants.

For Quebec residents, this medical expense is supplementary to the Quebec Prescription Drug benefit.

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

As part of its pre-authorization process, the Administrator may request that a drug be purchased from a preferred pharmacy network that has been approved by the Administrator. If the Covered Person should choose to use another pharmacy, the amount reimbursed to the Covered Person will be based on the amount which would have been

charged by the Administrator's approved pharmacy network. The Administrator will not be responsible for any amounts in excess of the amounts that would have been reimbursed had the Covered Person used the approved pharmacy network.

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

If the drug is an Original Drug which has a Generic equivalent, the amount payable will be based on the Lowest Priced Interchangeable Drug. However, if the Covered Person provides proof, satisfactory to the Administrator that, due to a valid medical reason as verified by his attending Physician, that he must take the Original Drug, the Administrator 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.

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

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

ii) The services are Medically Required; and

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

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

c) Licensed ambulance service in a Medical Emergency for transportation to the nearest Hospital equipped to provide the required treatment, or for transportation therefrom, when the physical condition of the

Covered Person precludes the use of any other means of transportation.

d) Room and board charges made in a facility licensed to provide rehabilitative or convalescent care provided:

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

i) The confinement was recommended by a Physician; and

ii) The confinement takes place within 14 Days of a period of Hospitalization; and

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.

e) Room and board charges made by a chronic care Hospital.

f) Charges for diagnostic laboratory tests and medical imaging services, other than x-rays by a paramedical practitioner, provided:

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

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

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

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

i) Oxygen, oxygen tent and oxygen supplies

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

iii) Artificial eyes, including repairs and replacements

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

v) Manual wheelchairs or electric wheelchairs when the Covered Person is incapable of operating a manual wheelchair due to a medical condition

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

vii) Apnea monitors for respiratory dysrhythmias

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

ix) Continuous glucose monitor

x) Percutaneous or transcutaneous nerve stimulator

xi) Intermittent positive pressure breathing machine

xii) Continuous positive pressure breathing machine

xiii) Breast prostheses

xiv) Surgical brassieres

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

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

xvii) Foot orthoses which are Medically Required by a health practitioner operating within the scope of his license and which

have been specifically designed and constructed for the Covered Person by a certified specialist in foot orthoses. Off the shelf foot orthoses which have not been specifically designed and constructed for the Covered Person will not be eligible for coverage

xviii) Contact lenses following cataract surgery

xix) Intraocular lenses following cataract surgery

xx) Braces with rigid support; back supports; shoulder harnesses; head halters, trusses and cervical collars

xxi) Splints, other than dental splints, and casts

xxii) Canes, crutches and walkers

xxiii) Hernia belts

xxiv) Wigs required as a result of chemotherapy

xxv) Colostomy and ileostomy apparatus

xxvi) Catheters

xxvii) Speech aids

xxviii) Stump socks

xxix) Blood and plasma transfusions

xxx) Radiotherapy or coagulotherapy

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

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

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

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

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

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

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

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

k) **Applicable only to the Silver and Gold Options:** Charges for eyeglasses (including sunglasses and safety glasses) when prescribed by an ophthalmologist or an optometrist.

l) **Applicable only to the Silver and Gold Options:** Charges for contact lenses, when prescribed by an ophthalmologist or an optometrist.

m) **Applicable only to the Silver and Gold Options:** Charges for corrective laser surgery, when prescribed by an ophthalmologist or an optometrist.

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

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

EXCLUSIONS AND REDUCTIONS

This benefit does not cover any of the following expenses:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- products for the care of contact lenses;
- proteins or dietary supplements, amino acids;

- baby food;
- mouthwash, bandages and throat lozenges;
- shampoos, oils, creams;
- toilet products including soaps and emollients;
- skin softeners and protectors;
- vitamins, vitamin supplements or multivitamins;
- minerals;
- homeopathic products;
- anabolic steroids.

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

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

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

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

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

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

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

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

iv) Is a member of a profession that is not regulated by an officially recognized federal or provincial regulatory body in the

jurisdiction where the services were provided and, in the opinion of the insurer, does not meet the insurer's standards relevant to his professional conduct or practice, or

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

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

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

CALCULATION OF REIMBURSEMENT

Reimbursement

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

Maximum Benefit Per Covered Person

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

Co-ordination of Benefits

When a Covered Person is eligible to receive benefits simultaneously under this coverage and any other coverage which pays expenses for care, services and supplies which are for or by reason of health 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 Member dies while covered under this benefit and prior to any extension of coverage as provided for under the Extension of Benefits provision, coverage under this benefit shall continue for his Dependents who were covered under this benefit at the time of his death, until the earliest of:

a) 24 months after the Member's death; or

b) The date on which the Dependents' coverage would have terminated had the Member then been living; or

c) The termination date of this benefit.

EXTENSION OF BENEFITS

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

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

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

As used in this provision, Disabled and Disability mean:

a) With respect to a Member, 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 Member whose coverage under the group plan is cancelled due to termination of:

a) His employment; or

b) His group membership,

will be able to convert his Supplemental Health benefit to an individual insurance contract without having to submit evidence of health to the Administrator.

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

The Member must make application and pay all required premiums for the individual insurance contract within 60 Days of the termination date of his coverage under the group plan. Failure to submit the application and premium within such 60 Days will prevent the Member from obtaining the insurance under the individual insurance contract.

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

TERMINATION

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

SUPPLEMENTAL HEALTH–
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 Covered Person is absent from his province of residence provided:

a) The Covered Person is insured under the Supplemental Health Insurance at the time of the Medical Emergency or personal emergency; and

b) **For Members who are under age 70, and their Dependents:**

The Medical Emergency or personal emergency occurs during the first 60 Days of the Covered Person's absence from his province of residence.

If, however, the absence is due to his attendance at an accredited educational institution on a full-time basis, the Medical Emergency or personal emergency occurs during the school year for which he is enrolled at the institution; and

For Members who are 70 age and over, and their Dependents:

The Medical Emergency or personal emergency occurs during an absence of the Covered Person from his province of residence when such absence's expected length was 30 Days or less.

If, however, the absence is due to his attendance at an accredited educational institution on a full-time basis, the Medical Emergency or personal emergency occurs during the school year for which he is enrolled at the institution.

Moreover, if the absence was expected to be 30 Days or less but is extended due to unforeseen circumstances, coverage will be provided only for a Medical Emergency or personal emergency which occurs during the first 30 Days of the absence.

If the absence is expected to exceed 30 Days, there is no coverage under this benefit during the entire absence; and

c) The Covered Person's absence was due to business, a vacation or full-time attendance at an accredited educational institution; and

d) The services and supplies had to be provided before the Covered Person could return to his province of residence without endangering his health; and

e) 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 benefit.

The services will be provided by the Administrator's medical assistance service provider. The Covered Person will be required to contact the Administrator's medical assistance service provider to request the services in an emergency.

DEFINITIONS

As used in this benefit:

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

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

Immediate Family: The Covered 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 Administrator's medical assistance service provider will provide a 24 hour hotline, 365 Days a year, staffed by multilingual co-

ordinators to connect the Covered Person to a network of specialists who will handle the emergency.

b) Medical Care

The Administrator's medical assistance service provider will:

- If the Covered Person is unable to locate a Physician or Hospital, provide a referral to a Physician or an appropriate Hospital;
- Upon request of the Covered Person, organize consultations with Physicians or Specialists in order to obtain the best medical care available in the area;
- Provide assistance with admittance to a Hospital;
- Confirm to Physicians and Hospitals the medical expenses that are covered under the group plan for the Covered Person.

c) Medical Transportation

The Administrator's medical assistance service provider will:

- Arrange and pay for the transportation or transfer of the Covered Person by appropriate means to a Hospital as recommended by the attending Physician, and which the Administrator's medical assistance service provider agrees to;
- Arrange and pay for the return of the Covered 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 Administrator's medical assistance service provider will arrange for the Covered 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 Administrator's medical assistance service provider will make the necessary arrangements to pay medical expenses which are covered

under the Emergency Medical Expenses Incurred Outside the Province of Residence section of the Supplemental Health benefit;

- When necessary in order for the Covered Person to obtain needed medical treatment, the Administrator's medical assistance service provider will advance up to $10,000 (Canadian), after consultation with the Administrator.

e) Return of Deceased

- Should the Covered Person die, the Administrator's 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 Administrator's medical assistance service provider will organize the return of the Covered Person's Dependent Children under age 16 who are left unattended due to the Hospitalization of the Covered Person. In addition, the Administrator's 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 a Covered Person or a Member of the Immediate Family

- The Administrator's medical assistance service provider will organize the return of the Covered Person and/or a Member of the Immediate Family who has lost the use of his return ticket due to the Covered Person's Hospitalization or death. The Administrator's medical assistance service provider will arrange and pay for economy transportation to return the Covered 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 Administrator's medical assistance service provider will arrange and pay for round-trip economy class transportation for a Member of the Immediate Family to visit the Covered 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 a Covered Person for a period of more than 24 hours or because of a Covered Person's death, the expenses for commercial accommodation and meals incurred due to the delay by the Covered Person, by a Member of the Immediate Family accompanying the Covered Person or visiting the Covered 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 Administrator's medical assistance service provider.

j) Vehicle Return

- The Administrator's medical assistance service provider will pay up to $1,000 to return the Covered Person's vehicle, either private or rental, to the Covered Person's residence or the nearest appropriate vehicle rental location.

k) Emergency Drugs

- Should a Covered Person require drugs for the treatment of a medical condition and such drugs are not available locally, the Administrator's medical assistance service provider will co-ordinate a search for the drugs and once located arrange for the delivery of the drugs. The Covered Person will be responsible for the cost of the drugs unless the drugs are covered under the Supplemental Health benefit.

PERSONAL EMERGENCY TRAVEL ASSISTANCE SERVICES

The following services will be provided during a personal emergency:

a) Telephone Interpretation Service

- The Administrator's medical assistance service provider will provide the Covered Person with telephone interpretation services in most foreign languages.

b) Messages

- The Administrator's medical assistance service provider will relay a message, upon request, from the Covered Person to his home, office or elsewhere, or hold messages for the Covered Person or the Members of his Immediate Family for up to 15 Days.

c) Legal Assistance

- The Administrator's medical assistance service provider will assist the Covered Person in finding local legal aid when required, and will also help the Covered 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 Administrator's medical assistance service provider will provide the Covered Person with travel information related to transportation, vaccinations and precautionary measures before, during and after the Covered Person's trip.

e) Lost Baggage or Travel Documents

- If the Covered Person loses or has his travel documents and/or baggage stolen, the Administrator's medical assistance service provider will help him contact the appropriate authorities.

EXCLUSIONS AND REDUCTIONS

In addition to the exclusions and reductions outlined in the Exclusions and Reductions provision of the Supplemental Health benefit, the Medical

Emergency Assistance Services provided under this benefit will be subject to the limitations, exclusions and terms and conditions that are applicable under the Emergency Medical Expenses Incurred Outside the Province of Residence provision of the Supplemental Health benefit.

LIABILITY

The Planholder, the Administrator and its medical assistance service provider 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 Physicians, Hospitals, clinics, lawyers and other authorized practitioners or institutions to which the Administrator's medical assistance service provider directs Covered Persons are independent contractors and act on their own behalf and are not employees, agents or subordinates of the Planholder, the Administrator and its medical assistance service provider.

The Planholder, the Administrator and its medical assistance service provider are not responsible and assume no liability for the negligence or other acts or omissions by the Physicians, Hospitals, clinics, lawyers or other authorized practitioners or institutions to which the Covered Person is directed by the Administrator's medical assistance service provider.

REIMBURSEMENT

If a cash advance was made by the Administrator or its medical assistance service provider to cover a charge that had been made, or if a charge was paid by the Administrator or its medical assistance service provider and the Member submits such charge as a covered expense under the Supplemental Health benefit at a later date, the Member will only be reimbursed the difference between the eligible amount of the covered expense and the amount of the cash advance or the amount already paid by the Administrator or its medical assistance service provider, subject to the Deductible and Reimbursement level that are applicable to the expense.

SUPPLEMENTAL HEALTH–
EMERGENCY OUT OF PROVINCE ASSISTANCE (cont'd)

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 provision of the Supplemental Health benefit or (ii) the amount advanced or paid was in excess of the Planholder's responsibility under the group plan, the Member will be responsible for reimbursing the Administrator the cash advancement or the excess amount, whichever is applicable, within 90 Days of the Covered Person returning to his province of residence. Should the Member fail to pay back the cash advance or excess amount, the Administrator will have the right to reduce future health claims or any other claims by the Member or his Dependents under the group plan by the amount owing.

DENTAL CARE

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

DEFINITIONS

As used in this benefit:

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

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

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

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

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

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

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

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

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

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

DENTAL EXPENSES

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

Preventive Treatments (any expenses related to implants will only be covered under Implants of the Major Treatments section, if included)

a) Examinations and Diagnoses

i) Complete oral examination:

Once per lifetime

ii) Recall examination:

Applicable only to the Bronze and Silver Options:
Once every 6 months for a Covered Person under age 21 or once every 9 months for any other Covered Person

Applicable only to the Gold Option:
Once every 6 months

iii) Emergency oral examination

iv) Specific oral examination

b) X-rays

i) Intra-oral - periapical:

One complete series every 24 months

ii) Intra-oral - occlusal

iii) Intra-oral - interproximal

iv) Extra-oral

v) Sialography

vi) Panoramic:

Once every 24 months

vii) Radiopaque dyes

c) Tests and Laboratory Examinations

i) Microbiologic culture

ii) Biopsy of oral tissue - soft

iii) Biopsy of oral tissue - hard

iv) Cytologic smear

v) Pulp vitality tests

vi) Caries susceptibility tests

d) Preventive Services

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

2 unit(s) every 6 months

ii) Topical application of fluoride

iii) Initial oral hygiene instruction

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

Whenever laboratory fees are incurred for services listed under the Preventive Treatments section, they will be limited to 60% of the fee established for the service.

Basic Treatments (any expenses related to implants will only be covered under Implants of the Major Treatments section, if included)

a) Basic Services
   - i) Finishing restorations
   - ii) Pit and fissure sealant
   - iii) Caries control
   - iv) Interproximal discing
   - v) Prophylactic odontomy

b) Restorative
   - i) Amalgam restorations
   - ii) Composite restorations

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

d) Periodontics
   - i) Surgical services
   - ii) Provisional matching
   - iii) Adjunctive periodontal procedure

Root planing and curettage are covered up to a maximum of 14 teeth in any 12 months. These procedures are only covered if testing of periodontal pockets indicates 4 mm or more.

Scaling is covered up to a maximum of 10 units in any 12 months.

e) Dentures - removable

i) Adjustments

ii) Repairs

iii) Rebasing and relining

iv) Prophylaxis and polishing

f) Oral Surgery

i) Removal of erupted tooth (uncomplicated)

ii) Surgical removals (complicated)

iii) Surgical exposure and movement of tooth

- transplantation: maximum of $150
- surgical repositioning: maximum of $150

iv) Enucleation of tooth

v) Remodelling and recontouring of oral tissues

- alveoloplasty
- gingivoplasty and/or stomatoplasty
- vestibuloplasty
- remodelling of floor mouth
- extension of mucous folds

vi) Surgical excision and incision

- excision of tumors and cysts
- enucleation of cysts/granulomas
- cheiloplasty (lip shave)
- graft of bone to jaw

- marsupialization
- incision and drainage and/or exploration
- incision for removal of foreign bodies: maximum of $150

vii) Treatment of fractures

- mandibular or maxillary (including wiring): open reductions limited to a maximum of $750
- alveolar fractures
  - debridement, teeth removed
  - replantation of avulsed tooth (includes splinting)
  - repositioning of traumatically displaced tooth
  - repairs and lacerations: if over 6 cm, limited to a maximum of $750

viii) Frenectomy/frenoplasty

ix) Antral surgery

g) Adjunctive General Services

i) Anaesthesia (in relation to surgery)

Whenever laboratory fees are incurred for services listed under the Basic Treatments section, they will be limited to 60% of the fee established for the service.

Applicable only to the Silver and Gold Options:
Major Treatments

a) Dentures - removable

i) Complete dentures

ii) Partial dentures

b) Dentures - fixed

i) Cast post

ii) Pontic

iii) Butterfly bridge

iv) Abutments

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

- stress breakers and/or precision attachments: maximum of $150 plus laboratory fees
- telescoping of crown unit: maximum of $450 plus laboratory fees

Initial installation of fixed or removable dentures will be covered only in the case of teeth extracted while the person is covered under this benefit or a similar benefit.

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

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

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

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

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

c) Restorative

i) Crowns

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

iii) Metal inlay and onlay restorations

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

v) Prefabricated post (pivot)

vi) Recementing of inlays, onlays and crowns

vii) Removal of inlays, onlays and crowns

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

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

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

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

d) Space Maintainers (for loss of primary teeth)

i) Stainless steel crown types

Whenever laboratory fees are incurred for services listed under the Major Treatments section, they will be limited to 60% of the fee established for the service.

Applicable only to the Silver and Gold Options:
Orthodontic Treatments: limited to a Child under 20 years of age at time treatment begins

i) Oral examination

ii) Observation and diagnosis

iii) Cephalometric radiographs

iv) Diagnostic casts - unmounted

v) Removable active appliances for tooth guidance

vi) Fixed or cemented appliances

vii) Appliances to control harmful habits

viii) Retention appliances

ix) Comprehensive treatment

Whenever laboratory fees are incurred for services listed under the Orthodontic Treatments section, they will be limited to 60% of the fee established for the service.

EXCLUSIONS AND REDUCTIONS

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

a) Related directly or indirectly to a full mouth reconstruction, to correct vertical dimension;

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

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

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

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

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

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

h) For implants and services related to implants such as, but not limited to, surgical services, except if specifically mentioned as being covered under this benefit;

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

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

TREATMENT PLAN

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

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

PAYMENT OF BENEFITS

Fees

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

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

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

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

Proof

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

Alternative Treatment Plan

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

CALCULATION OF REIMBURSEMENT

Reimbursement

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

Maximum Benefit Per Covered Person

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

Co-ordination of Benefits

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

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

ii) Any government-sponsored plan; and

iii) Any non-insured employee benefit plan.

SURVIVOR BENEFIT

If the Member dies while covered under this benefit and prior to any continuation of coverage as provided under the Extension of Benefits provision, coverage under this benefit shall continue for his Dependents who were covered under this benefit at the time of his death, until the earlier of:

a) 24 months after the Member's death; or

b) The date on which the Dependent's coverage would have terminated had the Member then been living; or

c) The termination date of this benefit.

EXTENSION OF BENEFITS

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

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

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

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

CONVERSION PRIVILEGE

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

a) His employment; or

b) His group membership,

will be able to convert his Dental Care benefit to an individual insurance contract without having to submit evidence of health to the Administrator, provided he is also converting his Supplemental Health benefit. Failure to convert his Supplemental Health benefit will prevent the Member from converting his Dental Care benefit.

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

The Member must make application and pay all required premiums for the individual insurance contract within 60 Days of the termination date of his coverage under the group plan. Failure to submit the application and premium within such 60 Days will prevent the Member from obtaining the insurance under the individual insurance contract.

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

TERMINATION

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

MEDICAL SECOND OPINION SERVICE

(This Benefit is applicable only to those Members and their Dependents, if any, who elected to be insured under the Bronze, Silver and Gold Options.)

A Participant will be able to access the Medical Second Opinion service on behalf of himself or a Dependent, if the Participant or the Dependent is diagnosed with a covered serious medical condition, provided that the Participant and his Dependents are covered under the Supplemental Health Insurance benefit of the group policy.

SERVICE

Upon identification of a covered serious medical condition, this service allows the Participant or the Dependent to quickly obtain a second opinion from leading medical specialists affiliated with renowned Canadian medical teaching institutions. These medical specialists are connected to global resources and clinical expertise, facilitating consultation with other world-class experts when required.

COVERED SERIOUS MEDICAL CONDITIONS [1]

The covered serious medical conditions for which a Participant or a Dependent can access the Medical Second Opinion service are:

◆ AIDS	◆ Any disease requiring amputation
◆ Benign brain tumour	◆ Cancer
◆ Cardiovascular conditions, including heart attack (myocardial infarction), coronary bypass surgery, or aortic surgery	◆ Coma
◆ Complications of diabetes	◆ Deafness
◆ Emphysema	◆ Hip and knee replacement
◆ Loss of speech	◆ Loss of eyesight
◆ Major lung and bone disorders	◆ Major trauma
◆ Motor neuron diseases	◆ Neuro-degenerative diseases (e.g. Alzheimer's disease, Multiple Sclerosis, Parkinson's disease…)
◆ Paralysis	◆ Renal insufficiency or kidney failure
◆ Severe burns	◆ Stroke (Cerebrovascular accident) and related conditions
◆ Thrombophlebitis and embolism	◆ Vital organ transplants

[1] This list is not exhaustive. The Participant or Dependent needs to contact Second Medical Opinion to verify the eligibility of any life-threatening illness.

NOTE: If the specialist cannot confirm a diagnosis based on the Participant's or Dependent's file, he may recommend that additional test(s) or physical consultation be considered to help further refine the diagnosis. Once these test(s) or physical consultations have been completed, the specialist will re-evaluate the Participant's or Dependent's request for a medical second opinion.

A FAST, RELIABLE SIX-STEP PROCESS

1. The Participant or Dependent calls Medical Second Opinion to confirm his eligibility at 1 855 422-4622 to validate its eligibility;
2. A coordinator of the Medical Second Opinion team opens a file and gathers the medical records with the consent of the Participant or Dependent;
3. The coordinator provides the specialist from Medical Second Opinion with the medical records;
4. The specialist reviews the case and prepares the final report;
5. The coordinator from Medical Second Opinion sends the final report to the Participant or Dependent. Upon agreement with the Participant or Dependent, the coordinator forwards a copy of the final report to the attending physician;
6. The attending physician consults with the specialist from Medical Second Opinion, if required.

TREATMENT OPTIONS

Upon confirming the diagnosis, the Participant or Dependent is offered the best treatment options and enhanced access to advanced knowledge within the Canadian healthcare system. Effective treatment is often available near home.

Sometimes, Medical Second Opinion specialists may recommend that the Participant or Dependent considers treatment in another part of Canada, or even in another country. Should the recommended treatment be available only outside the province of residence, Medical Second Opinion will make all necessary arrangements on behalf of the Participant or Dependent by coordinating transportation, admission to the medical institution and repatriation. (2)

(2) The eligible Participant or Dependent is responsible for all costs for transportation, hospitalization and treatment, unless such costs are covered by the group policy and/or the provincial health plan. The Participant or Dependent should contact Industrial Alliance and the provincial health plan to determine what costs, if any, are covered.

CONFIDENTIALITY

Medical Second Opinion's privacy policy complies with requirements under the Personal Information Protection and Electronic Documents Acts (PIPEDA), as well as provincial privacy legislation.

HOW TO ACCESS MEDICAL SECOND OPINION

To obtain a second medical opinion after a diagnosis of a covered serious medical condition, the Participant or Dependent has to call 1 855 422-4622.

You may contact your Plan Administrator to obtain a Medical Second Opinion brochure.

TERMINATION OF MEDICAL SECOND OPINION SERVICE

A Participant's ability to access the Medical Second Opinion service on behalf of himself or a Dependent will terminate on the date the Participant is no longer insured under the Supplemental Health Insurance benefit of the group policy.

In addition, if the agreement between Industrial Alliance and Medical Second Opinion service should terminate, the Participant and his Dependents will no longer be able to access the Medical Second Opinion service.

HEALTH SPENDING ACCOUNT COVERAGE

SUMMARY OF COVERAGE
CREDITED AMOUNT PER EMPLOYEE

The employees are covered under this Health Spending Account ("HSA") Agreement No. 27345 as follows:

For employees covered under the previous HSA:	Remaining credits based on your allocation decision on the commencement of each Calendar Year as reported by the Employer plus unused flexible credits per Participant.
For employees not covered with previous carrier who become eligible on the HSA Effective Date:	Proportional amount of remaining credits based on your allocation decision as reported by the Employer and calculated on the number of months remaining in the fund year excluding the current month.
For employees who become eligible during the HSA Year:	Proportional amount of remaining credits based on your allocation decision as reported by the Employer and calculated on the number of months remaining in the fund year excluding the current month.
For employees eligible on the HSA Renewal Date:	**Applicable only to employees who have elected to opt out of the Health/Dental benefits or who have elected the Bronze Option under the Health/Dental benefits** Remaining credits based on your allocation decision as reported by the Employer plus unused flexible credits per Participant.
Carryover Type:	Credits Carryover

DEFINITIONS

Dependent means a person who is considered an eligible dependent of the employee for a medical expense tax credit claim under the Income Tax Act.

Expenses means the health and dental expenses that the Administrator considers eligible under this HSA Agreement.

To be eligible the expenses must:

a) Be listed as medical expenses under the Income Tax Act, its regulations and Interpretation Bulletins; and

b) Not be eligible for reimbursement under any other plan (group, government or private).

Group Policy means the group insurance policy 27345 issued by Industrial Alliance Insurance and Financial Services Inc.

HSA Effective Date: April 1st, 2021

Health Spending Account Year ("HSA Year"): January 1st to the 31st December.

ELIGIBLE EMPLOYEES

Subject to all of the terms and conditions of this Agreement, an employee shall become eligible for coverage on the latest of the following dates:

a) The Effective Date of this HSA Agreement, if he is then an employee covered under the Group Policy; or

b) On the date the employee is covered under the Group Policy.

CARRYOVER TYPE – CREDIT CARRYOVER (fund carryover)

Coverage

The amount credited to each employee's HSA will be used to reimburse the Expenses submitted. The employee will be able to submit and be reimbursed for Expenses for himself or any Dependent.

Utilization of the credits and grace period

Credits allocated to an employee's HSA for a HSA Year may be carried forward into the next HSA Year.

The employee has a grace period of 90 days at the end of the HSA Year during which the credits were carried forward to utilize the unused credits. After that period, the credits will be forfeited from the employee's HSA.

During that 90 day period, the credits must be used to reimburse Expenses which were incurred during the HSA Year to which these credits were carried forward.

Expenses and grace period

Expenses incurred during a HSA Year must be submitted during this same HSA Year.

The employee has a grace period of 90 days at the end of this HSA Year to submit the Expenses that were not submitted. After that period, the Expenses are not reimbursed.

During that 90 day period, the Expenses must be reimbursed from the credits of the HSA Year in which these Expenses were incurred.

Sufficient credits

There must be sufficient credits in the employee's HSA for Expenses to be reimbursed.

If an employee submits Expenses and there are insufficient credits in the employee's HSA, the employee will be reimbursed up to the extent of the credits available in his HSA.

If an employee submits Expenses and there are no credits in the employee's HSA, no Expenses will be reimbursed.

TERMINATION OF HSA COVERAGE

The employee's HSA coverage automatically terminates on the earliest of the following dates:

a) The date this HSA Agreement is terminated; or

b) The date on which the employee retires; or

c) The date the employee is no longer covered under the Group Policy; or

d) The date the Accountholder terminates coverage under this HSA Agreement for the employee.

NOTICE AND PROOF OF HSA CLAIM

Notice and proof of any claim must be submitted to the Administrator in the format required by the Administrator. The proof of claim must include all information that the Administrator requires and deems necessary. The Administrator is not liable for any claim that is not submitted in accordance with this Agreement. Claims must be submitted within the prescribed period in the provision Carryover Type under the section Health Spending Account Coverage.

HSA CLAIMS IN CASE OF TERMINATION OF HSA COVERAGE

The employee has 90 days from the date his HSA coverage terminates to submit any claims incurred prior to such date. After that period, the credits are forfeited from the Employee's HSA and the Expenses are not reimbursed.

HSA CLAIMS IN CASE OF HSA AGREEMENT TERMINATION

If the HSA Agreement and the Group Policy are terminated, the Administrator will not be responsible for claims submitted after the date the HSA terminates.

However, If the HSA Agreement is terminated but the Group Policy is still in force, claims for Expenses incurred on or prior to the HSA termination date can be submitted within 90 days from that date.

The Administrator will not be responsible for claims submitted after the end of 90 day period.

If the Group Policy is terminated before the end of the 90 day period, the Administrator will not be responsible for claims submitted after the date the Group Policy terminates.

MODIFICATION TO HSA CREDITS DUE TO LIFE EVENT

If during a HSA Year, the employee should experience a life event (marriage, civil union, common-law union, divorce, separation, birth of a child, adoption of a child, death of a Dependent), additional credits are added to the employee's HSA. If, however, as a result of the change, credits should be reduced, this reduction will only be effective as of the next HSA Year.

The employee's credits will not be reduced during a HSA Year.

The additional credits are calculated in proportion to the number of months remaining in the current HSA Year.

The employee may transfer his credits from his Wellness Account to his HSA.

WELLNESS ACCOUNT (PERSONAL SPENDING ACCOUNT) COVERAGE

Wellness Account is also known as a "Personal Spending Account".

SUMMARY OF COVERAGE
CREDITED AMOUNT PER EMPLOYEE

The employees are covered under this Wellness Account Agreement Agreement No. 27345 as follows:

For employees covered under the previous Wellness Account:	Remaining credits based on your allocation decision on the commencement of each Calendar Year as reported by the Employer plus unused flexible credits per Participant.
For employees not covered with previous carrier who become eligible on the Wellness Account Effective Date:	Proportional amount of remaining credits based on your allocation decision as reported by the Employer and calculated on the number of months remaining in the fund year excluding the current month.
For employees who become eligible during the Wellness Account Year:	Proportional amount of remaining credits based on your allocation decision as reported by the Employer and calculated on the number of months remaining in the fund year excluding the current month.
For employees eligible on the Wellness Renewal Date:	**Applicable only to employees who have elected to opt out of the Health/Dental benefits or who have elected the Bronze Option under the Health/Dental benefits** Remaining credits based on your allocation decision as reported by the Employer plus unused flexible credits per Participant.
Carryover Type:	Credits Carryover

DEFINITIONS

Group Policy means the group insurance policy 27345 issued by Industrial Alliance Insurance and Financial Services Inc.

Wellness Account Effective Date: April 1st, 2021

Wellness Account Renewal Date: January 1st, 2022 and January 1st of each year thereafter.

Wellness Account Year: January 1st to the 31st December.

ELIGIBLE EMPLOYEES

Subject to all of the terms and conditions of this Agreement, an employee shall become eligible for coverage on the latest of the following dates:

a) The Effective Date of this Wellness Account Agreement, if he is then an employee covered under the Group Policy; or

b) On the date the employee is covered under the Group Policy.

ELIGIBLE EXPENSES

The Administrator is not responsible for determining whether expenses are eligible for reimbursement. The Accountholder determines which expenses are eligible or reimbursement under the Wellness Account.

The credits allocated to each employee's Wellness Account are used by the Administrator to reimburse the eligible expenses submitted.

Eligible expenses:

Fitness-related services

- fitness club memberships
- registration fees for fitness-related programs or lessons, such as aerobic classes, yoga, dance lessons and figure skating
- sports team memberships and registration fees.
- annual memberships, such as golf.

- court fees, green fees, ski passes, lift tickets and race registrations.
- personal trainers.

Fitness-equipment
- durable equipment such as treadmills, exercise bikes and universal gym.
- camping equipment.

Health-related services
- weight management programs (excluding food).
- smoking cessation programs.
- nutrition programs and counselling.
- maternity services (prenatal classes and mid-wife services).
- services of the following alternative health practitioners: reflexologist, iridologist, herbalist, homeopath, athletic therapist, Chinese medical practitioner, Shiatsu therapist, osteopathic practitioner and acupressurist.
- stress management programs.
- cholesterol and hypertension screening.
- first aid and CPR (cardiopulmonary resuscitation) training.
- health assessments.
- allergy tests.
- vitamins and supplements, including herbal products.
- other alternative wellness services: Reiki, Ayurvedic medicine, touch therapy, Rolfing and light therapy.
- EAP.

Insurance Premiums
- insurance premiums paid for Critical Illness, Life and Long Term Care.

Work-life balance
- child care expenses.

Educational and personal development
- tuition fees for university, college or continuing education (including books and supplies).
- language training.
- tutoring.

- professional membership fees or dues
- fees associated with maintaining a professional designation.
- hobby and general interest classes
- personal computer and accessories.
- art classes.

Professional services
- legal expenses.

Financial
- Registered Retirement Savings Plan (RRSP) contributions.

Other
- Public transit passes.
- Pet insurance and veterinary services.

Coverage

The amount credited to each employee's Wellness Account will be used to reimburse the expenses submitted. The employee will be able to submit and be reimbursed for expenses for himself.

Utilization of the credits and grace period

Credits in the employee's Wellness Account for a Wellness Account Year must be used to reimburse the expenses incurred during the same Wellness Account Year.

The employee has a grace period of 90 days at the end of the Wellness Account Year to utilize the unused credits. After that period, the credits will be forfeited from the employee's Wellness Account.

During that 90 day period, these credits may only be used to reimburse expenses which were incurred during the Wellness Account Year to which these credits were allocated.

Expenses and Grace Period

Expenses incurred during a Wellness Account Year must be submitted during this same Wellness Account Year.

The employee has a grace period of 90 days at the end of this Wellness Account Year to submit the expenses that were not submitted. After that period, the expenses are not reimbursed.

During that 90 day period, the expenses must be reimbursed from the credits of the Wellness Account Year in which these expenses were incurred.

Sufficient Credits

There must be sufficient credits in the employee's Wellness Account for expenses to be reimbursed.

If an employee submits expenses and there are insufficient credits in the employee's Wellness Account, the employee will be reimbursed up to the extent of the credits available in his Wellness Account.

If an employee submits expenses and there are no credits in the employee's Wellness Account, no expenses will be reimbursed.

TERMINATION OF COVERAGE

The employee's Wellness Account coverage automatically terminates on the earliest of the following dates:

a) The date this Wellness Account Agreement is terminated; or

b) The date on which the employee retires; or

c) The date the employee is no longer covered under the Group Policy; or

d) The date the Accountholder terminates coverage under this Wellness Account Agreement for the employee.

NOTICE AND PROOF OF CLAIM

Notice and proof of any claim must be submitted to the Administrator in the format required by the Administrator. The proof of claim must include all information that the Administrator requires and deems necessary. The Administrator is not liable for any claim that is not submitted in accordance with this Agreement.

CLAIMS IN CASE OF TERMINATION OF COVERAGE

The employee has 90 days from the date his Wellness Account coverage terminates to submit any claims incurred prior to such date. After that period, the credits are forfeited from the employee's Wellness Account and the expenses are not reimbursed.

CLAIMS IN CASE OF WELLNESS ACCOUNT TERMINATION

If the Wellness Account Agreement and the Group Policy are terminated, the Administrator will not be responsible for claims submitted after the date the Wellness Account terminates.

However, if the Wellness Account Agreement is terminated but the Group Policy is still in force, claims for expenses incurred on or prior to the Wellness Account termination date can be submitted within 90 days from that date.

The Administrator will not be responsible for claims submitted after the end of 90 day period.

If the Group Policy is terminated before the end of the 90 day period, the Administrator will not be responsible for claims submitted after the date the Group Policy terminates.

MODIFICATION TO WELLNESS ACCOUNT CREDITS DUE TO LIFE EVENT

If during a Wellness Account Year, the employee should experience a life event (marriage, civil union, common-law union, divorce, separation, birth of a child, adoption of a child, death of a Dependent), additional credits are added to the employee's Wellness Account.

The employee's credits will not be reduced during a Wellness Account Year.

The additional credits are calculated in proportion to the number of months remaining in the current Wellness Account Year.

The employee may transfer his credits from his HSA to his Wellness Account.

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

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

Health and Dental Claims

The Member must submit a completed claim form with the original receipts (if applicable) to the following address:

For Members residing in Quebec

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

For Members residing outside Quebec

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

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

Disability Claims

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

For Members residing in Quebec

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

For Members residing outside Quebec

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

IMPORTANT NOTICE
For Persons Hospitalized Outside their Province of Residence

The Covered Person is required to contact the medical assistance service provider at the following number as soon as the person is reasonably able to do so after the commencement of Hospitalization. Failure to do so may result in the Planholder limiting or denying the Covered Person's claim.

From within Canada or the United States	1-800-203-9024	(toll free)
From outside Canada or the United States	514-499-3747	(collect)

PROTECTING PERSONAL INFORMATION

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

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

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

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

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

Member's Right to Access His or Her Personal Information

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

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

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

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

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