NISHNAWBE-ASKI LEGAL SERVICES CORP.

NISHNAWBE-ASKI LEGAL SERVICES CORP.

JASON CARON

59086 80757

Employee Benefits for First Nations

CINUP

Certificate Of Insurance

DESJARDINS FINANCIAL SECURITY
INDUSTRIAL ALLIANCE
HOMEWOOD HEALTH

CERTIFICATE DETAILS

JASON CARON
255 PICCADILLY AVE.
THUNDER BAY ON P7B 5L3

Issue Date **12Feb2024**

Company **NISHNAWBE-ASKI LEGAL SERVICES CORP.**
Division# **59086 NISHNAWBE-ASKI LEGAL SERVICES CORP.**
Certificate# **0063480757** *Birth Date* **08May1989**
Class **SB - Status Blend**
Beneficiary **JUNGBIN RIM**

Benefits:			***Effective Date***
Life	Three Times Annual Earnings	$142,000	23Jan2024
AD&D	Three Times Annual Earnings	$142,000	23Jan2024
Dependent Life	$10,000 Spouse / $5,000 Child		23Jan2024
Weekly Indemnity	Payable for up to 16 weeks	$682	23Jan2024
Long Term Disability	Payable up to age 65	$2,955	23Jan2024
Employee Assistance	Confidential support service		23Jan2024
Extended Health	100% All Benefits	FAMILY	23Jan2024
Dental	100% Basic / 80% Major / 50% Ortho	FAMILY	23Jan2024
Critical Illness	Level Benefit	$30,000	23Jan2024

2024-02 CU

BOOKLET-API

This certifies that the individual named is insured on the listed Effective Date(s). This certificate replaces and cancels any Group Certificate previously issued to the certificate holder in connection with the group benefit plan. It is valid only while the individual is insured under the terms of the group policy or policies. Benefits are administered by Johnston Group Inc. If you have any questions about your benefits, please contact CINUP:

CINUP Customer Care
1051 King Edward Street
Winnipeg MB R3H 0R4
1 800 665 1234
Email: contactus@cinup.ca

You can also contact us through our website, where you can find general plan information:
www.cinup.ca

Manage your benefits online at www.my-benefits.ca

CINUP

JASON CARON
255 PICCADILLY AVE.
THUNDER BAY ON P7B 5L3

Benefits Card

Division & Certificate Numbers

Use the Division & Certificate Numbers to identify yourself when calling our Customer Service line and on all correspondence and claim forms.

Prescription Drug Purchases

Use this card for your prescription drug purchases at any pharmacy displaying the ASSURE logo. Please refer to your Benefit Booklet for details.

Dental Claims

Use this card at the dental office. Our CDAnet carrier number can be found on the bottom of the card.

Travel Health

For 24-hour emergency Medical Travel Assistance while outside your province of residence, call the number shown. In the event of an emergency hospital admission, the Medical Travel Assistance service MUST be notified within 48 hours.

CU 59086 80757

BOOKLET-API

CINUP

Division **59086**
Certificate **0063480757**
CDANet: Carrier # 627223
Customer Support 1-800-665-1234
Administered by Johnston Group Inc.

22 641028 0063480757 01
CARON, JASON
NISHNAWBE-ASKI LEGAL SERV

Voyage Assistance
Canada/USA: 1 800 465 6390
Worldwide: 514 875 9170

assure

CINUP

1.800.665.1234

This card is issued to you as part of your firm's group insurance benefit plan. Only you and your covered dependents may use the card to access the benefits provided in your plan. By using the card, you accept the conditions and limits of the coverage including any future modification or cancellation of the card. Because unauthorized use of this card is fraud, please report a lost or stolen card immediately to JG Benefits Inc. at **1.800.665.1234**.

CINUP

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CU 59086 80757

BOOKLET-API

CINUP

Division **59086**
Certificate **0063480757**

CDANet: Carrier # 627223
Customer Support 1-800-665-1234
Administered by Johnston Group Inc.

22 641028 0063480757 01
RIM, JUNGBIN
SPOUSE (02)

Voyage Assistance
Canada/USA: 1 800 465 6390
Worldwide: 514 875 9170

assure

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Table of Contents

WELCOME TO CINUP

We are very pleased to welcome you to the Member benefits program referred to as CINUP. CINUP is a Member benefits program specifically designed to meet the needs of Status and Non-Status Members.

The group insurance benefits detailed in this Member booklet have been designed in accordance with First Nations and Inuit Health Branch (F.N.I.H.B.)/First Nations Health Authority (F.N.H.A.) which permits employers to offer their employees the most comprehensive portfolio of benefits based on their financial budget.

Your Member benefits plan described in this booklet has been arranged by NISHNAWBE-ASKI LEGAL SERVICES CORP.. The Member Benefits personnel at CINUP are very keen to make sure that both the employer and all eligible employees and their dependents receive the excellent level of service they both expect and deserve. If the team can be of any assistance, please contact their staff.

This group insurance program is administered by **JG Benefits Inc.** located in Winnipeg, Manitoba. In the event that any questions arise in the future about the benefit coverage, please do not hesitate to contact your employer's Plan Administrator or contact the CINUP Customer Care Centre at:

Telephone: (800) 665-1234
Fax: (833) 702-4687
Email: contactus@cinup.ca

Claim Submission: Claim forms are available from your employer or online at *www.cinup.ca.* Upon completion, claims should be sent to the CINUP Customer Care Centre at:

CINUP

1051 King Edward Street

Winnipeg, MB R3H 0R4

Fax: (800) 457-8410

Important: To avoid delays, always include your Full Name and Certificate #, your Employer Name and Group Policy # on any claim forms or correspondence submitted.

Changing your Records: To ensure your coverage is kept up-to-date, it is vital that you advise your Plan Administrator of any changes, such as change of name, change in marital status, change of beneficiary, or application for benefits previously waived. Changes reported more than 31 days after they occur may require evidence of insurability.

Disclaimer: This Booklet outlines the benefits that are available under CINUP. In the event of a discrepancy between this document and the Group Master Policy, the latter will govern.

REGISTER FOR *MY-BENEFITS*

Access your coverage online with my-benefits

Register now by going to www.my-benefits.ca. Click on Sign me up and then the I am a Plan Member (Employee) button. Verify your identity, choose your own user ID, and your registration is complete. **It's that simple**.

You now have immediate, secure access to your group insurance plan. Submit most of your Health and Dental claims electronically, quickly, and easily... with claim payments deposited directly into your account within 48 hours of being processed.

Once you are registered, you can download the free *my-benefits* app to your mobile device. No need to carry cards in your wallet as your coverage information and prescription drug card are stored on your mobile device.

Look for *my-benefits* at the iPhone App Store and Google Play.

my-benefits health

By registering, you also gain access to our health and wellness site, where you will find up-to-date news, articles, tools, and information on medical conditions and treatments. Locate doctors, clinics, hospitals, support groups, and private or public services in your area.

Use our **Health Risk Assessment** tool to learn about your health risks and what habits and behaviors you may be able to adjust to improve your overall health.

BENEFIT SUMMARY

Firm # 59086 NISHNAWBE-ASKI LEGAL SERVICES CORP.

Certificate # 80757 JASON CARON

CLASS SB Status Blend

This *Benefit Schedule* outlines the principal features of the benefits available under your benefit program. More detailed information regarding each benefit can be found in the *Benefit Descriptions* section. In the event of a discrepancy between this document and any contracts of insurance or services, the latter will govern.

Benefits are underwritten or provided by:

Benefit	Insurance Company	Group Policy #
BASIC MEMBER LIFE INSURANCE	DESJARDINS FINANCIAL SECURITY	641028
ACCIDENTAL DEATH & DISMEMBERMENT	INDUSTRIAL ALLIANCE	100008700
DEPENDENT LIFE INSURANCE	DESJARDINS FINANCIAL SECURITY	641028
WEEKLY INDEMNITY	DESJARDINS FINANCIAL SECURITY	641028
LONG TERM DISABILITY	DESJARDINS FINANCIAL SECURITY	641028
EMPLOYEE ASSISTANCE PROGRAM	HOMEWOOD HEALTH	1574
EXTENDED HEALTH CARE	DESJARDINS FINANCIAL SECURITY	641028
DENTAL (Plan II-10)	DESJARDINS FINANCIAL SECURITY	641028
CRITICAL ILLNESS	DESJARDINS FINANCIAL SECURITY	641028

Your CINUP advisor is:

WP PENSIONS + BENEFITS

497 ELIZABETH STREET

BURLINGTON, ON

L7R2M4

Phone: 905-632-7557

BENEFIT SCHEDULE

BASIC MEMBER LIFE INSURANCE BENEFIT - 23Jan2024

Benefit:	Life coverage provides a benefit for your beneficiary if you die while covered. Your Life benefit: • is 3 times your annual basic earnings, rounded to the next higher $1,000, and • has a maximum amount of coverage of $500,000. The Non Evidence Maximum is $400,000 of benefit.
Reduction in coverage:	On the 65th birthday of the Member, the amount applicable to the Member will be reduced by 50%.
Termination:	Age 71 of the Member, or retirement, whichever occurs first.

ACCIDENTAL DEATH & DISMEMBERMENT - 23Jan2024

Benefit:	Payable in case of accidental death or bodily injury from an accident. The coverage: • equals 3 times your annual basic earnings, rounded to the next higher $1,000 if not already a multiple. • has an overall maximum of $500,000. The Non Evidence Maximum is $400,000 of benefit.
Reduction in coverage:	On the 65th birthday of the Member, the amount applicable to the Member will be reduced by 50%.
Termination:	Age 71 of the Member, or retirement, whichever occurs first.

DEPENDENT LIFE INSURANCE - 23Jan2024

Benefit:	The spouse's benefit is $10,000 and the children's benefit is $5,000 per child. Dependent coverage for newborn children takes effect from birth.
Termination:	Age 71 of the Member, or retirement, whichever occurs first.

MEMBER WEEKLY INDEMNITY BENEFIT - 23Jan2024

Benefit:	Pays a weekly benefit if you become totally disabled: • based on 75% of weekly earnings, rounded to the next $1, • with a non-evidence maximum of $1,385 per week, and • an overall maximum of $1,385 per week.

Maximum:	*The maximum amount under this benefit cannot be lower than the maximum benefit payable under the Employment Insurance Act for the plan to be eligible under the Employment Insurance Premium Reduction Program.
Elimination Period:	Benefits begin after an Elimination Period of 0 days for an accident / 7 days for sickness, and benefits are payable for up to 16 weeks.
First Day Hospital:	No
Termination:	Age 71 of the Member, or retirement, whichever occurs first.

LONG TERM DISABILITY - 23Jan2024

Benefit:	Long Term Disability coverage provides you a benefit if you are totally disabled. Benefits payable: • are based on 75% of monthly earnings, rounded to the next $1, and • have an overall maximum of $7,500 of monthly benefit. The Non Evidence Maximum is $7,500 of monthly benefit.
Elimination Period:	The Elimination Period is 112 days. Benefits begin the day after the elimination period is completed, and
Definition of Disability:	During the elimination period and the following 2 years, unable to perform the duties of your own occupation. Afterwards, you will be considered disabled if you are unable to do the duties of any occupation.
Termination:	Coverage terminates at the earlier of retirement or age 65.

EMPLOYEE ASSISTANCE PLAN (EAP) - 23Jan2024

Benefit:	Voluntary, confidential support (counselling, coaching, resources) designed as short term, solution-focused assistance for employees and their family members. Your EAP is a proactive option for professionally helping you manage your health and happiness for a broad range of personal or family issues. There is no limit to the number of assessed problems covered under the plan
Termination:	Coverage terminates at the earlier of retirement or termination of employment.

EXTENDED HEALTH CARE - 23Jan2024

Emergency Travel Coverage (Voyage Assistance)

To access these services under your Health coverage, contact the travel assistance firm at:

- Inside Canada or the US: **1.800.465.6390**
- Outside Canada or the US (call collect): **514.875.9170**

(Refer to Benefit Description Section for full details)

Deductible Amount:	Nil

Percentage Of Reimbursement	

Drugs:	• Generic drugs: 100% of the lowest priced equivalent drug available on the market.
	• Brand name drugs:
	  o 100% of the brand name drug if no equivalent drug is available on the market or if the prescription states "NO SUBSTITUTION".
	  o 100% of the lowest priced equivalent drug available on the market, provided the prescription does not state "NO SUBSTITUTION".

Hospitalization Expenses:	100%
Travel Insurance	Regular Members only: 100%
Paramedical and Other Expenses:	100%
Vision Care:	Eye exams: 100% Eyeglasses, Contact Lenses and Eye surgery: 100%
Limits For Eligible Expenses	
Drugs:	Unlimited
Short-Term Hospitalization Expenses:	The cost of a semi-private room for each day of Hospitalization with no limit as to the number of days.
Hostel Care:	Reasonable and Customary Charges of the per diem rate.
Long-term Hospitalization Expenses:	Convalescent / Rehabilitation Centre: Payable amount of $60 per day and a combined maximum of 180 days per hospitalization period.
Travel Insurance	Regular Members only: Lifetime maximum payable amount of $5,000,000 per Insured Person. Chief and Council and/or Elected officials working less than 24 hours per week and/or who are paid an honorarium are not eligible for the Travel Insurance benefit.
Nursing Care:	Payable amount of $5,000 per Insured Person each Calendar Year.

Paramedical Services:	For the following paramedical practitioners, eligible expenses will be covered up to a maximum of $500 per Insured Person each Calendar Year.
	• *Acupuncturist*
	• *Audiologist*
	• *Chiropractor*
	  o (including 1 x-ray per calendar year (not included in the maximum))
	• *Massage therapist or reflexologist***
	• *Naturopath*
	• *Osteopath*
	  o (including 1 x-ray per calendar year (not included in the maximum))
	• *Podiatrist, chiropodist or foot care nurse***
	  o (including 1 x-ray per calendar year (not included in the maximum))
	  o Alberta and Ontario only - Podiatry coverage is payable from first dollar
	• *Speech therapist*
	• *Dietitian*
	For *Occupational Therapist, Athletic Therapist or Physiotherapist***, eligible expenses will be covered up to a maximum of $1,000 per Insured Person each Calendar Year.
	*For services of a licensed Clinical Psychologist, Social Worker, Registered Clinical Counsellor, Canadian Certified Counsellor, Psychotherapist or any other certified mental health practitioner** covered under the plan and belonging to an accredited association or organization that answers to a disciplinary committee (subject to the approval of the Insurance Company)* eligible expenses will be covered up to a maximum of $1,000 per Insured Person each Calendar Year.
	For *Cardiac Rehabilitation*, eligible expenses will be covered up to a lifetime maximum of $300 per Insured Person.
	***The amount specified applies to all disciplines in that grouping.*

Vision Care:	*Eye exams:* One examination per Insured Person once in any 24 month period for adults and any 12 month period for dependent children subject to a reasonable and customary maximum. *Eyeglasses, lenses:* Covered per Insured Person once in any 24 month period for adults and dependent children subject to a maximum of $300. *Laser eye surgery:* Maximum combined with above Eyeglasses, lenses benefit.
Pocketpills:	Pocketpills makes medication more accessible and affordable for you and your dependents. Fill prescriptions online, consult a pharmacist from the comfort of home, and get all your medications delivered directly to your door. Go to pocketpills.com/cinup for more information.

Teladoc Medical Expert:	Teladoc Medical Expert is a service that helps you make medical decisions with confidence. Whether you're dealing with a chronic condition, questioning surgery or facing a life-threatening illness, Teladoc Medical Expert can guide you in the right direction with the following services: • Expert Medical Opinion • Find a Doctor • Care Finder • Personal Health Navigator
Teladoc Mental Health Navigator:	Mental Health Navigator is a confidential virtual service that provides you with an expert's review of your current mental health condition to either confirm or modify your diagnosis or treatment plan to make sure you are receiving the care and support that is right for you.
Teladoc myStrength:	myStrength is a flexible and comprehensive digital mental health program with proven tools to help manage stress, depression, sleep quality and more. Access is available anytime, in one app.
Teladoc Mental Health Care:	With Mental Health Care members can connect with psychologists, psychiatrists and licensed therapists via phone or video session eliminating the need to travel or wait at the provider's office.
Teladoc:	The Teladoc Telemedicine service allows you to consult with a physician about non-urgent medical matters by video conference, by phone, or by app from wherever you are in Canada or the United States, 24 hours a day, 365 days a year. During your visit, you can receive a diagnosis, treatment recommendations, and even be prescribed medication when necessary.
EHN Program:	EHN Canada is the country's largest network of treatment services for mental health, workplace trauma, and addiction with over 100 years of collective experience. A nationwide team of doctors, nurses, psychotherapists, social workers, occupational therapists, and support counsellors provide treatment using evidence-based best practice in mental health and addiction.
Termination:	Coverage terminates at the earlier of retirement or termination of employment.

DENTAL CARE - 23Jan2024

(Refer to Benefit Description Section for full details)

Fee Guide:	Benefits are based on the current Dental fee guide in your province of residence
Deductible Amount:	Nil
Percentage of Reimbursement	
Preventive Services:	100%
Basic Services, Endodontics and Periodontics:	100%

Status / Status Blend Members:	Claims for preventive, basic, endodontic and periodontic services will initially be reimbursed at 15%. The claim must then be submitted to NIHB. Any remaining unpaid balance may then be re-submitted. Reimbursement from all parties cannot exceed the reimbursement percentage of the incurred expense.
Major Restorative Services:	80%
Orthodontics:	50% Eligible Expenses for children up to age 18 only.
Maximum Benefit	
Preventive Services, Basic Services, Endodontics, Periodontics and Major Restorative Services:	Combined maximum of $1,500 per Insured Person each Calendar Year.
Orthodontics:	Lifetime Maximum of $1,500 per Insured Person.
Limitations:	Fees for composite restorations performed on either anterior or posterior teeth are eligible.
Services Covered	
Basic Services Covered	• Recall Exams - Once every 6 months • Complete Exams - Once every 3 calendar years • Tests, lab exams, treatment planning • Fluoride treatments - Once every 6 months • Polishing - Once every 6 months • Scaling/Root Planing - Reasonable and Customary • X-rays - Complete series of periapical films, panoramic radiographs or cephalometric films, limited to one series in any 24 months • Consultations • Pit and Fissure sealants limited to one application per tooth every 36 months (dependents under age 18 only) • Bitewings - Reasonable and Customary • Space maintainers for children • Fillings (nonbonded, composite, acrylic & silicate) • Extractions - Uncomplicated and complex • Oral surgery • General anaesthesia (if performed in conjunction with an eligible expense) • Relining and rebasing of dentures • Repairs to dentures / fixed bridgework • Adjustment to dentures (3 months after insertion) • Oral Hygiene Instruction is covered once per lifetime

Endodontic and Periodontal services covered	• Treatment of disease of the pulp chamber and canals of the teeth (root canals, pulpectomy) • Treatment of the gums and bones supporting teeth (periodontic surgery & appliances) • Root Canal Therapy - limited to one treatment per tooth per lifetime
Major Services Covered	• Crowns • Replacement of crowns (existing crown must be 5 years old) • Fixed bridgework • Replacement of bridgework (existing bridge must be 5 years old) • Dentures • Replacement of dentures (existing denture must be 5 years old) • Denture adjustments
Orthodontic Services Covered	• Services for diagnostic purposes • Preventive orthodontic treatment • Comprehensive orthodontic treatment
Termination	
Termination	Coverage terminates at the earlier of retirement or termination of employment.

CRITICAL ILLNESS - 23Jan2024

Benefit:	A critical illness benefit of $30,000 will be paid as a lump sum to the insured in the event they are diagnosed with a critical illness as defined in this policy.
Termination:	At the earlier of retirement or age 65.

GENERAL GUIDELINES

Participation: Mandatory

Eligibility Requirements:

Minimum Number of Working Hours: Permanent and annual renewable (rolling) contract Employees working a minimum of 20 hours per week. Individuals working for the Employer on a contract basis will be considered as Employees provided the employment contract is for a minimum of 24 months and all other eligibility requirements are met.

Eligibility Period:

All benefits commence immediately following 3 months of continuous employment.

Waiver of Premium: Premiums are waived in the event of Total Disability for Basic Member Life Insurance, Dependent Life Insurance, and Member Long Term Disability Benefit. Where there is Member Long Term Disability Benefit coverage premiums are waived at the end of the Elimination Period of the Member Long Term Disability Benefit. Where there is no Member Long Term Disability Benefit coverage, premiums are waived after 6 months of Total Disability.

This booklet gives a brief outline of the Group Insurance Program provided by your Employer under CINUP. This booklet does not create or confer any rights to benefits; it is for descriptive purposes only. The exact terms of the plan are described in the more detailed provisions of the group policies. In the event of a discrepancy between the booklet and the group policies, the terms of the policies will be applicable. Your Group Insurance Benefits Card, in addition to your Group Insurance Member Booklet is subject to eligibility requirements and all other terms, conditions and limitations of the master policies.

Your Employer has appointed a Plan Administrator who looks after your insurance. The administrator arranges for enrolment in the plan, changes to insurance, termination from the plan and beneficiary designations.

GENERAL PROVISIONS

MEMBER ELIGIBILITY

All permanent employees in the active service of the Employer are eligible once they have completed the waiting period as stated in the *Benefits Schedule - General Guidelines*. A permanent Employee is one who works a minimum of 20 hours per week.

Part-time employees in Saskatchewan working less than 20 hours per week may be eligible for limited benefits. Please contact the CINUP Customer Care Centre to verify whether your organization would be eligible for these benefits.

An Employee not actively at work on the day the insurance would normally commence will not be eligible until they return to permanent work.

Employees of an organization or other business formally associated or affiliated with the Employer as a subsidiary or otherwise are eligible for insurance, provided that such organization is listed in the group policies.

DEPENDENT ELIGIBILITY

Eligible dependents include a legal spouse or common-law spouse*, as well as any children under Age 21, or 26 if in full-time attendance in school**. *Adopted by custom* children, siblings children, grandchild, etc., may be eligible if acceptable supporting documentation is submitted. Please contact CINUP, or your Plan Administrator for further information.

** Common law spouse must cohabitate with the Member for a minimum of 12 months.*

*** Must submit "Confirmation of School Attendance" for over age dependent children.*

The dependent child Age restriction does not apply to a developmentally or physically disabled dependent child, regardless of Age, provided that the Member provides satisfactory proof of the dependent child's disability within 31 days of the limiting ages above, and as required thereafter.

LATE APPLICANT

You have 31 days from the date you become eligible to apply for insurance benefits.

Submitting an application more than 31 days after becoming eligible for coverage may result in retroactive charges going back to the date you should have been enrolled. Late submission also may result in you becoming a *Late Applicant. Late Applicants* may be required to provide proof of insurability, which could result in delayed coverage, costs to you for the completion of medical forms, tests, etc., or possibly denial of all coverage entirely.

WAIVING EXTENDED HEALTH CARE (EHC) AND DENTAL CARE COVERAGE

If you have similar coverage through a spouse's or partner's group insurance plan through their employer, Extended Health and/or Dental Care coverage under CINUP may be waived. You may also hold *duplicate* coverage under both plans. [See Coordination of Benefits]

If you are single and do not have coverage through a spouse's plan, you do not have the option to waive coverage under CINUP.

MEMBERS INSURED UNDER THEIR SPOUSE'S PLAN

If coverage under your spouse's EHC and/or Dental plan terminates, either because the particular plan terminates or because your spouse becomes ineligible for either or both plans, you are eligible for immediate coverage under your employer's EHC and/or Dental Care Benefits. Any application received after this 31 day period will be considered a *Late Applicant*.

CHANGES IN DEPENDENT STATUS

A Member can change coverage from single to family, or family to single, after a birth, adoption, marriage, separation, divorce or death. If the Member wishes to change from single to family coverage, and does not report the change during the 90 days following the date of the change, the dependents may be considered Late Applicants.

If a Member holds dependent coverage, any subsequent dependents will be provided coverage as soon as CINUP is informed of the new dependent and eligibility has been confirmed. The Member may be asked to provide information to confirm eligibility, such as guardianship papers, or a cohabitation date in the case of a common-law relationship.

TERMINATION OF INSURANCE

Employee Termination

Insurance coverage will cease on the earliest of:

- the date the policy terminates;
- the date you reach the Age Limit for each benefit as specified in the *Benefit Schedule*;
- the date you are no longer in an eligible class;
- the date your class is no longer eligible;
- the last day for which you made any required Employee contribution;
- the date your employment terminates.

Coverage may continue if:

- you are disabled;
- you are on a government regulated leave, i.e., maternity/parental/compassionate care, but no longer than is provincially or federally required;
- your employment is terminated due to loss of eligibility, but no longer than is provincially or federally required.

Dependent Termination

You will cease to be insured for dependent coverage on the earliest of:

- the date your insurance is terminated;
- the date the policy is terminated;
- the date you are no longer in a class eligible for dependent coverage;
- the date you no longer have dependents;
- the last day for which you made any required dependent contribution.

A dependent's insurance will terminate on the earlier of:

- the date you no longer are insured for dependent insurance, or
- the day your dependent loses status as a dependent.

On termination of insurance, you may qualify for Extension of Coverage or Conversion Privilege, as described in certain benefits of the policies.

Should you become temporarily laid off, take a leave of absence or be absent due to disability, please consult your plan administrator as to the status of your coverage under this plan.

ACCESS TO INFORMATION

Where legislated, you have the right to obtain copies of the following documents:

- your enrolment form or application for insurance, and
- any written statement or other record not otherwise part of the application, provided to the insurer as evidence of insurability.

All requests for copies of documents should be directed to the CINUP Customer Care Centre.

COORDINATION OF BENEFITS

Coordination of benefits is available if both spouses in a family are regularly employed and Extended Health Care (EHC) and/or Dental Care plans are provided by both places of employment.

Under the *Coordination of Benefits* provision, you are entitled to claim benefits from both plans, as long as the total benefits received do not exceed the actual expenses incurred.

If the services are provided to you, Desjardins Financial Security / Johnston Group Inc. would be the *primary* carrier and would pay benefits first. The other carrier would then be responsible for considering any unpaid eligible expenses.

If the services are provided to your spouse, the other insurer would be the *primary* carrier and would pay benefits first. Your spouse should submit the claim form to their insurer. After receiving payment, any unpaid eligible expenses can be submitted to Johnston Group Inc. with completed claim forms along with the statement of benefits paid from the other insurer.

If the services are provided to a dependent child, the plan of the covered person with the earlier month and day of birth would be the *primary* carrier. The claim would then be processed according to the procedures listed above.

If you are separated or divorced, the plan that will pay benefits for your dependent children will be determined in the following order:

- the plan of the parent with custody of the child;
- the plan of the spouse of the parent with custody of the child;
- the plan of the parent without custody of the child;
- the plan of the spouse of the parent without custody of the child.

DEFINITIONS

Wherever used in the policy:

Accident	means any event due to sudden and unforeseeable external causes that inflicts bodily injuries that are certified by a Physician, directly and independently of any other cause. It does not mean any form of disease, or degenerative process, an inguinal, femoral, umbilical or incisional hernia, or any infection other than an infection of a visible, external cut or wound accidentally sustained.
Actively At Work	means, on any day, the performance by the Employee of all the usual and customary duties of their job with the Employer for the scheduled number of hours for that day.
Age	means the age of the Insured Person on their last birthday when stated or calculated, or on the day when an event referred to under the policy occurs.
Child/Children	means a person who is aged from birth (live birth) up to 21 years of Age or under Age 26 if in full-time attendance at a recognized college or university and is the Member's natural offspring or a child adopted by law. If dependent upon and living with the Member and is aged from birth (live birth) up to 21 years of Age or under Age 26 if in full-time attendance at a recognized college or university, the following other Children will also be eligible: 1. A step-child or foster child; 2. A child adopted by custom; and 3. Any other child who meets the foregoing criteria. The Age limit will not apply where the Child is developmentally or physically disabled and proof of the disability is provided within 31 days of the limiting Age. The requirement that the Child be living with the Member will be waived if the Child must reside in another location to attend school that is not available in their community.
Continuing Medical Care	means the treatment a Member receives. It must be accepted by the medical profession as an effective, appropriate and essential treatment in the diagnosis or care of the specific illness or injury. It must be reasonable, considered as standard practice and provided or prescribed by a Physician or, when the Insurer deems necessary, by a specialist in the appropriate field. Such care is not limited to examination and tests, and must be provided at the frequency required for the specific illness or injury.
Dependent	means a Spouse or Child who is domiciled in Canada. However, if a Dependent is domiciled outside Canada, such Dependent may be deemed to be domiciled in Canada provided such individual is covered under a provincial medical plan and prior written approval is obtained from the Insurer.

Earnings	means the regular rate of pay of an Employee paid by the Employer, including dividends, but excluding bonuses, overtime pay and any non regular form of remuneration. For the Member Weekly Indemnity Insurance benefit that is registered for premium reduction under the Employment Insurance Act, if applicable, bonuses, overtime pay or any other form of pay included in regular compensation and declared to the Insurer is part of Earnings.
Employee	means a person who is domiciled in Canada, except as below, and who is: • employed by the Employer on a permanent or contract basis for not less than the number of hours specified in the *Benefit Schedule*; • retired, having been immediately prior to retirement a person specified in 1) above and who also meets the eligibility requirements as specified in the *Benefit Schedule* (where applicable). • If an Employee is domiciled outside Canada, such Employee may be deemed to be domiciled in Canada provided prior written approval is obtained from the Insurer.
Employer	means any companies listed on the application of the Policyholder for the policy - a type of First Nation legal business, company or entity, which has at least 25% ownership in such legal business, company or entity: • band council; • municipality; • partnership; • proprietorship; • corporation; • educational authority; • a company that employs a minimum of 25% First Nation persons as part of the total number of Employees.
Family-Related Leave	means any leave of absence from work taken by a Member in accordance with such provincial or federal legislation, or an agreement between the Member and the Employer.
Hospital	means any hospital that is designated as such by law and is intended for the care and treatment of sick and injured individuals, and which has organized facilities for diagnosis and major surgeries as well as 24 hour nursing service. The term does not include a nursing home, home for the aged or chronically ill, rest home, Convalescent Hospital, or a place for the care and treatment of alcoholism or drug abuse.
Illness	means any health deterioration or bodily disorder certified by a Physician. For the purposes of the policy, organ donations and related complications are also considered illnesses.
Immediate Family	means a person who is the Spouse, child(s), parent(s), sibling(s), children-in-law, parent-in-law, or sibling-in-law of the Member.
Insurance Act	means the Insurance Act in force in the jurisdiction where a Subscriber resides.
Insured Person	means the Member or one of their insured Dependents, as the case may be.

Insurer	means Desjardins Financial Security.
Maternity Leave	means any leave of absence from work due to pregnancy in accordance with any labour standards legislation that is applicable in the Insured Person's province of residence. Maternity Leave consists of a voluntary portion and a *health related portion*. The *health related portion* of the Maternity Leave commences on the date of the delivery and lasts for at least 6 weeks (8 weeks for a Caesarean delivery). The person is considered to be on Maternity Leave during the entire period for which they are receiving maternity benefits under any provincial or federal legislation. If they're absent from work due to a Total Disability that commenced before or during pregnancy, the Member is considered to be on Maternity Leave in accordance with any provincial or federal legislation.
Parental Leave	means any leave of absence from work taken by a Member to take care of their newborn or adopted child, in accordance with such provincial or federal labour standards legislation, or an agreement between the Member and the Employer.
Member	means an Employee who is insured under the policy.
Physician	means a legally qualified medical practitioner lawfully entitled to practice medicine in the place where the member provides the medical services.
Policyholder	means the company or group indicated on the application and specified on the cover page of the policy.
Spouse	means a person who is domiciled in Canada and who is: • the legal Spouse of the Member by virtue of a religious or civil marriage ceremony; or • the common-law Spouse of the Member with whom the Member has been living in a conjugal relationship continuously for a period of at least 12 months. At any one time, only one person may be insured as a Spouse of the Member.
Usual, Customary, and Reasonable	means the following: • Usual is the usual charge for a given service or supply by an individual providing services or supplies hereunder in their personal practice. • Customary is that range of usual charges by individuals providing services or supplies hereunder of similar training and experience for the same service within a specific limited geographic or socio-economic area. • Reasonable is a charge which meets the above two criteria, or, in the opinion of the provider's professional association, is justifiable in the special circumstances of the particular case in question.

ELIGIBILITY

EMPLOYEE ELIGIBILITY

An Employee is eligible for insurance:

- on the EFFECTIVE DATE, if the member meets the Eligibility Requirements specified in the *Benefit Schedule*; or
- after the EFFECTIVE DATE, on the date on which the member meets the Eligibility Requirements specified in the *Benefit Schedule*.

Except where prohibited, a Member, whose insurance under the policy terminated due to termination of employment and who is re-hired by the Employer within 12 months immediately following the termination of their insurance, will be eligible for the reinstatement of their insurance on the date the Member resumes employment, provided application for reinstatement is made within 31 days of eligibility.

DEPENDENT ELIGIBILITY

A Member with a Dependent on the date they become eligible for insurance under the policy will be eligible for Dependent insurance on such date.

A Member without Dependents who is insured under the policy will be eligible for Dependent insurance on the date the member acquires a Dependent.

Where Spouses are both Employees and insured under the policy, each Spouse will be considered a Dependent of the other and both Spouses may cover their eligible Children.

INSURANCE APPLICATION

An eligible Member must complete an application or an application for exemption for themselves and for their Dependents, if any, within 31 days of the date on which the member becomes eligible.

EVIDENCE OF INSURABILITY

Evidence of insurability means any declaration relating to an individual's physical health or to other factual information that could have a bearing on the acceptance of the risk. Only declarations that are provided on the forms approved by the Insurer will be accepted.

COMMENCEMENT OF INSURANCE AND WAIVER OF PREMIUM

COMMENCEMENT OF MEMBER INSURANCE

The insurance of any Member will become effective on the latest of the following dates, provided that Member is Actively At Work on such date:

- the Effective Date of the policy,
- the date on which the Member first becomes eligible, provided their written application, completed using the form required by the Insurer, is received by the Insurer within 180 days of their date of eligibility,
- the date on which the insurability of the Member is approved by the Insurer, if the application of the Member for insurance is received by the Insurer more than 180 days after the date of their eligibility, the date on which their written application, completed using the form required by the Insurer, is signed by the member.

If a Member is not Actively At Work on the date their insurance would have otherwise commenced, such insurance will commence on the first day the Member is subsequently Actively At Work.

If the Member is not Actively At Work on the date their insurance would have otherwise commenced, due solely to a paid leave or a statutory holiday, then the Member will be considered Actively At Work on such date.

If a Member requests an amount of insurance that exceeds the maximum amount the Insurer will provide without evidence of insurability, as specified in the *Benefit Schedule*, this excess amount will become effective on the latest of the dates specified in the preceding provision or on the date on which the insurability of the Member is approved, if later.

COMMENCEMENT OF DEPENDENT INSURANCE

The insurance for the Dependent of a Member will become effective on the latest of the following dates:

- the date the insurance of a Member first becomes effective under the policy,
- the date a Member insured under the policy first becomes eligible for Dependent insurance, provided written application is made within 90 days of the date of such eligibility,
- the date the insurability of the Dependent is approved by the Insurer, if evidence of insurability is requested of a Member because their application for insurance is received more than 180 days after the date the Member became eligible, the date on which their written application, completed using the form required by the Insurer, is signed by the Member.
- the date the insurability of the Dependent is approved by the Insurer, if the application of the Member for Dependent insurance is made more than 90 days after the Member first became eligible for such insurance, the date on which the written application completed using the form required by the Insurer, is signed by the Member.

The insurance for any individual becoming an eligible Dependent of a Member insured with Dependent insurance will become effective on the date on which such individual becomes a Dependent as defined in this policy.

WAIVER OF PREMIUM

For the Benefits listed in the WAIVER OF PREMIUM provision in the *Benefit Schedule*, as of the Beginning of Waiver of Premium mentioned in the WAIVER OF PREMIUM provision in the *Benefit Schedule*, premiums will be waived for a Member who becomes Totally Disabled while insured under the policy but prior to attaining Age 65 for retirees and age 70 for all other Members, if the Member submits Proof of Claim satisfactory to the Insurer. Premiums will continue to be waived for as long as the Total Disability persists. For the purpose of this provision, premiums will cease to be waived on the earliest of the following dates:

- the date on which the Member is unable or unwilling to provide satisfactory proof of Total Disability to the Insurer, if such proof is not provided within 3 months of the request;
- the date on which the Member ceases to be Totally Disabled;
- for the Life Insurance Benefit, the date on which the Member converts their insurance under the CONVERSION PRIVILEGE provision;
- the date on which the Member attains Age 65 for retirees or the earlier of attaining Age 70 or retirement for all other Members; or
- in respect of each of the Benefits listed in the WAIVER OF PREMIUM provision in the *Benefit Schedule*, the date on which each Benefit or the policy terminates except for the Basic Member Life Insurance Benefit, the Dependent Life Insurance Benefit, the Member Optional Life Insurance Benefit, the Spouse Optional Life Insurance Benefit and the Member Long Term Disability Benefit.

Under the policy, any provision for an increase in coverage is suspended during a Total Disability.

A recurrence of Total Disability within 6 months after the termination of a previous period of Total Disability for which premiums have been waived under the policy shall be deemed a continuation of the previous period if due to the same or related causes.

In the case of the Life Insurance Benefit, if a Totally Disabled Member dies more than 31 days after their insurance terminates, prior to attaining Age 65, and written notice and proof of Total Disability has not been received by the Insurer, the amount of Life Insurance applicable to such Member in accordance with the *Benefit Schedule* that was in effect at the time their insurance terminated will be payable provided that

- the Member became Totally Disabled while insured under this Benefit,
- the Total Disability of the Member was uninterrupted from the onset of their Total Disability to the date of their death,
- the Member dies within 12 months from the onset of their Total Disability,
- the Member did not convert any or all of their insurance under the CONVERSION PRIVILEGE provision at the time their insurance terminated, and
- satisfactory proof of the Total Disability and death of the Member is received by the Insurer within 90 days of their death.

To be eligible for WAIVER OF PREMIUM, the Insurer must receive written notice of Total Disability within 12 months of the date the Member becomes Totally Disabled, and proof satisfactory to the Insurer of Total Disability within 90 days following the date the Insurer received written notice.

In the event of recurrent Total Disability, the Insurer must receive written notice and proof of claim within 12 months of the date of such recurrence.

TERMINATION OF INSURANCE

TERMINATION OF MEMBER INSURANCE

Except as specifically provided to the contrary elsewhere in the policy, the insurance of the Member will terminate on the earliest of the following dates:

- the date the Member no longer qualifies as an Employee, as defined in the policy;
- the date the Member ceases to belong to a class of Members eligible for insurance;
- the date the Member reaches the applicable Age Limit specified in the *Benefit Schedule*;
- the end of the period for which required premiums were paid on behalf of the Member;
- the date the Member ceases to be Actively At Work, except where there is retiree coverage; or
- the date of termination of the policy.

TERMINATION OF DEPENDENT INSURANCE

Except as specifically provided to the contrary elsewhere in the policy, the Dependent insurance of a Member will terminate on the earliest of the following dates:

- the date the insurance of the Member terminates,
- the date the Member no longer has any Dependents,
- the end of the period for which required premiums for Dependent insurance were paid on behalf of the Member, or
- the date Dependent insurance under the policy is terminated.
- The insurance of any Dependent of a Member will terminate on the date the Dependent no longer qualifies as a Dependent, as defined in the policy.

CONTINUATION OF INSURANCE

If a Member ceases to be Actively At Work, the insurance may be continued as specified in the policy.

CLAIMS

NOTICE AND PROOF OF CLAIM

Notice and proof of any claim must be received by the Insurer within the time limit, if any, specified for each Benefit. However, if the policy terminates, no payment will be made unless the notice and proof of a claim is submitted to the Insurer within 120 days of the date of termination of the policy.

Failure to submit notice or proof of claim within the prescribed time limit does not invalidate the claim, provided that the notice and proof of the claim are sent as soon as reasonably possible. However, no payment will be made if the notice and proof of claim are sent more than 12 months after the expenses were incurred.

No action or proceedings may be brought against the Insurer for the recovery of any claim within 60 days or after 3 years following the expiration of the time in which proof of claim is required.

BENEFICIARY

Subject to legal provisions, a Member may designate or revoke, at any time, one or several beneficiaries of the insurance on written notice to the Head Office of the Insurer. The rights of a beneficiary who dies before the Member revert to the latter.

The Insurer assumes no responsibility with respect to the validity of any beneficiary designation or revocation.

The death benefit payable when a Dependent dies is paid to the Member, if alive. If the Member is deceased, the death benefit is paid as follows:

- in the event of the Spouse's death to the Spouse's legal heirs;
- in the event of the death of the Member's Dependent Child, to the Spouse, if alive, or if the Spouse is deceased, to the legal heirs of the Dependent Child.

CLAIMS

Claims under the policy must be submitted to the Insurer on the appropriate form.

Any living benefits will be paid to the Member unless otherwise indicated in the policy.

Within 90 days of a death, the beneficiary or the Member must submit to the Insurer proof of death, including a death certificate, proof of the Age, and Earnings of the Member or the insured Dependent, as well as any other information deemed useful by the Insurer.

If the designated beneficiary is the estate or personal representative of the deceased, or is a minor, or dies before the Member, or is not competent to give valid release, the Insurer reserves the right to pay, at its option and at its discretion, a part of the proceeds of the Member Life Insurance Benefit in an amount not exceeding $5,000 to any person the Insurer deems equitably entitled to such amount to cover the Member's burial expenses. Such payment will fully discharge the Insurer, and the other insurers, provided this payment is made in good faith.

MEDICAL EXAMINATIONS

From time to time, the Insurer will be entitled to have a claimant examined by a Physician or Physicians of its choice.

BASIC MEMBER LIFE INSURANCE

DEFINITIONS

As used in this Benefit:

**** Own Occupation During Elimination Period and the Subsequent 24 Months***

Total Disability or Totally Disabled means	• during the Elimination Period provided for in the Long Term Disability Benefit and the succeeding 24 months: *a state of incapacity, resulting from an Illness or Accident, which wholly prevents the Member from performing each and every essential duty of their regular occupation;* • after the Elimination Period and the succeeding 24 months have elapsed, *a state of incapacity, resulting from an Illness or Accident, which wholly prevents the Member from working in any occupation for which the Member is suited by education, Training and Experience.* Whether or not any such gainful occupation is available in the area where the Member resides does not affect their entitlement to disability benefits. A Member who needs a driver's license issued by the government to perform the duties of their regular occupation is not considered disabled simply because their license has been revoked or has not been renewed.
Training and Experience	means all of the knowledge and skills the Member acquired while in school, in the performance of their current or former professional activities or during their non-working hours.

EVIDENCE OF INSURABILITY

Evidence of insurability satisfactory to the Insurer will be required of a Member applying for any amount of Basic Member Life Insurance in excess of the amount specified in the Benefit Schedule as the Non-Evidence Maximum of Insurability under the Basic Member Life Insurance Benefit.

PAYMENT OF BENEFIT

Upon receipt of Proof of Claim satisfactory to the Insurer that a Member died while insured under this Benefit, the Insurer will pay the amount of Life Insurance applicable to such Member in accordance with the Benefit Schedule and other applicable policy provisions.

LIVING BENEFIT

Subject to the approval of the Insurer, any Member whose life expectancy is less than 24 months may apply for payment of a portion of the amount of Life Insurance applicable to them, subject to the following conditions:

- A Totally Disabled Member may be required to be examined by a Physician designated by the Insurer;
- a Totally Disabled Member must qualify for approval for the Waiver of Premium under the Basic Member Life Insurance Benefit of the policy;

- any individual having an interest in the insurance money must sign a consent to such payment on a form provided by the Insurer.

The Living Benefit is equal to 50% of the amount of Life Insurance applicable to the Member in accordance with the Benefit Schedule. In addition, this amount may not be less than $5,000 or more than $100,000.

At the death of the Member, the Value of the Living Benefit will be deducted from the amount that would otherwise have been payable under the Basic Member Life Insurance Benefit.

The Policyholder is responsible for the premium payments for any Member who has received an advance payment, unless a Waiver of Premium has been granted.

Value of the Living Benefit means the aggregate of the payments made under the Living Benefit, plus the reasonable costs of verifying the medical condition of the Totally Disabled Member, plus the interest thereon from the date of payment until the date of death of the Totally Disabled Member.

The interest rate is set according to the annual average rate of return on one-year guaranteed investment certificates issued by Canadian trust companies. The rate will be that established immediately after the payment of the Living Benefit, as published in the monthly or weekly issue of the Bank of Canada Statistical Summary.

LIVING BENEFIT EXCLUSION

The Living Benefit will not be payable if there has been any material misrepresentation or nondisclosure in the application, whether within two years or not. If the application or coverage is discovered to be null and void after the Living Benefit is paid, the Value of the Living Benefit will be repaid to the Insurer by the recipient of the Living Benefit.

BENEFIT TERMINATION

This Benefit terminates on the date the Member attains the Age Limit specified in the Benefit Schedule or on the earliest of the dates indicated in the TERMINATION OF MEMBER INSURANCE provision.

CONVERSION PRIVILEGE

If the Life Insurance of a Member aged 65 or younger terminates or is reduced (for any reason other than due to policy termination for *Residents of Quebec* only), the Member will be entitled to convert any amount of insurance, up to the terminated amount, to an individual policy without evidence of insurability.

In addition, the amount of insurance that may be converted will be further limited to the lesser of:

- the maximum amount applicable in the province of residence of the Member; or
- the difference between the amount of Life Insurance in force on the date of termination of insurance and the amount of insurance for which the Member is eligible under another group life insurance at the time of exercising their conversion right.

For *Residents of Quebec* only, if the Life Insurance of a Member aged 65 or younger terminates because of the termination of this policy and provided that the Member was insured under this Benefit for five consecutive years immediately prior to such policy termination, the Member will be entitled to convert to an individual policy any amount of insurance, up to the higher of $10,000 or 25% of the Member's amount of insurance, without evidence of insurability. However, such amount of insurance will be reduced by any

group life insurance for which the Member becomes eligible during the 31 days following the termination of this policy.

The individual policy selected in accordance with the above will be subject to the following conditions:

- The Member must submit written application for conversion to the Insurer and must pay the first premium within 31 days of the termination of their insurance under this Benefit;
- The individual policy may be insurance for a non-convertible Term to Age 65, insurance for a non-renewable 1-Year Convertible Term or any regular permanent plan issued by the Insurer at the date of conversion, excluding special permanent plans as may be designated by the Insurer from time to time. The individual policy will not include any special benefit provisions for which an extra premium is charged and will not be a plan under which the amount of insurance may or will increase in the future; at least one permanent plan will be available for conversion at all times. A Dividend Option under which dividends are used to obtain additional insurance may be elected at the time of conversion, if permitted by the Insurer;
- In the event the individual policy selected is insurance for a non-renewable 1-Year Convertible Term, the Member may elect to pay a single premium or quarterly premiums. This policy can be converted to one of the plans described above, but cannot be converted to insurance for another 1-Year Convertible Term;
- The individual policy issued will conform to the conditions, terms, and amounts of individual insurance plans regularly used by the Insurer at the date of conversion;
- The individual policy premium will be based on the rate used by the Insurer on the effective date of that policy and that is applicable to the plan and the amount of the policy issued, the Age of the Member at nearest birthday and the class of risk to which they belong;
- If the amount of Life Insurance that may be converted is less than the minimum amount for which the Insurer will then normally issue the selected plan, the individual policy must be for the full amount that the Member may convert;
- The individual policy will not take effect prior to the end of the 31 day period immediately following the date of termination of insurance of the Member under this Benefit.

The amount of Life Insurance for which a Member who is insured under this Benefit is eligible in accordance with the Benefit Schedule will be reduced by the amount of any individual Life Insurance in force on the life of the Member that was issued previously in accordance with the CONVERSION PRIVILEGE of the policy or the corresponding provision of any other group policy issued by the Insurer.

EXTENSION OF BENEFIT AFTER TERMINATION

If a Member dies within 31 days of termination of insurance under this Benefit, the amount of Life Insurance the Member was eligible to convert will be payable.

NOTICE AND PROOF OF CLAIM

Before settling any death claim, the Insurer will require satisfactory written proof of the occurrence, cause and circumstances of the death, the eligibility of the deceased at the time of death, the date of birth of the deceased, and the right of the claimant to receive the proceeds.

Any death claim notice must be submitted to the Insurer within 30 days of the death and the written proof of claim must be submitted within 90 days of the death.

Subject to applicable legislation, the Insurer may request an autopsy in order to assess its liability in connection with a claim.

The benefit payable on the death of a Member will be paid to the beneficiary designated by the Member within 30 days of receipt of satisfactory proof of claim to the Insurer.

ACCIDENTAL DEATH & DISMEMBERMENT

COVERAGE	Any accident resulting in death, dismemberment, loss of sight, or paralysis - anywhere in the world - 24 hours a day - on or off the job.
ELIGIBILITY	Permanent Status and Non-Status employees of a member firm participating in the Policyholder's Basic Group Life policy or its replacement and work the minimum number of hours per week as specified in the GENERAL PROVISIONS section of this booklet. Status and Non-Status chiefs, council members and appointed or elected officials of a member firm participating in the Policyholder's Basic Group Life policy or its replacement who are paid an honorarium. Permanent Status and Non-Status Saskatchewan resident employees of a member firm participating in the Policyholder's Basic Group Life policy or its replacement who work a minimum of 15 hours per week.
AMOUNT OF INSURANCE	Your amount of insurance (Principal Sum) is equal to the amount of Basic Group Life Insurance in effect under the Policyholder's current Group Life policy or its replacement, subject to a maximum of $500,000. Additionally, a Hunting and Fishing Bonus of $10,000 applies if you sustain Injury while participating in hunting and/or fishing activities, excluding travel to and from the location of the hunting and/or fishing activity.

BENEFITS

Accidental Death, Dismemberment and Specific Loss Indemnity	The policy provides benefits for Injury resulting in any of the following losses which occur within 12 months after the date of the accident as follows:
The Principal Sum for loss of:	• Life; • Entire Sight of Both Eyes; • Speech and Hearing in Both Ears; • One Hand and the Entire Sight of One Eye; • One Foot and the Entire Sight of One Eye.
Three-Fourths of the Principal Sum for loss of:	• Entire Sight of One Eye; • Speech or Hearing in Both Ears.
The Principal Sum for loss or loss of use of:	• Both Hands; • Both Feet; • One Hand and One Foot.
Four-Fifths of the Principal Sum for loss or loss of use of:	• One Arm; • One Leg.

Three-Fourths of the Principal Sum for loss or loss of use of:	• One Hand; • One Foot.
One-Quarter of the Principal Sum for loss or loss of use of:	• Thumb.
One-Twelfth of the Principal Sum for loss or loss of use of:	• Finger (except Thumb).
Paralysis Benefits - Two Times the Principal Sum for:	• Quadriplegia (complete paralysis of both upper and lower limbs); • Paraplegia (complete paralysis of both lower limbs); • Hemiplegia (complete paralysis of upper and lower limbs of one side of body). Indemnity provided under this part for all losses sustained by an Insured Person as the result of any one accident will not exceed the following: • With the exception of Quadriplegia, Paraplegia and Hemiplegia, the Principal Sum; • With respect to Quadriplegia, Paraplegia and Hemiplegia, two times the Principal Sum or the Principal Sum if loss of life occurs within 90 days after the date of the accident. In no event will indemnity payable for all losses under this part exceed, in the aggregate, two times the Principal Sum as the result of the same accident. *"Injury"* whenever used in the policy means bodily injury caused by an accident occurring while the policy is in force as to the Member whose injury is the basis of claim and resulting directly and independently of all other causes in loss covered by the policy, and that is not caused or contributed to, directly or indirectly, by physical or mental illness or disease, or treatment for the illness or disease. *"Loss"* whenever used in the policy with reference to hand or foot means complete severance at or above the wrist or ankle joint but below the elbow or knee joint; as used with reference to arm or leg means complete severance at or above the elbow or knee joint; as used with reference to thumb means complete severance of one entire phalanx of the thumb; as used with reference to finger means complete severance of two entire phalanges of the finger; as used with reference to toes means complete severance of one entire phalanx of the big toe and all phalanges of the other toes; as used with reference to eye means the irrecoverable loss of the entire sight thereof; as used with reference to speech means the total and irrecoverable loss thereof; as used with reference to hearing means the total and irrecoverable loss thereof; and as used with reference to Quadriplegia, Paraplegia and Hemiplegia means the permanent and irrecoverable paralysis of such limbs. *"Loss of Use"* whenever used in the policy means a loss which is permanent, total, irrecoverable and continuous for a period of 12 months from the date of the accident.

BEREAVEMENT BENEFIT	If Injury results in your loss of life and indemnity becomes payable under the policy, the insurer will pay the reasonable and necessary expenses actually incurred by your spouse and dependent children for up to six sessions of grief counseling, by a professional counselor, subject to a maximum of $2,500.00.
BRAIN DAMAGE BENEFIT	If you sustain an Injury which results in Brain Damage, the insurer will pay the Principal Sum, less any amount paid or payable under 'Accidental Death, Dismemberment and Specific Loss Indemnity' of the policy as the result of the same accident, provided that: • you incur Brain Damage within 120 days from the date of the accident; and • you are hospitalized as a result of Brain Damage at least seven of the first 120 days of the Injury; and • a physician determines and the Company is satisfied that you have evidence of Brain Damage for at least six consecutive months. *"Brain Damage"* whenever used in the policy means irreversible physical damage to the brain causing complete incapacity of performing all the substantial and material functions and activities normal to everyday life.
CONTINUATION OF COVERAGE	If, under the Policyholder's current Basic Group Life policy, your life insurance is continued during any approved leave of absence, temporary lay-off, maternity or parental leave or disability leave, your coverage under this policy will also be continued, provided payment of premium is continued.
CRITICAL ILLNESS BENEFIT	If you are diagnosed with a Covered Condition by a specialist while the Critical Illness Benefit is in force, and survive for 30 days following the date of diagnosis, the insurer will pay $1,000, subject to all limitations and exclusions in the policy. Payment of the Critical Illness Benefit is limited to only the first Covered Condition to occur. *"Covered Condition"* whenever used in the policy means cancer (life-threatening), coronary artery bypass surgery, heart attack or stroke.
DAY CARE BENEFIT	If Injury results in your loss of life and indemnity becomes payable under the policy, the insurer will pay the reasonable and necessary expenses actually incurred, subject to five percent of your Principal Sum to a maximum of $5,000, for each of your dependent children under 13 years of age who (a) are enrolled in a legally licensed day care centre on the date of your death; or (b) enrol in a legally licensed day care centre within 12 months after the date of your death. The benefit will be paid each year immediately upon receipt of satisfactory proof that the dependent child is enrolled in a legally licensed day care centre, but not to exceed four consecutive annual payments with respect to any one dependent child. If, at the time of loss, you have no dependent children eligible for the Day Care Benefit, the insurer shall pay an additional amount of $2,500 to your designated beneficiary.

EDUCATION BENEFIT	If Injury results in your loss of life and indemnity becomes payable under the policy, the insurer will pay the reasonable and necessary expenses actually incurred, subject to five percent of your Principal Sum to a maximum of $5,000, for each of your dependent children who (a) are enrolled as full-time students in a school for higher learning above the secondary school level; or (b) were enrolled as full-time students at the secondary school level but enrol as full-time students in a school for higher learning within 12 months after the date of your death. The benefit will be paid each year immediately upon receipt of satisfactory proof that the dependent child is enrolled as a full-time student in a school for higher learning, but not to exceed four consecutive annual payments with respect to any one dependent child. If, at the time of loss, you have no dependent children eligible for the Education Benefit, the insurer shall pay an additional amount of $2,500 to your designated beneficiary.
EXTENSION OF COVERAGE	Your coverage under the policy may be continued for a period of up to 12 consecutive months for you if your employment has been terminated by a member firm, provided such continuation of coverage is required by the Employment Standards Act or by a severance package agreement received by you from the member firm and payment of premium is continued.
FAMILY TRANSPORTATION BENEFIT	If, following an injury which results in a loss covered by the policy, you are confined as an inpatient in a hospital located from a point of not less than 150 kilometers from your normal place of residence, the insurer will pay the reasonable expenses actually incurred by any member of your immediate family for hotel accommodation and transportation by the most direct route to you, not to exceed in the aggregate the amount of $15,000 for all such expenses.
FUNERAL EXPENSE BENEFIT	If Injury results in your loss of life and indemnity becomes payable under the policy, the insurer will pay the reasonable and necessary funeral expenses actually incurred, subject to a maximum of $5,000.
HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT	If, following an Injury which results in a Loss covered by the policy, you are required to use a wheelchair to be ambulatory, the insurer will pay the reasonable and necessary expenses actually incurred within three years of the date of the accident causing such Loss for (a) the cost of alterations to your principal residence; and/or (b) the cost of modifications to one motor vehicle utilized by you, when such modifications are approved by the provincial vehicle licensing authorities where required for the purpose of making them wheelchair accessible, subject to a maximum of $15,000 as the result of any one accident.
IDENTIFICATION BENEFIT	If Injury results in your loss of life and indemnity becomes payable under the policy, and provided identification of your body is required by the police or similar law enforcement agency, the insurer will pay the reasonable and necessary expenses actually incurred by a member of your immediate family for lodging and board (not to exceed a maximum duration of three consecutive nights) and transportation by the most direct route to and from the location of your body, subject to a maximum of $10,000. The body's location must not be less than 150 kilometers from the family member's normal place of residence.

IN-HOSPITAL INDEMNITY BENEFIT	If, following an Injury, you are confined in a hospital as a resident inpatient for more than five consecutive days, the insurer will pay (a) a monthly benefit of one percent of your Principal Sum; or (b) for periods of less than one month, one thirtieth of the above monthly benefit per day. This benefit is limited to (a) a monthly amount not to exceed $2,500 and (b) a total of 12 months for any covered accident. Benefits are retroactive to the first day of hospital confinement.
PSYCHOLOGICAL THERAPY BENEFIT	If Injury results in a Loss covered by the policy and you require psychological therapy as prescribed by a physician, the insurer will pay the reasonable and necessary expenses actually incurred, subject to a maximum of $1,000, until the full maximum has been paid, two years have elapsed from the date of Injury, or you die, whichever occurs first.
REHABILITATION BENEFIT	If, following an Injury which results in a Loss covered by the policy, you require special training in order to be qualified to engage in a special occupation in which you would not have engaged except for such Injury, the insurer will pay the reasonable and necessary expense incurred for such training within three years of the date of the accident, subject to a maximum of $15,000 as the result of any one accident.
REPATRIATION BENEFIT	If Injury results in your loss of life and indemnity becomes payable under the policy, the insurer will pay the reasonable and necessary expenses actually incurred for preparation and transport of your body to your city of residence, subject to a maximum of $15,000.
SEAT BELT BENEFIT	If, due to a vehicular accident, Injury results in a loss covered by the policy, your Principal Sum will be increased by 10% if, at the time of the accident, you were driving or riding in a vehicle and wearing a properly fastened seat belt. The driver of the vehicle must hold a current and valid driver's license authorizing them to operate such vehicle and neither be intoxicated nor under the influence of drugs at the time of the accident. Due proof of seat belt use must be provided as part of the written proof of loss.
SPOUSAL RETRAINING BENEFIT	If Injury results in your loss of life and indemnity becomes payable under the policy, the insurer will pay the reasonable and necessary expenses actually incurred within three years from the date of such accident by your Spouse who engages in a formal occupational training program in order to become specifically qualified for active employment in an occupation for which the member would not otherwise have sufficient qualifications, not to exceed in the aggregate the amount of $15,000 for all such expenses.
SURGICAL REATTACHMENT BENEFIT	If Injury results in the complete severance of your limb or appendage or part of either your limb or appendage, and if such severed limb, appendage or part is surgically reattached, the Company will pay the Surgical Reattachment Benefit in accordance with the limitations outlined in the policy. The maximum amount payable for this benefit and "Accidental Death, Dismemberment and Specific Loss Indemnity" of the policy is the Principal Sum for all losses sustained by you as the result of any one accident.

WAIVER OF PREMIUM	In the event you become totally disabled while under age 65 and your waiver of premium claim is accepted and approved under the member firm's current Group Life policy, premiums payable under the Basic AD&D policy will be waived as of the same date the claim is accepted and approved by the Group Life policy Underwriter.
WORKPLACE MODIFICATION AND ACCOMMODATION BENEFIT	If, following an Injury which results in a Loss covered by the policy, you require special adaptive equipment and/or workplace modification in order to reasonably accommodate your return to active full-time employment with the member firm providing this benefit, the insurer will pay the reasonable and necessary expenses actually incurred by the member firm subject to a maximum of $5,000 as the result of any one accident, provided the member firm (a) agrees to provide the required equipment and/or make modifications to your workplace; and (b) acknowledges performance of the essential duties of your occupation may be altered. All required equipment and/or workplace modification must have prior approval by the insurer.
AGGREGATE LIMIT OF INDEMNITY	The part titled "Accidental Death, Dismemberment and Specific Loss Indemnity" of the policy is subject to an Aggregate Limit of Indemnity of $3,500,000 for all losses resulting from any one accident. This means that in the event of an accident that results in an accumulation of losses exceeding $3,500,000, the amount payable with respect to each Insured Person will be reduced proportionately.
EXPOSURE AND DISAPPEARANCE	If due to accident you are unavoidably exposed to the elements and such exposure, within 12 months of the date of the accident, results in a Loss for which indemnity would otherwise have been payable under the policy, such Loss will be deemed to be the result of Injury. Where, due to the accidental wrecking, sinking or disappearance of a conveyance in which you were riding, you disappear, and if your body is not found within 12 months after the date of such wrecking, sinking or disappearance, it will be presumed, subject to there being no evidence to the contrary and subject to all other terms and conditions of the policy, that you suffered loss of life as a result of Injury.
EXCLUSIONS	Coverage does not apply to any loss caused or contributed to by: • flying as a pilot or crew member in any aircraft; • suicide or self-destruction while sane or insane; • full-time, active service in the armed forces of any country; • declared or undeclared war or act of war; • flying in owned, operated or leased aircraft of a member firm of the Policyholder; • participation in a riot, insurrection, civil commotion or disturbance; • medical treatment or surgery, except if the medical treatment or surgery was needed because of an accident.

BENEFICIARY	The beneficiary or beneficiaries of the Member shall be that person or those persons designated by the Member under the member firm's current Group Life policy. If no such designation has been filed, the beneficiary in respect of loss of life of the Member shall be the estate of the Member. All other indemnities payable will be payable to the Member, with the exception of indemnities payable under "Bereavement Benefit", "Day Care Benefit", "Education Benefit", "Family Transportation Benefit", "Identification Benefit", "Spousal Retraining Benefit" and "Workplace Modification and Accommodation Benefit".
AD&D CLAIMS PROCEDURES	Claim forms are available from your plan administrator or from IA. IA reserves the right to request additional information when processing the claim. Written notice of accidental death, dismemberment, loss of sight, hearing, paralysis or loss of use of limbs is to be given to IA within a period of 30 days from the date of the accident. For all other claims, completed claim forms must be filed with IA within 90 days after the date of the Injury and no later than 12 months regardless of whether expenses have been incurred.

This wording is for illustrative purposes only and carries no contractual or other rights. All rights with respect to the benefits of the Member will be governed by the group master policy.

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

DEPENDENT LIFE INSURANCE

PAYMENT OF BENEFIT	Upon receipt of Proof of Claim satisfactory to the Insurer that a Dependent died while insured under this Benefit, the Insurer will pay the amount of Dependent Life Insurance applicable to such individual in accordance with the Benefit Schedule and other applicable policy provisions.
COMMENCEMENT OF NEWBORN CHILDREN INSURANCE	Insurance for a newborn Child of a Member with insured Dependents will commence in accordance with the terms specified in the Benefit Schedule and the policy provisions, including those that pertain to the COMMENCEMENT OF DEPENDENT INSURANCE.
BENEFIT TERMINATION	This Benefit terminates on the date the Member attains the Age Limit specified in the Benefit Schedule or on the earliest of the dates indicated in the TERMINATION OF DEPENDENT INSURANCE provision.
SPOUSE CONVERSION PRIVILEGE	If the Dependent Life Insurance of a Spouse aged 65 or younger, insured for a minimum amount of $5,000, terminates, the Member, or the Spouse in the event of the death of such Member, may convert the Dependent Life Insurance on the Spouse to an individual policy, without evidence of insurability, subject to the following conditions: • The written application for conversion must be submitted to the Insurer and the first premium paid within 31 days of the date of termination of the insurance of the Spouse under this Benefit; • The individual policy may be any regular permanent plan issued by the Insurer at the date of conversion, excluding special permanent plans as may be designated by the Insurer from time to time. The individual policy will not include any special benefit provisions for which an extra premium is charged and will not be a plan under which the amount of insurance may or will increase in the future; at least one permanent plan will be available for conversion at all times; • The individual policy issued will conform to the conditions, terms and amounts of individual insurance plans regularly used by the Insurer at the date of conversion; • The individual policy premium will be based on the rate used by the Insurer on the effective date of that policy and that is applicable to the plan and the amount of the policy issued, the Spouse's Age at nearest birthday and the class of risk to which the Spouse belongs; • If the amount of Dependent Life Insurance that may be converted is less than the minimum amount for which the Insurer will normally issue the selected plan, the individual policy must be for the full amount that the Spouse may convert; • The individual policy will not take effect prior to the end of the 31 day period immediately following the date of termination of insurance on the Spouse under this Benefit.

EXTENSION OF BENEFIT AFTER TERMINATION	If a Spouse dies within 31 days of the termination of their insurance under this Benefit, the amount of Dependent Life Insurance payable will be the amount that the Member or the Spouse, in the event of the death of such Member, was eligible to convert.
NOTICE AND PROOF OF CLAIM	Before settling any death claim, the Insurer will require satisfactory written proof of the occurrence, cause and circumstances of the death, the eligibility of the deceased at the time of death, the date of birth of the deceased, and the right of the claimant to receive the proceeds. Subject to applicable legislation, the Insurer may request an autopsy in order to assess its liability in connection with a claim.

MEMBER WEEKLY INDEMNITY BENEFIT

DEFINITIONS

As used in this Benefit:

Elimination Period	means the period, as specified in the Benefit Schedule, of continuous Total Disability that must be completed before Weekly Indemnity Benefits commence under this Benefit. If a Member can and does continue their coverage under this Benefit throughout any absence or leave (other than a Maternity, Parental or Family-Related absence or leave) as described in the policy, and such Member becomes Totally Disabled during such leave, the Elimination Period will be deemed to commence on the date the Member is scheduled to return to active work.
Hospitalization	means to be admitted to a Hospital as an inpatient for more than 18 consecutive hours.
Maximum Benefit Period	means the maximum number of weeks during which benefits are payable. This period is specified in the Benefit Schedule. If this benefit, in accordance with the Benefit Schedule, is carved out with the Employment Insurance Act (EI) as a standard wrap around plan, the Maximum Benefit Period includes the number of weeks during which EI benefits are paid by Human Resources Development Canada.
Net Weekly Earnings	means the weekly Earnings in effect immediately prior to commencement of Total Disability less all income taxes and contributions to the Canada/Quebec Pension Plan and Employment Insurance payable thereon.
Total Disability or Totally Disabled	means the inability of the Member as a result of an Illness or Accident to perform all the usual duties of their main occupation and which requires Continuing Medical Care. A Member who needs a driver's license issued by the government to perform the duties of their regular occupation is not considered disabled simply because their license has been revoked or has not been renewed.

PAYMENT OF BENEFIT

Upon receipt of Proof of Claim satisfactory to the Insurer that:

- a Member became Totally Disabled while insured under this Benefit and remained Totally Disabled during the Elimination Period, and
- the Member is under Continuing Medical Care of a Physician, as defined under the DEFINITIONS provision of the policy,

the Insurer will pay Weekly Indemnity Benefits for as long as the Member is Totally Disabled, in accordance with applicable policy provisions, up to the Maximum Benefit Period.

To qualify for Weekly Indemnity Benefits, any Accident causing the Total Disability, as defined in the DEFINITIONS above, must be confirmed by a Physician and sustained not more than 30 days prior to the onset of such disability.

The "health related portion" of the Maternity Leave taken by a Member is considered to be a period of Total Disability for the purposes of benefit payment under this Benefit, whether the Member's insurance was continued during the leave or not. The maternity benefits payable under any public or private plan are deducted from the benefits payable to the Member for this period, in accordance with the provisions of this contract.

For a Total Disability that begins during the voluntary leave portion of a Maternity Leave, or during a Parental or Family-Related Leave, benefits are payable from the later of the following dates, provided the current benefit remained in force and provided the Member is still Totally Disabled and insured under this Benefit:

- the end of Elimination Period;
- the scheduled date of return to work.

The amount of Weekly Indemnity Benefit payable under this Benefit will be the amount specified in the Benefit Schedule based on the Earnings in effect immediately prior to commencement of Total Disability.

The Weekly Indemnity payments may be taxable in accordance with the Benefit Schedule.

Weekly Indemnity Benefits are payable weekly in arrears, commencing on the later of

- the completion of the Elimination Period; and
- the first day the Member consults a Physician.

The Elimination Period is expressed in calendar days.

Any payments for a period of less than one week will be at the daily rate of 1/7th of the Weekly Indemnity Benefit.

DISABILITY MANAGEMENT

The Insurer may at any time require a Totally Disabled Member to participate in a disability management program or to take up rehabilitative employment that is considered appropriate by the Insurer.

The Insurer will actively co-ordinate all disability management program services listed below and will also facilitate and ensure case follow-up:

- co-ordination of access to health care services;
- support program for returning to work;
- negotiations for a gradual return to work;
- rehabilitation program, which may include evaluation, treatment, training, placement and job search services.

If a Totally Disabled Member, while receiving Weekly Indemnity Benefits, takes part in a disability management program or takes up rehabilitative employment under the supervision of their Physician and with the approval of the Insurer:

- the Member will still be considered Totally Disabled while taking part in this program, subject to the Maximum Benefit Period specified in the Benefit Schedule;
- if, while taking part in this program, a Member becomes Totally Disabled again, the terms and conditions of this Benefit will re-apply to the Member as if they had been Totally Disabled during the rehabilitation period;

- the Maximum Benefit Period during any period of Total Disability will continue to apply even if the Member is taking part in an approved disability management program or rehabilitative employment;
- if, while taking part in this program, the Member earns any income, the Weekly Indemnity Benefits payable by the Insurer to the Member will be reduced by the amount produced by the following formula:

(A / B) x C

A = Income earned from any rehabilitative activity

B = Weekly Earnings of the Member immediately prior to commencement of Total Disability

C = Weekly Indemnity Benefits otherwise payable under this Benefit

- while the Member is taking part in a disability management program, the Insurer will reduce their Weekly Indemnity Benefits so that their ***total income from all sources***, if any, does not exceed 100% of their Net Earnings immediately prior to commencement of Total Disability if this Benefit is non-taxable, or 100% of their gross Earnings immediately prior to commencement of Total Disability if this Benefit is taxable.

The Member's ***total income from all sources*** includes any of the following listed below that the Member has received or is eligible to receive:

- any weekly benefits payable under this Benefit;
- any weekly Earnings or payment from the Employer;
- any disability benefits payable under the Canada Pension Plan or the Quebec Pension Plan, but excluding benefits payable on behalf of the Member's Dependents and any increase in benefits after benefit payments commence due solely to the cost-of-living;
- any disability benefits payable under the Workers' Compensation Act or similar legislation or any other government plan, excluding benefits payable under the Employment Insurance Act;
- any benefits payable from a retirement or pension plan provided by the Policyholder, excluding any increase in benefits after benefit payments commence due solely to the cost-of-living;
- any indemnity payable for loss of time under any government plan requiring or providing automobile insurance benefits on a no-fault basis, provided that these plans have been approved as an acceptable limitation and still permit this Benefit to be registered for premium reduction under the Employment Insurance Act, as amended from time to time.

A Member who refuses to take part in a disability management program, does not participate in such program in good faith, or does not take up rehabilitative employment considered appropriate by the Insurer will no longer be eligible for Weekly Indemnity Benefits under the policy.

RECURRENT TOTAL DISABILITY

Successive periods of Total Disability occurring after the Weekly Indemnity Benefits became payable are considered to be the same period of Total Disability unless they are separated by at least:

- 2 consecutive weeks of active full-time employment, if Total Disability is due to the same cause or related causes; or
- 1 day of active full-time employment, if Total Disability is due to an entirely unrelated cause.

Whenever successive periods of Total Disability are considered to be the same period of Total Disability, the Elimination Period will not be applied a second time and the same amount as for the initial Total Disability minus any payments already made will be payable for the remainder of the Maximum Benefit Period.

REDUCTION OF WEEKLY INDEMNITY BENEFITS, LIMITATIONS AND EXCLUSIONS

Reduction of Weekly Indemnity Benefits

Weekly Indemnity Benefits payable under this Benefit will be reduced by

- any benefits the Member is eligible to receive under any Workers' Compensation Act or similar legislation;
- if the Maximum Benefit Period exceeds 17 weeks, any disability benefits the Member is eligible to receive under the Canada Pension Plan or the Quebec Pension Plan excluding
    - benefits payable on behalf of their Dependents; and
    - any increase in benefits due solely to the cost-of-living, after benefit payments commence;
- any income replacement indemnity payable to a Member under
    - the Automobile Insurance Act of the Province of Quebec;
    - the Ontario Motorist Protection Plan; or
    - any other government no-fault automobile insurance plan
    - provided that these plans have been approved as an acceptable limitation and still permit this Benefit to be registered for premium reduction under the Employment Insurance Act, as amended from time to time;
- any Earnings or payments from the Employer;
- any income replacement benefits paid to the Member under any other federal or provincial legislation;
- any benefit paid to the Member under any Employee benefit plan established by the Policyholder, and;
- any severance or wrongful dismissal payments.

The Insurer may, at its discretion, estimate the amount of a government plan award pending notice of the actual award.

The Insurer may also reduce the Weekly Indemnity payments even if the Member, who is required to make the necessary application, fails or refuses to exercise their rights under the above-mentioned legislation or plans.

If the Member receives a lump-sum payment from any of the sources indicated above, the Insurer will reduce the Weekly Indemnity payments by this amount, calculated on a weekly basis.

Limitations

No benefits are payable for a Total Disability period

- during the voluntary leave portion of the Maternity Leave as described under the DEFINITIONS section, for a Total Disability occurring during this period;
- during a Parental or Family-Related Leave, for a Total Disability occurring during this period;
- during any work stoppage due to a strike, lock-out, Leave of Absence or lay-off, for a Total Disability occurring during this period;

- during the imprisonment of the Member due to conviction of an offence;
- if the Member remains outside Canada for longer than 3 months for any reason whatsoever, unless the Insurer gives prior written consent to continue paying benefits during this period.

Exclusions
No benefits are payable for a Total Disability resulting directly or indirectly from any one of the following causes:

- war, whether the war be declared or not, or service in the armed forces of any country, or participation in a riot, insurrection or civil commotion;
- committing, or attempting to commit a criminal offence;
- cosmetic surgery or treatment, unless such surgery or treatment is required as a result of an Accident that occurred while the Member was insured under this Benefit;
- alcohol or drug abuse unless, for such abuse, the Member is actively taking part in a therapeutic program supervised by a Physician on an on-going basis, is receiving Continuing Medical Care or treatment for rehabilitation, satisfactory to the Insurer, at an established treatment centre qualified to provide the necessary treatment or care;
- driving a motorized vehicle while impaired by drugs, or with an alcohol level that exceeds the limit set under the Criminal Code of Canada.

TERMINATION OF BENEFITS

Weekly Indemnity Benefits payable under this Benefit will cease on the earliest of:

- the date the Member ceases to be Totally Disabled;
- the date the Member engages in any gainful occupation other than an approved gainful occupation for the purpose of rehabilitation;
- the date the Member fails to furnish satisfactory proof of continued Total Disability to the Insurer;
- the date payments have been paid up to the Maximum Benefit Period for any period of Total Disability;
- the date the Member refuses to participate in a disability management program or to take up rehabilitative employment considered appropriate by the Insurer; and
- the date the Member attains the Age Limit under this Benefit. However, if a Member is Totally Disabled prior to this Age Limit and on attaining it the Member is still so disabled and has not yet received 15 weeks of benefit payments for that disability, notwithstanding the Age Limit of this Benefit, coverage will be extended to the earliest of
    - the date such Member has received 15 weeks of benefits,
    - the date such Member ceases to be Totally Disabled, or
    - the date such Member retires.

EXTENSION OF BENEFIT AFTER TERMINATION

If a Member is Totally Disabled on the date their insurance terminates, the Insurer will continue insurance for that Total Disability as if the insurance under this Benefit for that Member were still in force, provided such Total Disability continues uninterrupted, subject to all other provisions of the policy.

NOTICE AND PROOF OF CLAIM

Written proof of a claim must be submitted to the Insurer within 60 days of the date Total Disability commenced.

Subsequent written proof satisfactory to the Insurer of continued Total Disability must be submitted to the Insurer at its request.

MEMBER LONG TERM DISABILITY

DEFINITIONS

As used in this Benefit:

** Own Occupation During Elimination Period* and the Subsequent 24 Months

Total Disability or Totally Disabled means	• during the Elimination Period provided for in the Long Term Disability Benefit and the succeeding 24 months, o *a state of incapacity, resulting from an Illness or Accident, which wholly prevents the member from performing each and every essential duty of their regular occupation;* • after the Elimination Period and the succeeding 24 months have elapsed, o *a state of incapacity, resulting from an Illness or Accident, which wholly prevents the member from working in any occupation for which the member is suited by education, Training and Experience.* Whether or not any such gainful occupation is available in the area where the Member is domiciled does not affect this entitlement to Long Term Disability Benefits. A Member who needs a driver's license issued by the government to perform the duties of their regular occupation is not considered disabled simply because their license has been revoked or has not been renewed.
Elimination Period	means the period, as specified in the Benefit Schedule, of continuous Total Disability that must be completed before Long Term Disability Benefits commence under this Benefit. If a Member can and does continue their coverage under this Benefit throughout any absence or leave (other than a Maternity, Parental or Family-Related absence or leave) as described in the policy, and such Member becomes Totally Disabled during such leave, the Elimination Period will be deemed to commence on the date the Member is scheduled to return to active work.
Maximum Benefit Period	means the maximum period during which monthly benefits are payable, as specified in the Benefit Schedule.
Net Monthly Earnings	means the monthly Earnings in effect immediately prior to commencement of Total Disability less all income taxes and contributions to the Canada/Quebec Pension Plan and Employment Insurance payable thereon.
Training and Experience	means all of the knowledge and skills the Member acquired while in school, in the performance of their current or former professional activities or during their non-working hours.

EVIDENCE OF INSURABILITY

Evidence of insurability satisfactory to the Insurer will be required of a Member applying for any benefit amount of Long Term Disability in excess of the amount specified in the Benefit Schedule as the Non-Evidence Maximum of Insurability under the Member Long Term Disability Benefit.

PAYMENT OF BENEFIT

Upon receipt of Proof of Claim satisfactory to the Insurer that:

- a Member became Totally Disabled while insured under this Benefit and remained Totally Disabled during the Elimination Period; and
- the Member is under Continuing Medical Care of a Physician, as defined under the DEFINITIONS provision of the policy;

the Insurer will pay monthly Long Term Disability Benefits for as long as the Member is Totally Disabled, in accordance with applicable policy provisions, up to the Maximum Benefit Period.

The "health related portion" of the Maternity Leave taken by a Member is considered to be a period of Total Disability for the purposes of benefit payment under this Benefit, whether the Member's insurance was continued during the leave or not. The maternity benefits payable under any public or private plan are deducted from the benefits payable to the Member for this period, in accordance with the provisions of this contract.

For a Total Disability that begins during the voluntary leave portion of a Maternity Leave, or during a Parental or Family-Related Leave, benefits are payable from the later of the following dates, provided the current benefit remained in force and provided the Member is still Totally Disabled and insured under this Benefit:

- the end of Elimination Period;
- the scheduled date of return to work.

The amount of Long Term Disability Benefit payable will be the amount specified in the Benefit Schedule based on the monthly Earnings in effect immediately prior to the initial date of Total Disability.

Long Term Disability Benefits are payable at the end of each month following the completion of the Elimination Period.

Any payments for a period of less than one month will be at the daily rate of 1/30 of the monthly benefit.

Long Term Disability Benefits may be taxable in accordance with the Benefit Schedule.

REDUCTION OF LONG TERM DISABILITY BENEFITS, LIMITATIONS AND EXCLUSIONS

Direct Offset

Long Term Disability Benefits otherwise payable to the Member under this Benefit will be reduced by:

- any benefits the Member is eligible to receive under any Workers' Compensation Act or similar legislation; any disability benefit the Member is eligible to receive under the Canada Pension Plan or the Quebec Pension Plan excluding
    - benefits payable on behalf of their Dependents; and
    - any increase in benefits due solely to cost-of-living, after benefit payments commence;
- any indemnity payable for loss of time under any government plan requiring or providing automobile insurance benefits on a no-fault basis; and
- any disability benefit payable by a private pension plan.

Indirect Offset
In addition, the Insurer will further reduce Long Term Disability Benefits by any amount by which the total monthly income of the Member from all sources exceeds

- 85% of their gross monthly Earnings immediately prior to Total Disability, if the Long Term Disability Benefits are included in their income under the Income Tax Act (Canada); or
- 85% of their Net Monthly Earnings immediately prior to Total Disability, if the Long Term Disability Benefits are not included in their income under the Income Tax Act (Canada).

The total monthly income of a Member from all sources, whether the Member receives or is eligible to receive this income, will include all of the following:

- any Long Term Disability payments under this Benefit;
- any monthly Earnings or payments from the Employer;
- any disability benefits payable under the Quebec Pension Plan, excluding benefits payable on behalf of Dependents and any increase in benefits after benefit payments commence due solely to the cost-of-living;
- any disability benefits payable under the Canada Pension Plan, excluding benefits payable on behalf of Dependents and any increase in benefits after benefit payments commence due solely to the cost-of-living;
- any disability benefits payable under any Workers' Compensation Act or similar legislation or any other government plan, excluding the Employment Insurance Act;
- any disability benefits payable under any other group or association insurance plan;
- any disability benefit payable by a private pension plan, excluding any increase in benefits after benefit payments commence due solely to cost of living;
- any indemnity for loss of time payable under any government plan requiring or providing automobile insurance benefits on a no-fault basis.

In the event that a lump-sum payment is made under any of the above-mentioned sources in 1) and 2) in lieu of monthly payments, monthly benefits will be reduced by the equivalent monthly payment over a period of 60 months or by the number of months of disability for which the lump sum is paid, whichever is the lesser.

- *The Insurer may also reduce the monthly Long Term Disability payments even if the Member, who is required to make the necessary application, fails or refuses to exercise their rights under the above-mentioned legislation or plans.*
- *The Insurer may, at its discretion, estimate the amount of a government plan award pending notice of the actual award.*

Limitations
No benefits are payable for a period of Total Disability:

- during which the Member is not under Continuing Medical Care, for the Illness or bodily injury causing the Total Disability;
- during the voluntary leave portion of the Maternity Leave, as described under the DEFINITIONS section, for a total disability occurring during this period;
- during a Parental or Family-related Leave taken by a Member, as provided for under provincial or federal legislation, for Total Disability occurring during this period;
- during any work stoppage due to a strike, lock-out, Leave of Absence or lay-off, for a Total Disability occurring during this period;

- during the imprisonment of the Member due to conviction of an offence;
- if the Member remains outside Canada for longer than 3 months for any reason whatsoever, unless the Insurer gives prior written consent to continue paying benefits during this period.

No benefits are payable for any period of Total Disability beginning during the first 12 months of coverage of a Member, if such Total Disability was directly or indirectly the result of an Illness or Accident that was treated by a Physician or for which prescribed drugs were taken during the 3 month period immediately prior to the effective date of such coverage, except:

- when the policy has been in force for less than 12 months and the Member has been covered under a comparable benefit under the Employer's previous group insurance policy for any period of time immediately prior to the Effective Date of the policy, that period of time will apply in determination of the 12 month coverage period, or
- when the Member works a ten month school year with termination occurring at the end of each school year and rehiring or reinstatement occurring at the beginning of each school year. The Member's prior work period will be taken into consideration towards satisfying this clause.

Exclusions
No benefits are payable for a Total Disability resulting directly or indirectly from any one of the following:

- war, whether the war be declared or not, or service in the armed forces of any country, or participation in a riot, insurrection or civil commotion;
- committing, or attempting to commit a criminal offence;
- cosmetic surgery or treatment, unless such surgery or treatment is required as a result of an Accident that occurred while the Member was insured under this Benefit;
- alcohol or drug abuse unless, for such abuse, the Member is actively taking part in a therapeutic program supervised by a Physician on an on-going basis, is receiving Continuing Medical Care or treatment for rehabilitation and is staying in an established treatment centre qualified to provide the necessary treatment or care;
- driving a motorized vehicle while impaired by drugs, or with an alcohol level that exceeds the limit set under the Criminal Code of Canada.

RECURRENT TOTAL DISABILITY

Successive periods of Total Disability due to the same cause or related causes are considered to be the same period of Total Disability unless they are separated by at least

- 2 consecutive weeks of active full-time employment during the Elimination Period; or
- 6 consecutive months of active full-time employment immediately following a period of Total Disability for which Long Term Disability Benefits were paid under this Benefit.

Successive periods of Total Disability due to entirely unrelated causes are considered to be the same period of Total Disability, unless they are separated by at least 1 day of active full-time employment.

Whenever successive periods of Total Disability are considered to be the same period of Total Disability, the Elimination Period will not be applied a second time and the same amount as for the initial Total Disability minus any payments already made will be payable for the remainder of the Maximum Benefit Period.

DISABILITY MANAGEMENT

The Insurer may at any time require a Totally Disabled Member to participate in a disability management program or to take up rehabilitative employment that is considered appropriate by the Insurer.

The Insurer will actively co-ordinate all disability management program services listed below and will also facilitate and ensure case follow-up:

- co-ordination of access to health care services;
- support program for returning to work;
- negotiations for a gradual return to work;
- rehabilitation program, which may include evaluation, treatment, training, placement and job search services.

If a Totally Disabled member, while receiving Long Term Disability Benefits, takes part in a disability management program or takes up rehabilitative employment under the supervision of their Physician and with the approval of the Insurer:

- the member will still be considered Totally Disabled while taking part in this program, subject to a maximum of 24 months;
- if, while taking part in this program, a member becomes Totally Disabled again, the terms and conditions of this Benefit will re-apply to the member as if they had been Totally Disabled during the rehabilitation period;
- the Maximum Benefit Period during any period of Total Disability will continue to apply even if the member is taking part in an approved disability management program or rehabilitative employment;
- if, while taking part in this program, the member earns any income, the Long Term Disability Benefits payable by the Insurer to the member will be reduced by the amount produced by the following formula:

  (A / B) x C

  A = Income earned from any rehabilitative activity

  B = Monthly Earnings of the Member immediately prior to the commencement of Total Disability

  C = Long Term Disability Benefits otherwise payable under this Benefit

- while the Member is taking part in a disability management program, the Insurer will reduce their Long Term Disability Benefits so that their total income from all sources, if any, as listed in the INDIRECT OFFSET provision of the REDUCTION OF LONG TERM DISABILITY BENEFITS, LIMITATIONS AND EXCLUSIONS section of this Benefit, does not exceed 100% of their Net Earnings immediately prior to the commencement of Total Disability if this Benefit is non-taxable, or 100% of their gross Earnings immediately prior to the commencement of Total Disability if this Benefit is taxable.

A Member who refuses to take part in a disability management program, does not participate in such program in good faith or does not take up rehabilitative employment considered appropriate by the Insurer will no longer be eligible for monthly benefits payable under this Benefit.

TERMINATION OF BENEFITS

Long Term Disability Benefits will cease on the earliest of:

- the date the Member ceases to be Totally Disabled;
- the date the Member engages in any gainful occupation other than an approved gainful occupation for the purpose of rehabilitation;
- the date set by the Insurer the Member was required to provide satisfactory proof of total disability or to undergo a medical examination requested by the Insurer, but neglected or refused to do so;
- the date payments have been paid up to the Maximum Benefit Period for any one period of Total Disability;
- the date the Member refuses to participate in a disability management program or to take up rehabilitative employment considered appropriate by the Insurer; and
- the date the Member attains the Age Limit specified in the Benefit Schedule.

BENEFIT EXTENSION IN THE EVENT OF MEMBER'S DEATH

If a Totally Disabled Member dies while Long Term Disability Benefits are payable, the Insurer will pay a survivor benefit to the Member's Spouse. The amount of the survivor benefit will be a lump sum payment equal to 3 times the Member's monthly Long Term Disability Benefit.

In the absence of an eligible surviving Spouse, benefit payments will be made to the Member's Dependent Child (or children in equal shares) under age 21.

EXTENSION OF BENEFIT AFTER TERMINATION

If a Member is Totally Disabled on the date their insurance terminates, the Insurer will continue insurance for that Total Disability as if the insurance under this Benefit for that Member were still in force, provided such Total Disability continues uninterrupted, subject to all other provisions of the policy.

NOTICE AND PROOF OF CLAIM

Initial written notice of a claim must be submitted to the Insurer within 30 days of the expiry of the Elimination Period and initial written proof, within 60 days of the expiry of the Elimination Period.

In the event of the recurrence of Total Disability, written notice of a claim must be submitted to the Insurer within 30 days of the date of such recurrence and written proof within 60 days of the date of such recurrence.

Subsequent written proof satisfactory to the Insurer of continuing Total Disability must be submitted to the Insurer at its request.

EMPLOYEE ASSISTANCE PLAN (EAP)

Homewood Health offers team-based telephonic account support with quick and easy access to all of our online resources, including digital collateral. Your Employee Assistance Program (EAP) is a professional, confidential, and proactive service to support you with a wide range of personal, family, and work-related concerns. Your EAP is here for you whenever you need it, 24 hours a day, seven days a week, 365 days of the year

INDIGENOUS SUPPORT

Homewood Health is one of the largest EAP providers to Indigenous peoples in Canada.

- Elder and Knowledge Keeper Access
- Counsellor matching with experts in Indigenous & First Nations Culture, Residential School System and/or Racism
- Network of over 500 registered licensed counsellors specialized in Indigenous Culture
- Clinical experts experienced working with Indigenous, Inuit, Metis, First Nations

Connecting with an Elder for Indigenous support.

- Call 1-800-663-1142 and request Elder/Knowledge Keeper Support
- Provide us with your 'identified' Elder information
- If you do not have an Elder/Knowledge Keeper, we will connect you with a professional counsellor specialized in Indigenous Culture

WE GUARANTEE YOUR CONFIDENTIALITY

We are Homewood Health, a trusted company with years of experience delivering the best possible support for clients like you. Everyone is guaranteed confidentiality within the limits of the law. You won't be identified to anybody - including your employer.

People frequently use an EAP for personal challenges such as relationship concerns, family or parenting issues, anxiety, depression, addictions, grief, coping with the health issues, or work-related challenges.

We will match you with a counsellor who suits your needs and provide you with short-term solutions.

If you are identified as requiring additional, longer-term treatment or specialized support, our counsellors will refer you to community-based resources and programs which suit your unique needs.

HOW DOES THE COUNSELLING PROGRAM WORK?

Counselling services can be offered face-to face, over the phone, through video, or online. Offices are local and appointments are made quickly, with your convenience in mind. If you have a preference for location, gender, or appointment time, we'll do our best to accommodate your preferences.

When you need to speak with someone, simply call Homewood Health - staff will ask you for some basic information (to establish your eligibility for this benefit) and will help set up an initial appointment at a time that is convenient for you. An experienced counsellor will assess your concerns and help you develop practical solutions.

SENTIO SELF-DIRECTED iCBT

Self-Guided Online Cognitive Behavioural Therapy helping you take control of your mental health to start feeling better today.

- Mild to moderate depression, anxiety and other mental health issues
- Access therapy anytime of day from a smartphone, tablet or computer
- Over 20 treatment goals to choose from
- Video, audio, text resources and interactive exercises

INTEGRATED WELLNESS & COACHING

Proactive, Integrated Care offering coaching and online resources that will help you with your mental, physical, financial and social well-being.

- Financial
- Legal
- Nutrition
- Lifestyle Changes
- Relationships
- Elder and Family Care
- Physical wellness
- Career planning
- Workplace issues
- Pre-retirement planning
- Shift Work
- Smoking Cessation

DIGITAL MENTAL HEALTH PLATFORM

Improving your online user experience.
A simple to use, smart platform that is personalized based your unique needs and acts as a gateway to all your assistance and mental health resources.

How do I register for Homeweb?

- Step One: Visit www.homeweb.ca and click “Sign Up”.
- Step Two: Enter information into the required fields, choose an email and password, and click “Next Step”. Then, type in your firm name (name located on CINUP benefit card) and click “Find it!”. Select the correct company from the list provided.
- Step Three: Let us know how you are covered by Homewood, (e.g. through your organization or the organization of a family member), and let us know your relationship to the organization (e.g. employee, spouse, dependent, etc.). Submit the additional information required and click “Sign In” at the bottom of the page. Search, browse and get expert support.

ACCESS SPECIALIZED CARE TODAY

All calls are completely confidential. With support available 24/7.

- 1-800-663-1142 | TTY: 1-888-384-1152 | International (Call Collect): 604-689-1717
- Online at homeweb.ca

EXTENDED HEALTH CARE BENEFIT

DEFINITIONS

As used in this Benefit:

Calendar Year	means the period extending from January 1st to December 31st inclusive.
Convalescent/Rehabilitation Centre	means any facility or institution in Canada which is licensed as a convalescent hospital by the licensing body having jurisdiction for the care and treatment of sick and injured persons who require supervision of either a Physician or a registered nurse. This institution must provide nursing care 24 hours a day by a registered nurse and maintain a daily record of each patient under the care of a Physician. However, it does not include a nursing home, home for the aged, or the chronically ill, home for the mentally ill, rest home, or an institution for the care and treatment of alcoholism or drug addiction.
Day Surgery	means any surgery performed by a Physician that requires local or general anaesthesia, with the exception of any minor surgery performed in the office of the Physician.
Dentist	means a person who is licensed to practise dentistry by the appropriate authority of the jurisdiction where the services are provided.
Drugs available on prescription	means drugs prescribed by a Physician or a dental surgeon. This will also include certain drugs requiring a prescription when prescribed by other health practitioners where permitted to do so by provincial law.
Equivalent drug	means a brand or generic drug, deemed interchangeable under the provincial law applicable where the drug is sold.
Hospitalization	means: 1. to be admitted to a Hospital as an In-patient for more than 18 consecutive hours; or 2. any Hospital stay in order to receive Day Surgery.
In-patient	means a person admitted to and assigned a bed in a Hospital In-patient area on the order of a Physician.
Medical Emergency	means any acute and unexpected condition, Illness or injury requiring immediate medical treatment.
Medical Recommendation	means the order to provide medication or care given by a Physician, dental surgeon or a podiatrist duly authorized to do so in the normal performance of their profession.
Orthesis	means any orthopaedic appliance constructed of rigid material, such as metal or plastic, used to maintain a part of the body in the correct position. Elastic supports are not included in this category.

Period Of Hospitalization	means any continuous period of Hospitalization in a Canadian Hospital or successive periods of Hospitalization resulting from the same Illness or Accident and separated by less than 60 consecutive days during which the Insured Person was not hospitalized. If, during a given period, Hospitalization results from an Illness or Accident entirely unrelated to the Illness or Accident that resulted in the previous Hospitalization, this Hospitalization will be treated as a new Period Of Hospitalization.
Prosthesis	means an appliance used to replace all, or part, of a limb or organ.
Reasonable and Customary Charges	means the charges generally paid in the area where the services or supplies are provided for a like service or supply and limited to the prevailing charge in the area for the like service or supply. A like service or supply is one of the same nature and duration that requires the same skill and is performed by a provider of similar training and experience.
Stable	The health condition of an Insured Person who: 1. within 30 days prior to the trip departure date for active Employees, or 2. within 90 days prior to the trip departure date for Retirees (if covered); is not affected by any medical condition, or is affected by a medical condition that: 1. that does not require a change or no change is recommended in the treatment or dosage of prescribed drugs, 2. that does not demonstrate any symptoms that indicate a deterioration of the medical condition during the duration of the Trip, 3. that does not require a Hospitalization or to consult a specialist, 4. that does not require any medical examination or test for investigative purposes awaiting results, and 5. for which no treatment is either planned, pending or not completed.
Vehicle	means a car, a motor home or a van with a maximum load of 1,000 kilograms.

PAYMENT OF BENEFIT

Upon receipt of Proof of Claim satisfactory to the Insurer that a Member, or one of their Dependents, while insured under this Benefit, incurred Eligible Expenses, the Insurer will reimburse the portion of expenses in excess of the Deductible, where applicable, subject to the applicable Percentage of Reimbursement and the limits specified in the Benefit Schedule, and in accordance with the other applicable provisions of this Benefit and this policy.

To be eligible, the expenses must have been incurred as a result of Illness, pregnancy or an Accident, and cover care:

1. which is medically necessary to treat the Insured Person;
2. which is generally provided for an Illness or injury of similar type or seriousness; and
3. which, unless otherwise indicated, was on the prior recommendation of the attending Physician.

In addition, the Eligible Expenses will be limited to the Reasonable and Customary Charges generally paid in the area where the services are provided.

Eligible Expenses will be considered to have been incurred on the date the service or supply was provided.

COMMENCEMENT OF DEPENDENT INSURANCE

If a Dependent is hospitalized on the day their insurance would normally become effective, the effective date of insurance will be delayed, and their insurance will commence 24 hours after their discharge from the hospital. However, the newborn Child of a Member will become insured at birth.

DEDUCTIBLE

The Deductible is the amount of Eligible Expenses that the Member must pay in any Calendar Year before reimbursement will be made under this Benefit. The Deductible is specified in the Benefit Schedule.

CO-PAY

The Co-pay is the portion of Eligible Expenses that the Member must pay for each drug for which expenses were incurred before reimbursement will be made under this Benefit. The Co-pay is specified in the Benefit Schedule.

PERCENTAGE OF REIMBURSEMENT

The Percentage of Reimbursement specified in the Benefit Schedule is the percentage of Eligible Expenses in excess of the Deductible that will be reimbursed by the Insurer, in accordance with the provisions of this Benefit.

ELIGIBLE EXPENSES IN CANADA - EXTENDED HEALTH CARE

Eligible Expenses include charges for the following and must be incurred:

1. in the Member's province of residence; and
2. outside the Member's province of residence, but in Canada, for any reason other than a Medical Emergency.

Hospitalization Expenses

Hospital: Hospital charges for active treatment for each day of Hospitalization, with no limit as to the number of days, up to the maximum specified in the Benefit Schedule.

Convalescent/Rehabilitation Centre: semi-private accommodation in a licensed Convalescent or Rehabilitation Centre, provided that the Insured Person was admitted within 14 days of discharge from a Hospital to which the member was confined as an In-patient and that this stay was primarily required for rehabilitation and not custodial care, up to the maximum specified in the Benefit Schedule.

Hostel Care: If an Insured Person requires treatment or diagnostic testing be done at a Hospital located in their province of residence and is subsequently placed in a recognized medical hostel associated with that Hospital, the accommodation charges will be eligible. However, the medical hostel associated with the Hospital must be outside a 60 kilometre radius of the Insured Person's residence.

Drugs

1. Drugs that are necessary for treatment in respect of an Illness or injury and that are available only on prescription from a Physician or a dental surgeon (code "PR", "C" or "N" in the Compendium

of Pharmaceuticals and Specialties) and dispensed by a pharmacist, or by a Physician, if there is no pharmacist.

Also eligible are drugs available on prescription that are necessary for the treatment of certain pathological conditions, excluding homeopathic preparations, and for which the therapeutic indication suggested by the manufacturer in the Compendium of Pharmaceuticals and Specialties is directly linked to the treatment of the following pathological conditions:

cardiac problems; pulmonary problems; diabetes; arthritis; Parkinson's disease; epilepsy; cystic fibrosis; glaucoma.

2. Injectable drugs prescribed by a Physician for preventing or treating an Illness. Vaccines for Shingles are covered, all other vaccines are not covered.
3. Smoking cessation aids (products only), up to a lifetime maximum of $350 per Insured Person.
4. Fertility treatment (drugs only), directly referable to infertility, up to a lifetime maximum of $15,000 per Insured Person.
5. Obesity Prescription Drugs up to a lifetime maximum of $15,000 per Insured Person.
6. Status Members - drugs listed on the N.I.H.B./F.N.H.A. 'Drug Benefit List' are not eligible under CINUP. Consideration will be given to Drugs that have been declined on an exception basis through N.I.H.B./F.N.H.A.

Provincial Pharmacare / Drug Programs

Provincial Pharmacare/drug programs subsidize eligible prescription drugs and designated medical supplies in the provinces of **British Columbia, Saskatchewan and Manitoba**. To ensure proper co-ordination of benefits between your CINUP coverage and the provincial Pharmacare/drug programs, **Members in these provinces will need to provide CINUP with proof of provincial registration** if their prescription drug usage is in excess of $1500 per year. **However, certain drug treatments require provincial registration for coverage even if drug usage is below $1500**. Please register as soon as possible so that you do not experience a lapse in coverage.

You can register for provincial coverage by going to your respective provincial websites. Once the registration process has been completed, Plan Members should fax or email a copy of the written confirmation of your family's deductible. Failure to submit the confirmation will result in temporary suspension of prescription drug claims. If you have any questions, please contact the CINUP Customer Service Department at 1.800.665.1234 or contactus@cinup.ca, or fax at 1.833.702.4687.

Prior Authorization Program

All new drugs will be reviewed for efficacy and pharmaeconomic value before being added to the plan. CINUP may also take into consideration evaluation of a drug by provincial or national public payers or health technology assessment organizations before determining its eligibility.

Your plan covers drugs that are medically necessary. The Prior Authorization (PA) program applies to a small number of drugs for which prior approval is required before being covered by your plan. For a drug to be approved for coverage, you and your doctor will need to complete a PA form providing us with some medical information.

If the information you provide meets the plan’s medical criteria, then your prescription drug will be

approved for coverage. A list of drugs requiring pre-authorization as well as the PA form can be found on my-benefits (www.my-benefits.ca).

As part of its pre-authorization process, CINUP may request that a drug be purchased from a specialty preferred pharmacy network (PPN) that has been designated by CINUP. If your claim is approved and is subjected to the Specialty PPN, HealthWATCH® specialty care will contact you with instructions. Please note that if the Covered Person should choose to use another pharmacy the Covered Person is solely responsible for its cost.

HealthWATCH® specialty care can be reached at 1-855-512-3739 (8 am to 8 pm ET) for assistance.

2 Step Therapy

This plan includes a diabetic step therapy provision.

This provision permits CINUP to determine the appropriate order of glucagon-like peptide-1 (GLP-1) agonists therapies in the treatment of Diabetes based on evidence of clinical safety, efficacy and cost. The controls will apply to GLP-1 agonists approved by Health Canada for the treatment of diabetes, such as (but not limited to) Adlyxine, Mounjaro, Ozempic, Rybelsus, Trulicity, and Victoza.

Step Therapy is a program that ensures that plan members have tried first line, lower cost therapies before qualifying for reimbursement of higher cost therapies.

Health Professionals

Nursing Care: Services of a registered nurse, a licensed practical nurse or a registered nursing assistant are eligible, up to the payable amount specified in the Benefit Schedule per Insured Person, provided the patient is not confined in a Hospital and the services are medically necessary, are not rendered solely for custodial care, supervision or companionship and psychotherapy, and come within the competence of such nurse. In addition, the nurse must not be related to the member or to any of their Dependents by birth or marriage, and must not ordinarily reside in their or their Dependent's home.

Paramedical Services: Services of the practitioner disciplines specified in the Benefit Schedule and up to the maximum amount specified, provided that the practitioner is operating within their recognized field. The practitioner must be a member in good standing of their professional association that must be recognized by the Insurer. Unless otherwise indicated in the Benefit Schedule, these services do not require prior Medical Recommendation.

Ambulance

Emergency and non-emergency trips provided that:

1. the patient is non-ambulatory;
2. prior recommendation of an attending Physician is obtained;
3. the patient cannot be transported by any other means.

In the province of employment:

1. Ground transport - Reasonable and Customary Charges;
2. Air transport - reimbursement will be limited to the amount that would otherwise have been paid for ground transport.

Outside the province of employment, but within Canada:

1. Ground transport - maximum if $250 per trip, based on the provincial rate;
2. Air transport - reimbursement will be limited to the amount that would otherwise have been paid for ground transport.

Non-emergency transport will be limited to a lifetime maximum of $250 per Insured Person.

Mobility Aids

Conventional wheelchair, electric wheelchair, or scooter: Rental or purchase, at the discretion of the Insurer up to a lifetime maximum of $1,000 per Insured Person.

Walkers or crutches: Purchase or rental, at the discretion of the Insurer.

Orthopaedic Supplies

Spinal brace: Purchase, but not repair, at the discretion of the Insurer.

Brace for a limb, truss and plaster: Purchase, but not the repair or replacement, at the discretion of the Insurer.

Conventional or electric hospital bed: Purchase or rental, at the discretion of the Insurer up to a lifetime maximum of $1,000 per Insured Person.

Orthopaedic shoes or sandals: Orthopaedic shoes are defined as custom-molded shoes specifically designed for an individual to correct a foot defect, as well as open-toed shoes, in-flare or out-flare shoes, straight-laced shoes and shoes required for Denis Browne braces. The cost of modifications or adjustments to stock item footwear is also eligible; in-depth shoes and off-the-shelf shoes that are regular stock are excluded. Prescription by a physician, chiropractor, podiatrist, or chiropodist is required. Purchase of one pair each calendar year, up to $300 per insured person/each calendar year.

Orthesis And Prosthesis

Podiatric Orthesis or arch support: Purchase of custom made, up to a payable amount of $500 per Insured Person each Calendar Year. Biomechanical assessment by a physician, chiropractor, podiatrist, or chiropodist is required with each purchase.

Artificial limb: Purchase; the cost for the repair is also eligible; replacement is included when required due to physiological change.

Artificial eye: Purchase, including reimbursement for one polishing or one re-making of the artificial eye each Calendar Year, per Insured Person.

External breast Prosthesis: Purchase of an external breast Prosthesis when required because of total or radical mastectomy, including the purchase of 2 surgical brassieres, up to a payable amount of $200 per Insured Person for any period of 24 consecutive months.

Hearing aids: Purchase on the written prescription of an audiologist, up to a payable amount of $500 per Insured Person for any period of 60 months.

Wigs: Purchase of wigs required as a result of chemotherapy or accidental injury or illness, up to a lifetime maximum of $1,000 per Insured Person.

Therapeutic Equipment

Glucometer, reflectant meter or flash glucose reader: Purchase, or rental, upon medical recommendation, up to a payable amount of $200 and one device for any period of 36 consecutive months.

Oxygen, and equipment required for its administration: Purchase or rental, at the discretion of the Insurer, up to a maximum lifetime amount of $5,000.

Apnea monitor: Purchase or rental, at the discretion of the Insurer, up to a maximum lifetime amount of $1,000 per Insured Person, including supplies.

Blood Pressure Monitors: Purchase or rental, at the discretion of the Insurer, up to a payable amount of $300 per Insured Person every 5 years.

Diabetic supplies: Purchase, at the discretion of the Insurer. Includes test strips, lancets, needles, syringes, flash glucose monitor sensors, continuous glucose monitor receiver, sensors and transmitters.

Other therapeutic equipment: Purchase or rental, at the discretion of the Insurer, provided such equipment is medically required and is intended to cure or treat the affliction, up to a lifetime payable amount of $1,000 per Insured Person. This category of equipment includes, for example, non-union bone stimulators, insulin pumps, aerosol therapy equipment and intermittent positive pressure breathing machines.

Medical Supplies

Catheters, colostomy, ileostomy or uretherostomy supplies: Purchase, up to a lifetime maximum amount of $1,000 per Insured Person.

Elastic support stockings: Purchase of medically necessary surgical elastic stockings on the written recommendations of a physician. They must have a compression factor of 20mmHG or higher - limited to 6 pair per person per calendar year.

Intra-uterine devices: Purchase, up to a lifetime maximum of $250 per Insured Person.

Gavage supplies, tracheotomy supplies, opaque glass, compression garments for treatment of burns, medicated dressings: Purchase, up to a lifetime maximum of $1,000 per Insured Person.

Medical alert bracelet: Purchase, up to $200 per Insured Person each Calendar Year.

Dental Treatment due to an Accident

The services of a dentist required to repair and replace healthy teeth as a result of an accidental blow to the mouth received while the Insured Person is covered under this Benefit or a comparable benefit in force immediately before the effective date of this Benefit, but not as a result of voluntarily or involuntarily putting food or any other object in their mouth. Dental services must be rendered within 90 days of the accident; otherwise, a treatment plan deemed satisfactory by the Insurer will be required before that deadline. No benefit is payable for services provided more than 2 years after the date of the accident.

Vision Care

Eye examinations: Including eye refraction provided they are performed by a qualified ophthalmologist or a licensed optometrist, up to the amount specified in the Benefit Schedule.

Artificial crystalline lenses: Purchase of crystalline lenses implanted surgically as a replacement for natural crystalline if the Insured Person has cataracts, up to a payable amount of $200 per Insured Person each Calendar Year.

Eyeglasses, contact lenses or laser eye surgery and their replacement, provided they are prescribed in writing by a qualified ophthalmologist or a licensed optometrist and dispensed by a qualified ophthalmologist, a licensed optometrist or a qualified optician; or laser eye surgery up to the amount specified in the Benefit Schedule. Prescription industrial safety glasses are eligible for Members only and prescription sunglasses are eligible for all Members and dependents.

Teladoc Medical Expert

Teladoc Medical Expert provides access to expert medical specialists who help you understand your medical condition and treatment options, so you can make the right choice about your care. As long as you hold an Extended Health Care Benefit you and your dependents will have unlimited access to the following Teladoc Medical Expert services:

Expert Medical Opinion: More than a second opinion regarding a medical diagnosis or treatment plan, Teladoc Medical Experts will conduct an in-depth analysis of your medical records, including imaging scans, X-rays, test results and any available pathology (which can be retested). You will receive a written summary of their findings, which includes a diagnosis and treatment recommendations that you can share with your doctor.

Personal Health Navigator: Personal Health Navigator can help you navigate the Canadian healthcare system and get you the information you need for a variety of health topics. Teladoc Medical Expert provides you with a variety of tools and resources when you're facing a medical uncertainty, and can offer advice and wellness support if you need it. You'll gain peace of mind knowing you're making an informed decision about your healthcare.

Find a Doctor: If you're searching for a local specialist let Teladoc Medical Expert do the work for you. They will search their database of top Canadian specialists and take info account your unique medical history and geographic location, matching you with the right physician for your condition.

Care Finder: If you need a specialist outside of Canada they can make it possible through their Care Finder service. They will cater the search to your unique medical history and geographic location, as well as availability of the specialist and/or facility

Accessing Teladoc Medical Expert: Contact Teladoc Medical Expert directly at 1 877 419 2378. Please have your CINUP Benefits Card ready to identify yourself using your firm and certificate numbers. When you contact Teladoc Medical Expert, you will be assigned a Member Advocate (a Registered Nurse) who will assess your medical issue, answer your questions, determine what service would best meet your needs and keep you informed about the progress of your case.

Teladoc Medical Expert is available to all CINUP insureds and their dependents as defined in your benefit plan as well as your parents and parents-in-law. You are responsible for any expenses associated with medical treatment (not covered by your provincial or health care plan), travel and lodging. Teladoc Medical Expert does not make referrals or appointments for members.

Teladoc Mental Health Navigator

The Mental Health Navigator program offers guidance and navigation to members with a mental health condition seeking an expert opinion on an existing diagnosis and treatment.

Mental Health Navigator: Mental Health Navigator provides a discreet and confidential way to seek mental health support from the comfort of your home. You are supported every step of the way by your personal navigator and expert mental health professionals including Canadian psychiatrists and psychologists. You will be provided with an assessment of your diagnosis and recommended an appropriate treatment plan.

Accessing Mental Health Navigator: Members can access this service online at Teladoc.ca, via phone by calling 1-877-419-2378, or by signing into or creating an account on the Teladoc mobile app.

Teladoc myStrength

myStrength is a self-guided platform that uses a digital-first approach to delivering evidence-based interventions to help resolve clinical conditions, build resiliency, manage stress, improve mood, or sleep better.

Convenience: Members can interact with Teladoc Health expert coaches trained in mental health engagement via text through the app. Coaches will help you navigate through the myStrength programs and offer support to better engage with myStrength.

myStrength's evidence based resources address 13 focus areas:

- Depression
- Anxiety
- Stress
- Sleep and insomnia
- Mindfulness and meditation
- Chronic pain
- Substance use disorders
- Drug, opioid and alcohol recovery
- Balancing emotions
- Nicotine
- Trauma
- LGBTQ+
- Lifestyle (pregnancy, parenting, relationships and more)

Accessing myStrength: Members can access this service online at Teladoc.ca, via phone by calling 1-877-419-2378, or by signing into or creating an account on the Teladoc mobile app.

Teladoc Mental Health Care

Mental Health Care: Mental Health Care allows you easy access to arrange confidential virtual therapy sessions with provincially licensed psychologists and therapists by phone or video. You can conveniently connect and build ongoing relationships with mental health professionals who are available seven days a week. Pick a time that is convenient for you and choose your preferred provider based on your needs.

The Mental Health Care service is only available for adults. Children under the age of 18 are not eligible.

The cost of the counselling services may be eligible under your Extended Health Care plan. Please refer to the Paramedical Services section of your Benefit Schedule for coverage details.

To help ensure the best experience for all members seeking support through the Mental Health Care service and optimize the capacity of visits, there is a service charge for missed visits or those cancelled with less than 24 hours-notice. Members will be charged the cost of the visit. Cancellation or missed appointments fees are not eligible for reimbursement under your Extended Health Care plan.

Accessing Mental Health Care: Members can access this service online at Teladoc.ca, via phone by calling 1-877-419-2378, or by signing into or creating an account on the Teladoc mobile app.

Teladoc Telemedicine

Teladoc Telemedicine service allows you to consult with a physician about non-urgent medical matters by video conference, by phone, or by app from wherever you are in Canada or the United States, 24 hours a day, 365 days a year. During your visit, you can receive a diagnosis, treatment recommendations, and even be prescribed medication when necessary.

Convenience:

• You have confidential access to a doctor via app or telephone who is available anytime.

• You get treated for non-emergency conditions like the flu, bronchitis, and much more.

• When necessary, prescriptions are sent directly to your pharmacy of choice.

Greater Access:

• Visits occur within an hour of contact, so you get the care you need when you need it, without the wait.

• The service is even available when you travel to the United States.

Clinical Quality:

• Each doctor is board-certified by the College of Family Physicians of Canada to ensure the highest standards of quality.

• Every visit provides the opportunity for a copy of your visit to be sent to your family physician.

Accessing Teladoc Telemedicine:

Simply download the Teladoc app from Apple or Google Play, complete the registration, and request a consultation either, by video conference or by phone, at 1-877-419-2378. Prior to your first consultation, you must complete an electronic health record for the doctor to review. For more information visit **teladoc.ca**

Teladoc Telemedicine services are available to all insureds and their dependents holding an Extended Health Coverage benefit. You are responsible for any expenses associated with medical treatment (not covered by your provincial or health care plan), travel and lodging.

Teladoc Telemedicine service in the U.S. can only be accessed by telephone.

In Quebec, telemedicine services must be offered by video conference.

EHN Programs:

Intensive Outpatient Program (IOPs)

The Intensive Outpatient Programs (IOPs) delivered by EHN offer the immersion of inpatient treatment with the flexibility of outpatient care.

- **Who is the program for?**
  - Employees, Spouses and eligible dependent children aged 18 and over.
- **The IOP program includes treatment for both group-based and individual.**
  - The group-based IOPs treat:
    - Concurrent Addiction and Mental Health
    - Mood and Anxiety
    - Workplace Trauma
    - Behavioral Addictions
  - The IOP program for employees consists of:
    - 8 weeks of intensive programming with
      - 9 hours of therapy per week, consisting of 8 hours of group sessions and 1 hour of individual counselling every week and
    - 10 months of aftercare

Comprehensive Teen Program

The Healthy Minds Comprehensive Teen Program is an online therapeutic program designed to help teens struggling with mental health concerns including (but not limited to) depression and anxiety. This virtual program provides a supportive and structured treatment experience that is tailored to help youth make meaningful changes to their life and wellbeing.

- **Who is the program for?**
  - Teens aged 14 to 18 (grades 9 to 12) who are struggling with mental health
  - Caregivers who are looking for education and coaching to better support their teen strategies for youth
- **The six-month program includes:**
  - 9 weeks of therapy
  - 2 hours of group sessions and 50 minutes of individual counselling per week treatment
  - Education on developing understanding and coping techniques, such as Acceptance and Commitment Therapy (ACT) and Dialectical Behaviour Therapy (DBT)
  - 4 months of bi-weekly aftercare groups for long-term recovery
  - Access to corresponding Wagon app with specialized content for teens
  - 12 hours of dedicated caregiver support and education

Wagon App

The Wagon App is provided to clients in aftercare and online programs. The app is instrumental in goal setting, daily check-in, coping tools and progress reports.

- To ensure that the programs offered are applicable to your specific needs, EHN will lead you through an intake process.
- There will be requirements for a tablet or laptop and a reasonable internet or wi-fi connection to ensure that the virtual sessions will flow seamlessly.
- The program is designed to ensure the best outcome on your road to recovery so this will require you to attend all scheduled meetings. Missed scheduled meetings will conclude your program.

To Access the Program:

By Phone: Call into EHN Canada and speak directly with an intake specialist 1.866.920.0184

By Email: Email the outpatient team to get the process started for admission.
Outpatient_admissions@EHNCANADA.com

Online: www.ehnonline.ca

TRAVELING IN CANADA FOR MEDICAL PURPOSES

The Traveling in Canada for Medical Purposes benefit protects you and your eligible dependents from the high cost of traveling within Canada to obtain medical treatment not available in your community.

The following expenses are eligible if adequate medical treatment is not available in your locale, provided transportation occurs to and from the nearest facility (greater than 600 kilometers return) equipped to provide the required treatment. Referral to a Dental Specialist are eligible. A referral letter from the physician and/or dentist is required to document the treatment is not available in your locale. Confirmation of appointment attendance is also a requirement.

Person shall mean patient covered by contract and also Attendant. If an Attendant is required, Attendant means any one medical attendant, or Spouse of the Member, or any one individual who has attained the age of the majority.

The Plan covers 100% of the expenses listed below to a combined lifetime maximum of $2,000 per patient covered by the contract:

- Round economy class travel via commercial airline, train or bus or if driving, coverage for gas expenses from home to treatment facility and the cost to return - $500 per person
- Accommodation - $100 per day per person
- All other incidentals (i.e. meals, parking, taxi) - up to $100 per day

The accommodation maximum noted above shall be considered a combined maximum where shared accommodation is appropriate for the patient and attendant i.e., the attendant is their Spouse or parent of the patient). In cases where the shared accommodation is not appropriate and a second room is required the maximum is $100 per day per person.

All expenses related to the patient and the incident will be included in the $2,000 per person lifetime maximum (ie., the spouse is the attendant, all expenses for the spouse would be covered under the patient's lifetime maximum).

ELIGIBLE EXPENSES - TRAVEL INSURANCE - AVAILABLE TO REGULAR EMPLOYEES ONLY

If an Insured Person incurs Medical Emergency expenses during the first 180 days of a stay outside their province of residence, the Insurer will reimburse the Eligible Expenses in accordance with the Benefit Schedule and the following conditions:

1. the Insured Person must be covered under government health and hospital insurance plans;
2. expenses must be eligible under the Extended Health Care Benefit; and
3. expenses must be related to a Stable health condition prior to the trip departure date.

The Member must contact the Insurer if the duration of the stay outside the province of residence is, or may be, longer than 180 days. Otherwise the Insured Person may not be covered under the Travel Insurance benefit.

Eligible Health Care Expenses

1. Hospital services and room and board charges in a semi-private room until the Insured Person is discharged from the Hospital;
2. Services of a Physician, a surgeon and an anaesthetist;
3. All other Eligible Expenses that are covered under this Benefit in the normal province of residence of the Insured Person, excluding Hospital and Convalescent Care Eligible Expenses, if insured.

Eligible Transportation Expenses

1. Expenses incurred for the repatriation of the Insured Person to their place of residence by a suitable means of public transportation to receive appropriate care as soon as their state of health allows it, provided the means of transportation originally arranged for the return trip cannot be used; repatriation must be approved and arranged by "Voyage Assistance". Furthermore, if "Voyage Assistance" recommends repatriation and the Insured Person declines, their insurance under the Travel Insurance provision will terminate.
2. Expenses incurred for the repatriation (at the same time as the repatriation provided for above) of any Immediate Family member insured under this Benefit, or any children accompanying and under the care of the plan member, if they cannot return to the point of departure by the means of transportation originally arranged for the return trip; repatriation must be approved and arranged by "Voyage Assistance".
3. Expenses incurred for the repatriation (at the same time as the repatriation provided for above) of a dog or cat accompanying the plan member up to a maximum of $500.
4. Expenses incurred for the repatriation (at the same time as the repatriation provided for above) of luggage brought with the plan member up to a maximum of $300. (Payment is for repatriation only; it does not cover the cost of lost luggage.)
5. Round-trip economy transportation for a qualified medical attendant who is not a family member, a friend, or a travelling companion, provided the presence of this attendant is ordered by the attending Physician and approved by "Voyage Assistance".
6. Round-trip economy air, bus or train transportation by the most direct route for one Immediate Family member to the Hospital where the Insured Person must be confined for at least 7 days (expenses will be reimbursed only if the Insured Person remains in Hospital for at least 7 days). This visit is eligible for reimbursement provided that the Insured Person is not accompanied by an Immediate Family member age 18 or over. The cost of living expenses for the Immediate Family member limited to $1,500. The visit must be considered beneficial to the patient by the attending Physician, and prior approval must be obtained from "Voyage Assistance".
7. Cost of returning the personal or rented Vehicle of the Insured Person if the Insured Person suffers from a disability as a result of a Medical Emergency, certified by a Physician, that prevents the member from operating this Vehicle and none of the Immediate Family members accompanying them are able to return it. The vehicle must be in good enough working condition to be returned without mechanical problems. A professional vehicle transport agency may be hired to return the Vehicle, but the return must be arranged and approved by "Voyage

Assistance". The amount reimbursed is limited to $2,500 per Trip to cover reasonable fees such as gas, meals, accommodation and an economy class ticket.

8. If the Insured Person should die, round-trip economy air, bus or train transportation by the most direct route for one Immediate Family member of the deceased to identify the body before repatriation (the trip must be pre-approved and arranged by "Voyage Assistance"). These expenses are not reimbursed if the Insured Person was accompanied by an Immediate Family member age 18 or over.
9. If the Insured Person should die, the costs of preparation and the return of the body or ashes to the place of residence by the most direct route (plane, bus or train), up to $5,000; the cost of the burial coffin is not covered. The return must be pre-approved and arranged by "Voyage Assistance".
10. If the Insured Person should die, cremation or burial at the trip location up to a maximum of $5,000; The cost of the casket or urn is not covered.

Eligible Daily Allowance

The cost of meals and accommodations for an Insured Person who must delay their return because of an Illness or bodily injury suffered by the Insured Person themself, an accompanying member of their Immediate Family or a travelling companion, as well as additional child care expenses for Children not accompanying the Insured Person. Eligible Expenses are limited to $200 per day per covered person for a maximum of 10 days and the Illness or injury must be certified by a Physician.

Eligible Long-distance Telephone Charges

Long-distance telephone charges to reach a member of the Immediate Family if the Insured Person is hospitalized, provided that the transportation allowance, provided under section d) above, to visit that person is not used and that the Insured Person is not accompanied by an Immediate Family member age 18 or over - up to $50 per day, and up to an overall maximum of $200 per Period Of Hospitalization.

Medical Decisions

Decisions by a Physician or other health care professional employed by, under contract to, or designated by "Voyage Assistance", regarding the medical need for providing any of the covered services outlined above are medical decisions based on medical factors and, as such, will be conclusive in determining the need for these services.

Voyage Assistance service

"Voyage Assistance" will take the necessary steps to provide the following services to any Insured Person who requires them:

1. 24 hour toll-free telephone assistance;
2. referral to Physicians or health-care facilities;
3. assistance for Hospital admission;
4. cash advances to the Hospital when required by the facility;
5. repatriation of the Insured Person to their home city, as soon as their state of health permits it;
6. establishing and staying in contact with the Insurer;
7. handling arrangements in the event of death;
8. repatriation of the Children of the Insured Person, if the Insured Person cannot be moved;
9. delivery of medical assistance and drugs to an Insured Person who is too far from health care facilities to be transported there;

10. arrangements to bring a member of the Immediate Family to the bedside of the Insured Person if they must be confined to Hospital for at least 7 days, provided that such visit is ordered by the attending Physician;
11. assistance in replacing lost or stolen travel documents so that the Insured Person can continue their trip;
12. referral to lawyers if legal problems arise;
13. translation services for emergency calls;
14. transmission of urgent messages to close friends or family in case of emergency; or
15. information prior to departure concerning passports, visas and vaccinations required in the country of destination.

In the event of a **MEDICAL EMERGENCY**, the insured must contact the travel assistance firm immediately.

Calls from:

Montreal area 514.875.9170

Canada and United States 1.800.465.6390 (toll-free)

Elsewhere (excluding North and South America) overseas code + 800 29485399 (toll-free)

Anywhere worldwide 514.875.9170 (collect call)

RESTRICTIONS, EXCLUSIONS AND LIMITATIONS

Eligible Expenses

Eligible Expenses are subject to the limitations and maximums indicated in the Benefit Schedule or this benefit.

No reimbursement will be made under this Benefit for the following:

1. services or treatment that a government health plan prohibits from being paid in whole or in part, except to the extent that it permits reimbursement of the excess amount;
2. services, treatment or supplies that a person receives without charge or that are reimbursed under a provincial or federal law. If a person is not covered under the laws in question, the Insurer will not reimburse the expenses that would normally be covered under the hospital or health insurance legislation in force in the Insured Person's province of residence;
3. services, treatment or supplies which are experimental in nature;
4. expenses incurred for surgically implanted prostheses, except for crystalline lenses if covered under this policy;
5. services, treatment or supplies provided to the Member by the Employer;
6. wheelchairs adapted or designed for sports activities;
7. electric beds;
8. monitoring devices such as stethoscopes, sphygmomanometers and similar equipment, and domestic appliances such as air purifiers, humidifiers, air conditioners, whirlpools and other similar equipment;
9. equipment such as "Obus form" type;
10. training, exercise programs, physical fitness programs using equipment or floor exercises, floating baths, mud baths, therapeutic baths, relaxation exercises, gym exercises, stretching and strengthening exercises, postural evaluations and ear candling;

11. diapers for incontinence;
12. dental services, except those provided for in this Benefit;
13. dental services and supplies for the purposes of full mouth reconstructions, for vertical dimension correction or for any other temporomandibular joint dysfunction;
14. travel for health reasons or for medical examinations required for insurance, consultation or assessment purposes;
15. services, treatment or supplies not included in the list of Eligible Expenses;
16. Eligible Expenses which result directly or indirectly from the following:
    a. cosmetic treatment, except those provided for in this Benefit;
    b. committing, or attempting to commit a criminal offence;
    c. any cause for which payment is provided under any Workers' Compensation Act or similar legislation or under any other government plan;
    d. war, whether the war be declared or not, or service in the armed forces of any country, or participation in a riot, insurrection or civil commotion;
    e. driving a motorized Vehicle while impaired by drugs, or with an alcohol level that exceeds the limit set under the Criminal Code of Canada; the Eligible Expenses incurred for detoxification treatment are not subject to this exclusion;
17. services, treatment or supplies for the treatment of alcoholism and drug addiction;
18. non-prescription sunglasses;
19. broken appointments, transportation costs, telephone or other indirect consultations;
20. any prescription drugs or medical expenses normally covered through a government program provided in a hospital, or any other means are not covered when offered on an out-patient basis or at a private clinic (unless legislated as in the province of Quebec);
21. services, treatment or supplies which are not medically necessary, or not of a reasonable and customary nature;
22. charges for group sessions;
23. imaging techniques/diagnostic laboratory tests.

Exclusions applicable to drugs

No reimbursement will be made under this Benefit for the following:

1. contraceptives (prophylactics and contraceptive jellies and foams) except those provided for under this Benefit;
2. the following products, whether or not prescribed:
    a. shampoos and other scalp care products, including hair growth products;
    b. beauty-care products;
    c. cosmetics;
    d. so-called "natural" products and homeopathic preparations;
    e. sun-tan emulsions (sunscreens);
    f. soaps;
    g. over-the-counter laxatives;
    h. over-the-counter antacids;
    i. skin softeners;
    j. disinfectants and ordinary dressings;
    k. mineral water;
    l. any infant milk formulas;
    m. proteins and food supplements (i.e. products used to supplement or complement a diet);

3. sclerosing injections used in the treatment of varicosities, telangiectasia or dilation;
4. products and drugs used in the treatment of sexual dysfunctions except for those provided for under this Benefit;
5. products used as smoking cessation aids, except those provided for in this Benefit;
6. expenses incurred for services, products or drugs that are used to treat specific conditions other than those for which they are approved;
7. expenses incurred for services, products or drugs that are taken in a higher dose, greater quantity or at a frequency that exceeds the Insurer's established criteria.

Exclusions applicable to drugs requiring prior authorization:

No reimbursement will be made under this Benefit for drugs that do not meet the Insurer's prior authorization criteria on the date the expenses were incurred.

Drug restrictions:

1. the Insurer reserves the right to apply certain restrictions for the reimbursement of drugs for which a less expensive equivalent drug is available on the market;
2. any one prescription for drugs or medicines must not be in excess of a 34 day supply and a 100 day supply in the case of maintenance drugs.

Exclusions and limitations applicable to Travel Insurance - Applicable to Regular Employees Only
If an Insured Person fails to contact "Voyage Assistance" immediately when they require Medical Emergency services that require Hospitalization outside the country, the Insurer may reduce or deny reimbursement of a portion of the incurred Eligible Expenses. It is understood that the Insurer is not responsible for the availability or quality of such services even after repatriation.

Exclusions applicable to the Extended Health Care Benefit also apply to the Travel Insurance provision. Furthermore, the Insurer will not pay any of the benefits provided for under the Travel Insurance provision in the following circumstances:

1. if the Insured Person is not covered under government health and hospital insurance plans;
2. if the purpose of the Trip is to receive medical or paramedical treatment or Hospital services;
3. for elective, non-emergency treatment or surgery, when this service could have been provided in the province of residence of the Insured Person without endangering their life or health, even if such service is provided as a result of a Medical Emergency;
4. if the Insured Person did not agree to:
    a. the treatment prescribed by the Physician or "Voyage Assistance";
    b. change hospital or clinic;
    c. be examined for diagnostic purposes;
    d. repatriation as recommended by "Voyage Assistance";
5. for the cost of the casket or urn;
6. if a Physician advised the Insured Person not to travel;
7. for health care and Hospital expenses incurred for an Insured Person who cannot be repatriated in their province of residence and who refuses medical treatment prescribed by the Physician, and approved by "Voyage Assistance";
8. if the Insured Member’s life expectancy is less than 12 months;
9. for expenses incurred for a pregnancy, miscarriage or childbirth, or any complications thereof, will not be covered if the expenses are incurred after the first 32 weeks of the pregnancy;

10. for an accident that occurs while travelling and resulting from the Insured Person participating in a sports activity in return for payment (including cash prizes) or a high-risk sport or activity, including without limitation:
    a. hang gliding, paragliding and kite surfing;
    b. skydiving and free falling;
    c. bungee jumping;
    d. climbing and mountain climbing;
    e. freestyle skiing and off-track skiing;
    f. amateur scuba diving, if the person does not hold at least a basic scuba diving license from a certified school;
    g. combat sports;
    h. motorized race and motorized training activities;
11. for any Medical Emergency incurred in a country, region or other types of destinations such as cruises or landmarks, for which the Canadian government issued level 4 alerts, prior to the trip departure date, the following travel warning:
    a. avoid all travel;
    b. Insured Members already in a Level 4 alert location must return as soon as possible and within 14 days of the date the alert was issued;
12. if the Insured Person refuses to disclose to the Insurer necessary information regarding other insurance plans under which the member also has travel insurance coverage, or if they refuse the use of such information by the insurer;
13. if the expenses incurred are related to a health condition that was not Stable prior to the trip departure date;
14. for death or expenses directly or indirectly related to:
    a. Drug use, or
    b. Medication or alcohol abuse.

Medication abuse means intake in excess of the recommended dosage. Alcohol abuse means a blood alcohol content in excess of that allowed under the Criminal Code of Canada.

Travel Insurance benefits are limited to the maximum specified in the Benefit Schedule.

CO-ORDINATION OF BENEFITS

This Benefit is subject to the CO-ORDINATION OF BENEFITS provision in the CLAIMS section of this policy, and to the provisions below.

Total benefits payable under this Benefit and, if applicable, the MEMBER ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT and the DEPENDENT ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT if included under this policy cannot exceed the amount of Eligible Expenses incurred.

If expenses incurred by the Insured Person are eligible for payment under both this Benefit and, if applicable, the MEMBER ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT and the DEPENDENT ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT if included under this policy, such expenses will be payable under the ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS prior to any payment under this Benefit. As such, the liability of the Insurer under this Benefit will be limited to the unpaid balance of these Eligible Expenses.

BENEFIT TERMINATION

This Benefit terminates on the date the Member attains the Age Limit specified in the Benefit Schedule or on the earliest of the dates indicated in the TERMINATION OF MEMBER INSURANCE provision.

DEPENDENT BENEFIT EXTENSION AFTER MEMBER'S DEATH

In the event of the death of the Member and subject to policy provisions, insurance under this Benefit will continue for insured Dependents, without premium payment, until the earliest of the following dates:

1. 24 months following the death of the Member;
2. the date on which the Dependent ceases to be eligible as a Dependent for a reason other than the death of the Member;
3. the date on which Dependent insurance would have terminated if the Member had not died; or
4. the date on which this Benefit or policy terminates.

NOTICE AND PROOF OF CLAIM

All claims, along with any receipts, must be submitted to the Insurer within 12 months of the date the expenses were incurred, or 120 days from termination of coverage.

All claims must be signed by the Member. Claims for a spouse or dependent children can be signed by the Member's spouse, as long as the spouse is a covered dependent under this plan.

SUBROGATION

Upon providing payment for incurred expenses or loss of income, CINUP, on behalf of the Plan Sponsor, is subrogated to all rights of recovery of the Member, or any Dependents, against any person or party and may bring action in the name of the Member, or Dependent, to enforce such rights.

DRUG CLAIMS

When incurring drug expenses, the Insured Person must show their payment card to the pharmacist. With this method of payment, which is referred to as "direct", the Insured Person only pays the pharmacist for the uninsured portion of the drug expenses incurred and, therefore, the Member is not required to submit a claim to the Insurer.

DENTAL CARE BENEFIT

DEFINITIONS

As used in this Benefit:

Calendar Year	means the period from January 1st to December 31st inclusive.
Dental Hygienist	means a person licensed by an accredited dental faculty to perform dental prophylaxis.
Dentist	means a person who is licensed to practise dentistry by the appropriate authority of the jurisdiction where the services are provided.
Fee Guide	means the Dental Association Fee Guide for General Practitioners and Specialists of the Province in which the Insured Person is resident, for the Calendar Year mentioned in the BENEFIT SCHEDULE.

LATE APPLICATION

With respect to this Benefit, if the Member applies for coverage for themself or their Dependents more than 31 days after the date of their eligibility, evidence of insurability will not be required by the Insurer. However, in all cases, the Insurer will limit the amount of Eligible Expenses in accordance with the RESTRICTIONS, EXCLUSIONS AND LIMITATIONS provision under this Benefit.

PAYMENT OF BENEFIT

On receipt of Proof of Claim satisfactory to the Insurer that an Insured Person, while covered under this Benefit, incurred Eligible Expenses which were necessary and which were for services recommended by a Dentist, the Insurer will reimburse the expenses in excess of the Deductible, if any, subject to the Percentage of Reimbursement and maximums specified in the Benefit Schedule, and in accordance with other applicable policy provisions.

To be eligible, the expenses must have been performed

1. by a Dentist; or
2. by a Dental Hygienist under the supervision of a Dentist; or
3. by a licensed denturist when such services are within the scope of their license.

Eligible Expenses will be considered to have been incurred on the date the service or supply was provided. However, with respect to a bridge, crown or denture, the date of insertion of such appliance will be the date such expense was incurred, and with respect to root canal therapy, the date of the final treatment will be the date that expense was incurred.

COMMENCEMENT OF DEPENDENT INSURANCE

If a Dependent is hospitalized on the day their insurance would normally become effective, the effective date of insurance is delayed, and their insurance will commence 24 hours after their discharge from the Hospital. However, the newborn Child of a Member will be covered at birth.

DEDUCTIBLE

The Deductible is the amount of Eligible Expenses that the Member must pay in any Calendar Year before reimbursement will be made under this Benefit. The Deductible is specified in the Benefit Schedule.

PERCENTAGE OF REIMBURSEMENT

The Percentage of Reimbursement specified in the Benefit Schedule is the percentage of Eligible Expenses in excess of the Deductible that will be reimbursed by the Insurer, in accordance with the provisions of this Benefit.

ELIGIBLE EXPENSES IN CANADA

PREVENTIVE SERVICES	
Examinations	• Complete oral examination, once every 3 Calendar Years • Recall oral examination, according to the frequency specified in the Benefit Schedule • Specific oral examination • Emergency oral examination
Radiographs (X-Rays)	• Complete series of periapical films, panoramic radiographs or cephalometric films, limited to one series in any 24 months • Intra oral films, including bitewing films and radiographs to diagnose a symptom or examine progress of a particular course of treatment • Interpretation of radiographs from another source • Photography • Radiograph of the hand and wrist as a diagnostic aid for dental treatment
Lab Tests and Examinations	• Bacteriologic cultures/smears to determine pathological agents • Biopsies • Pulp vitality tests • Unmounted diagnostic casts
Case Presentation and Explanation	• Consultation with a patient

Preventive Services	• Polishing according to the frequency specified in the Benefit Schedule • Light scaling for preventive and therapeutic purposes according to the frequency specified in the Benefit Schedule • Topical application of fluoride, according to the frequency specified in the Benefit Schedule • Finishing restorations • Pit and fissure sealants limited to one application per tooth every 36 months (for dependent children under age 18 only) • Interproximal disking • Space maintainers for missing primary teeth, for Children under Age 18 • Prophylactic odontotomy/enameloplasty • Occlusal equilibration, limited to 8 units per calendar year • Oral hygiene instruction (once per lifetime)
BASIC SERVICES, ENDODONTICS AND PERIODONTICS	
Restorations	• Amalgam (silver) • Composite restorations in accordance with the LIMITATIONS provision of the Dental Care section in the Benefit Schedule • Replacement fillings done within 12 months of original placement are not eligible • Retentive pins for amalgam and composite restorations • Preformed stainless steel and polycarbonate crowns, for Children under Age 18 • Caries / trauma / pain control, separate procedure from restoration
Endodontics	• Treatment of disease of the pulp chamber and pulp canals • Root canal therapy limited to one treatment per tooth per lifetime
Periodontics	Treatment of the soft tissue (gums) and bone supporting the teeth. However the following expenses are limited: • post-operative visits • curettage performed by a Dentist • root planing • periodontal appliance to control bruxism only • adjustments to periodontal appliance to control bruxism only, limited to one adjustment per Calendar Year
Maintenance of Removable Dentures	• Repair • Structure addition (to an existing removable dentures) • Relining • Rebasing • Adjustments to dentures, 3 months after insertion • Denture adjustments including minor adjustments

Oral Surgery	• Extractions - uncomplicated and complex • Removal of residual roots • Surgical exposure of teeth • Alveoplasty, gingivoplasty, stomatoplasty and osteoplasty • Alveolar ridge reconstruction • Extension of mucous folds • Excisions • Incisions • Frenectomy • Miscellaneous surgical procedures
Other Services	• appliances to control harmful oral habits • general anaesthesia only is eligible when administered in conjunction with an Eligible Expense
MAJOR RESTORATIVE SERVICES	
Removable Dentures	• Complete denture • Immediate complete denture • Complete or partial overdenture • Transitional denture • Partial denture including cast in chrome (but not in gold) • Partial denture remake • Remount with occlusal equilibration • Therapeutic tissue conditioning
FIXED PROSTHODONTICS (Bridges)	• Abutments and pontics • Repairs • Bridge removal • Recementation
Other Single Restorations	• Onlays, veneers, inlays, crowns o for a tooth that is fractured due to caries or traumatic injury and cannot be filled by amalgam or composite o temporary crowns are considered to be part of the final restoration o replacement of an existing onlay, veneer application, inlay or crown is included if such restoration is at least 5 years old o only metal crowns on molars are reimbursed • Porcelain repair • Post, pin and core once per tooth every 5 Calendar Years Retentive pins, pivots, cast posts • Recementation • Removal of an inlay or crown

ELIGIBLE EXPENSES OUTSIDE CANADA

Payment will be made for dental treatment rendered while travelling outside Canada, but only to the extent that payment would have been made under this Benefit if such treatment had been rendered in the normal province of residence of the Insured Person and provided that such treatment was rendered for emergency purposes only.

RESTRICTIONS, EXCLUSIONS AND LIMITATIONS

In the event of late application of the Member or their Dependents, in accordance with the Late Application provision under this Benefit, reimbursement will be limited to $250 per Insured Person for the first 12 months of coverage.

Reimbursement will not be made for any portion of the charge in excess of the suggested fee in the appropriate Fee Guide, as specified in the Benefit Schedule. When there are two or more courses of treatment available to adequately correct a dental condition, this plan will provide reimbursement for the treatment that incurs the lowest cost consistent with good dental care.

Reimbursement of lab fees will be limited to the reasonable and customary charge for such services in the area where the services are provided. However, in no event will the total reimbursement of lab fees exceed 60% of the suggested fee in the appropriate Fee Guide, as specified in the Benefit Schedule, for the particular dental treatment requiring the lab services.

Reimbursement of fees for composite restorations performed on posterior teeth may be limited to the fees for amalgam restorations as specified in the LIMITATIONS provision of the Dental Care section in the Benefit Schedule.

No reimbursement will be made under this Benefit for the following:

1. any dental treatment which is for cosmetic purposes when the form and function of the teeth are satisfactory and no pathological condition exists;
2. charges for nutritional counselling;
3. any dental services or supplies, including X-rays, provided for full mouth reconstruction, for vertical dimension correction, for the correction of temporomandibular joint dysfunction or for permanent splinting of teeth;
4. charges levied by a Dentist for broken appointments, completion of claim forms or advice by telephone;
5. expenses incurred for bacteriologic cultures/smears followed by a Chlorzoin treatment;
6. expenses incurred for implants;
7. expenses incurred for duplicate diagnostic casts (unmounted);
8. expenses incurred for anaesthesia administered by acupuncture;
9. any dental treatment that is not yet approved by the Canadian Dental Association or that is for experimental purposes;
10. dental services, treatment or supplies that the individual received without charge or that a government health plan prohibits from being paid;
11. services, treatment or supplies provided to the Member by the Employer;
12. any dental treatment rendered outside Canada except as specifically provided under the ELIGIBLE EXPENSES OUTSIDE CANADA provision;
13. dental services and supplies not included in the list of Eligible Expenses;
14. Eligible Expenses that result directly or indirectly from the following:

a. committing, or attempting to commit a criminal offence;
b. any cause for which payment is provided under any Workers' Compensation Act or similar legislation or under any other government plan;
c. war, whether war be declared or not, or service in the armed forces of any country, or participation in a riot, insurrection or civil commotion;

15. charges for services that are not reasonable and customary;
16. any services and supplies rendered for the treatment or correction of any congenital or developmental malformation;
17. facility fees.

Exclusions Related To Prostheses And Crowns	No reimbursement will be made under this Benefit for the following: 1. expenses incurred for the replacement of dentures and appliances that are lost, mislaid or stolen; 2. prosthetics with precision attachments or stress breakers; 3. precision attachments and telescoping crown units for fixed bridgework; 4. preformed stainless steel or polycarbonate crowns, except in the case of primary teeth; 5. transfer coping for crowns.
Exclusions Related To Orthodontic Treatment	No reimbursement will be made under this Benefit for the following: 1. myofunctional therapy; 2. replacement or repair of an orthodontic appliance; 3. patient motivation (psychological evaluation and progress, per visit); 4. procedure requiring the insertion of an adjustable orthodontic appliance before the person is insured under this Benefit.

CO-ORDINATION OF BENEFITS

This Benefit is subject to the CO-ORDINATION OF BENEFITS provision in the CLAIMS section of this policy.

PRE-DETERMINATION OF BENEFIT

When the total cost of any proposed dental treatment for an Insured Person is expected to exceed $500, the Member should submit a detailed treatment plan to the Insurer before treatment commences. The Insurer will then advise the Member of the amount of reimbursement for which the Insured Person is eligible in accordance with the provisions of this policy. The treatment plan should outline the type of treatment to be provided, the anticipated treatment dates, and the cost of such treatment.

The treatment plan submitted must be completed by the Dentist who first proposed the treatment, otherwise the Member will be required to submit a new treatment plan to the Insurer for re-assessment.

BENEFIT TERMINATION

This Benefit terminates on the date the Member reaches the Age Limit specified in the Benefit Schedule or on the earliest of the dates indicated in the TERMINATION OF MEMBER INSURANCE provision.

No benefits are payable for expenses incurred after the date the insurance of the Member terminates, even if a detailed treatment plan under the PRE-DETERMINATION OF BENEFIT provision was filed and benefits were determined by the Insurer prior to such termination date.

DEPENDENT BENEFIT EXTENSION AFTER MEMBER'S DEATH

In the event of the death of the Member and subject to policy provisions, insurance under this Benefit will continue for insured Dependents, without premium payment, until the earliest of the following dates:

1. 24 months following the death of the Member;
2. the date on which the Dependent ceases to be eligible as a Dependent for a reason other than the death of the Member;
3. the date on which Dependent insurance would have terminated if the Member had not died;
4. the date on which this Benefit or policy terminates.

PROOF OF CLAIM

The Insured Person domiciled in Quebec must show their government health card and payment card to a Dentist participating in the payment card program to be reimbursed for dental expenses. A simple telephone call allows the Dentist to validate the payment card, confirm that the care provided or prescribed is covered, and obtain confirmation of the amount payable directly to the Dentist by the Insurer and the amount payable by the Insured Person. The Dentist submits the benefit claim to the service provider and gives a copy to the Insured Person who only pays the uninsured portion of the dental expenses incurred. In the case of a Dentist who is not participating in the payment card program, the Insured Person must pay all treatment charges and submit a benefit claim to the Insurer.

For an Insured Person domiciled outside Quebec or if the Dentist uses the Electronic Data Interchange (EDI), the Member is not required to submit a claim to the Insurer. EDI allows the Dentist to validate the Insured Person's eligibility, confirm that the care provided or prescribed is covered, and obtain confirmation of the amount payable directly to the Member, or the Dentist, by the Insurer, and the amount payable by the Insured Person. The Dentist submits the benefit claim through EDI and gives a copy of the confirmation to the Insured Person. If the Dentist does not use the Electronic Data Interchange (EDI), the Insured Person must submit a benefit claim to the Insurer.

All claims, along with any receipts, must be submitted to the Insurer within 12 months of the date the expenses were incurred, or 120 days from termination of coverage.

The Insurer reserves the right to require radiographs and other types of diagnostics such as specialist reports, periodontal charts and study models.

SUBROGATION

Upon providing payment for incurred expenses or loss of income, CINUP, on behalf of the Plan Sponsor, is subrogated to all rights of recovery of the Member, or any Dependents, against any person or party and may bring action in the name of the Member, or Dependent, to enforce such rights.

PAYMENT OF ORTHODONTIC CLAIMS

Notwithstanding anything to the contrary under the CLAIMS provision of this policy, the payment of orthodontic claims will be made on one of the following bases:

1. If a single charge is estimated for the entire course of treatment and the Insured Person pays this charge to the orthodontist in prearranged instalments over an estimated period of treatment or in one lump sum, the Insurer will reimburse the Member each time they submit a bill, certificate or receipt that specifies the amount of expenses, the date and the nature of the treatment received; or
2. If in lieu of a single charge, a charge is made for each treatment as it is performed, the Insurer will reimburse the Member as each charge is incurred.

MEMBER CRITICAL ILLNESS

DEFINITIONS

As used in this Benefit:

Diagnosis	means, as established by a Specialist using tests or other diagnostic methods, the definite presence in the Member of a Critical Illness or Certain Illness. Surgeries specifically identified in this Benefit are also considered as Diagnoses.
Irreversible	means the condition cannot be improved by medical or surgical treatment at the time of Diagnosis. The medical or surgical treatment need not be undertaken if it would involve an undue risk to the Insured Person's health.
Pre-existing Condition	means, within the 24-month period preceding the date of the Insured Person's Commencement of insurance or effective date of last reinstatement of insurance, the existence of: 1. a condition or symptom(s) for which medical expenses were incurred, treatment was received, drugs or medicine was prescribed or a Physician or healthcare practitioner was consulted; or 2. a condition or symptom(s) for which an ordinarily prudent person would seek diagnosis, care or treatment.
Specialist	means a licensed Physician practising in Canada who has achieved certification as a specialist through the completion of certifying examinations in the applicable jurisdiction. The Specialist must be certified in the specific area of medicine relevant to the Diagnosis for which a claim is being made. In the absence or unavailability of a Specialist, the Diagnosis or the necessity of a Surgery may be established by a qualified Physician practising in Canada, as approved by the Insurer. The Specialist must not be the Insured Person, a relative or business associate of the Insured Person.
Surgery	means medically necessary surgery performed on the Member in accordance with the written advice of a Specialist. The surgery must be performed by a Physician in Canada.
Survival Period	except where otherwise indicated, means the 30 days following the date of Diagnosis or 30 days following the date of Surgery, at the end of which the Member is alive and has not experienced Irreversible cessation of all functions of the brain. The Survival Period does not include the number of days for which the Member is on life support. For the purposes of this Benefit, life support means the regular care of a licensed physician for nutritional, respiratory and/or cardiovascular support, including but not limited to cases where Irreversible cessation of all functions of the brain has occurred. For those Critical Illnesses which are subject to a qualifying period, the Survival Period runs concurrently with the qualifying period of the Critical Illness.
Total Disability or Totally Disabled	means a state of incapacity as defined in the DEFINITIONS for the Basic Member Life Insurance Benefit.

Critical Illness	means any one of the following conditions, as it is defined in this section: 1. Alzheimer's Disease 2. Aortic Surgery 3. Aplastic Anemia 4. Bacterial Meningitis 5. Benign Brain Tumour 6. Blindness 7. Cancer (life-threatening) 8. Coma 9. Coronary Artery Bypass Surgery 10. Deafness 11. Dilated Cardiomyopathy 12. Fulminant Viral Hepatitis 13. Heart Attack 14. Heart Valve Replacement 15. Kidney Failure 16. Liver Failure of Advanced Stage 17. Loss of Independent Existence 18. Loss of Limbs 19. Loss of Speech 20. Major Organ Failure on Waiting List 21. Major Organ Transplant 22. Motor Neuron Disease 23. Multiple Sclerosis 24. Muscular Dystrophy 25. Occupational HIV Infection 26. Paralysis 27. Parkinson's Disease 28. Primary Pulmonary Hypertension (idiopathic pulmonary arterial hypertension and familial pulmonary arterial hypertension) 29. Progressive Systemic Sclerosis 30. Severe Burns 31. Stroke (cerebrovascular accident)
Alzheimer's Disease	means a definite Diagnosis of a progressive degenerative disease of the brain. The Member must exhibit the loss of intellectual capacity involving impairment of memory and judgement, which results in a significant reduction in mental and social functioning, and requires a minimum of 8 hours of daily supervision. Exclusion: No benefit will be payable under this condition for all other dementing organic brain disorders and psychiatric illnesses.

Aortic Surgery	means the undergoing of Surgery for disease of the aorta requiring excision and surgical replacement of the diseased aorta with a graft. Aorta refers to the thoracic and abdominal aorta but not its branches.
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: 1. marrow stimulating agents, 2. immunosuppressive agents, 3. bone marrow transplantation.
Bacterial Meningitis	means a definite Diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least 90 days from the date of Diagnosis. Exclusion: No benefit will be payable under this condition for viral meningitis.
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 tumour must require surgical or radiation treatment or cause Irreversible objective neurological deficit(s). 1. Exclusion: No benefit will be payable under this condition for pituitary adenomas less than 10 mm. 2. Exclusion Period: No benefit will be paid under this condition if, within the first 90 days following the later of: a. the date of Commencement of Insurance; b. the effective date of last reinstatement of insurance under this Benefit; *the Member had any of the following:* a. signs, symptoms or investigations that lead to a diagnosis of benign brain tumour, without regard to the eligibility of the diagnosis under the policy or when the diagnosis is made; b. a diagnosis of benign brain tumour, without regard to the eligibility of the diagnosis under the policy. The medical information described above must be reported to the Insurer within 6 months of the date of the diagnosis. If this information is not provided, the Insurer has the right to deny any claim for Benign Brain Tumour, or for any Critical Illness caused by any benign brain tumour or its treatment.
Blindness	means a definite Diagnosis of the total and Irreversible loss of vision in both eyes, evidenced by: 1. the corrected visual acuity being 20/200 or less in both eyes; or 2. the field of vision being less than 20 degrees in both eyes.

Cancer (life-threatening)	means a definite Diagnosis of a tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. 1. Exclusions: No benefit will be payable under this condition for the following non-life-threatening cancers: a. carcinoma in situ; b. Stage 1A malignant melanoma (melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or level V invasion); c. any non-melanoma skin cancer that has not metastasized; d. Stage A (T1a or T1b) prostate cancer. 2. Exclusion Period: No benefit will be payable under this condition if, within the first 90 days following the later of: a. the date of Commencement of insurance; b. the effective date of last reinstatement of insurance under this Benefit; *the Member has any of the following:* a. signs, symptoms or investigations, that lead to a diagnosis of cancer without regard to the eligibility of the diagnosis under the policy or when the diagnosis is made; b. a diagnosis of cancer without regard to the eligibility of the diagnosis under the policy. This medical information as described above must be reported to the Insurer within 6 months of the date of the diagnosis. If this information is not provided, the Insurer has the right to deny any claim for cancer, or for any Certain Illness or Critical Illness caused by any cancer or its treatment.
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. Exclusion: No benefit will be payable under this condition for: 1. a medically induced coma, 2. a coma which results directly from alcohol or drug use, 3. a diagnosis of brain death.
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). Exclusion: No benefit will be payable under this condition for non-surgical or trans-catheter techniques such as balloon angioplasty or laser relief of an obstruction.
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.

Dilated Cardiomyopathy	means a definite Diagnosis of a condition of impaired ventricular function resulting in significant physical impairment of at least Class III of the New York Heart Association (NYHA) Classification of Cardiac Impairment. The Diagnosis must be confirmed by new, abnormal cardiac function demonstrated in echocardiography with a persistent low ejection fraction (less than 40%) for at least 3 months. For the purpose of this Benefit, NYHA Class III cardiomyopathy impairment means that the patient is comfortable at rest and is symptomatic during less than ordinary daily activities despite the use of medication and dietary adjustment, with evidence of abnormal ventricular function on physical examination and laboratory studies. Exclusion: No benefit will be payable under this condition for ischemic and toxic causes (including alcohol, prescription and non-prescription drug use) of dilated cardiomyopathy.
Fulminant Viral Hepatitis	means a definite Diagnosis of a submassive to massive necrosis of the liver caused by any virus leading precipitously to liver failure. Payment under this condition requires satisfaction of all of the following: 1. a rapidly decreasing liver size as confirmed by abdominal ultrasound; 2. necrosis involving entire lobules, leaving only a collapsed reticular framework (available histology to be included); 3. rapidly deteriorating liver function tests; 4. deepening jaundice. Exclusion: No benefit will be payable under this condition for: 1. chronic hepatitis; 2. liver failure caused by alcohol, toxins and/or drugs.
Heart Attack	means a definite Diagnosis of the death of heart muscle due to obstruction of blood flow that results in the rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following: 1. heart attack symptoms; 2. new electrocardiogram (ECG) changes consistent with a heart attack; 3. development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty. Exclusion: No benefit will be payable under this condition for: 1. elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves; or 2. ECG changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as described above.
Heart Valve Replacement	means the undergoing of Surgery to replace any heart valve with either a natural or mechanical valve. Exclusion: No benefit will be payable under this condition for heart valve repair.
Kidney Failure	means a definite Diagnosis of chronic Irreversible failure of both kidneys to function, as a result of which regular hemodialysis, peritoneal dialysis or renal transplantation is initiated.

Liver Failure of Advanced Stage	means a definite Diagnosis of liver failure due to cirrhosis and resulting in all of the following: 1. permanent jaundice; 2. ascites; 3. encephalopathy. Exclusion: No benefit will be payable under this condition for liver disease secondary to alcohol or drug use.
Loss of Independent Existence	means a definite Diagnosis of: 1. a total inability to perform, by oneself, at least 2 of the following 6 Activities of Daily Living, or 2. Cognitive Impairment, as defined below, for a continuous period of at least 90 days with no reasonable chance of recovery. Activities of Daily Living are: 1. Bathing - the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of equipment. 2. Dressing - the ability to put on and remove necessary clothing including braces, artificial limbs or other surgical appliances. 3. Toileting - the ability to get on and off the toilet and maintain personal hygiene. 4. Bladder and Bowel Continence - the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained. 5. Transferring - the ability to move in and out of a bed, chair or wheelchair, with or without the use of equipment. 6. Feeding - the ability to consume food or drink that already has been prepared and made available, with or without the use of adaptive utensils. For the purpose of this Benefit, cognitive Impairment means mental deterioration and loss of intellectual ability, evidenced by deterioration in memory, orientation and reasoning, which are measurable and result from demonstrable organic cause as diagnosed by a Specialist. The degree of Cognitive Impairment must be sufficiently severe as to require a minimum of 8 hours of daily supervision. Determination of a Cognitive Impairment will be made on the basis of clinical data and valid standardized measures of such impairments. Exclusion: No benefit will be payable under this condition for any mental or nervous disorder without a demonstrable organic cause.
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.
Loss of Speech	means a definite Diagnosis of the total and Irreversible loss of the ability to speak as the result of physical injury or disease, for a period of at least 180 days. Exclusion: No benefit will be payable under this condition for all psychiatric related causes.

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 necessary. To qualify under Major Organ Failure on Waiting List, the Member must become enrolled as the recipient in a recognized transplant centre in Canada or in 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 Insured Person's enrolment in the transplant centre.
Major Organ Transplant	means a definite Diagnosis of the Irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Transplant, the Member must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities.
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.
Multiple Sclerosis	means a definite Diagnosis of at least one of the following: 1. two or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions of demyelination; or, 2. well-defined neurological abnormalities lasting more than 6 months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination; or, 3. a single attack, confirmed by repeated MRI imaging of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one month apart.
Muscular Dystrophy	means a definite Diagnosis of hereditary muscle disorders in which, slow, progressive deterioration occurs, leading to increasing weakness and disability. Diagnosis must be supported by DNA analysis, electromyography and muscle biopsy.

Occupational HIV Infection	means a definite Diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Insured Person's normal occupation, which exposed the person to HIV contaminated body fluids. The accidental injury leading to the infection must have occurred after the later of the date of Commencement of Insurance, or the effective date of last reinstatement of insurance. Payment under this condition requires satisfaction of all of the following: 1. the accidental injury must be reported to the Insurer within 14 days of the accidental injury; 2. a serum HIV test must be taken within 14 days of the accidental injury and the result must be negative; 3. a serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive; 4. all HIV tests must be performed by a duly licensed laboratory in Canada or in the United States; 5. the accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States workplace guidelines. Exclusion: No benefit will be payable under this condition if: 1. the Member has elected not to take any available licensed vaccine offering protection against HIV; or 2. a licensed cure for HIV infection has become available prior to the accidental injury; or 3. HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use.
Paralysis	means 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.
Parkinson's Disease	means a definite Diagnosis of idiopathic and degenerative Parkinson's disease diagnosed by a duly qualified neurologist. The Diagnosis must be based on two or more of the following symptoms: 1. rigidity; 2. tremors; 3. bradykinesia.

Primary Pulmonary Hypertension (idiopathic pulmonary arterial hypertension and familial pulmonary arterial hypertension)	means a definite Diagnosis of primary pulmonary hypertension with a substantial right ventricular enlargement confirmed by investigations (including cardiac catheterization), resulting in permanent Irreversible physical impairment to the degree of at least Class IV of the New York Heart Association (NYHA) Classification of Cardiac Impairment. The NYHA Classification of Cardiac Impairment (source: Current Medical Diagnosis and Treatment - 39th Edition) states the following about Class IV: *"Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest."* Exclusion: No benefit will be payable under this condition for all other types of pulmonary arterial hypertension.
Progressive Systemic Sclerosis	means a definite Diagnosis of progressive systemic scleroderma with systemic involvement of the heart, lungs or kidneys. The Diagnosis must be unequivocally supported by biopsy and serological evidence. Exclusion: No benefit will be payable under this condition for: 1. localized scleroderma (linear scleroderma or morphea), 2. eosinophilic fasciitis, or 3. CREST syndrome.
Severe Burns	means a definite Diagnosis of third-degree burns over at least 20% of the body surface.
Stroke (cerebrovascular accident)	means a definite Diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism from an extra-cranial source, with: 1. acute onset of new neurological symptoms; and 2. 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. Exclusion: No benefit will be payable under this condition for: 1. transient ischaemic attacks; 2. intracerebral vascular events due to trauma; 3. lacunar infarctions which do not meet the definition of Stroke as described above.

EVIDENCE OF INSURABILITY

Evidence of insurability satisfactory to the Insurer will be required of a Member applying for any Amount of Insurance under Basic Member Critical Illness Benefit in excess of the amount specified in the Benefit Schedule as the Non-Evidence Maximum of Insurability.

PAYMENT OF BENEFIT

Payment for the Diagnosis of a Critical Illness or Certain Illness is conditional to prior reception of proof of claim satisfactory to the Insurer, confirming that

1. a Specialist has established the Diagnosis; and

2. the Member survived after the Diagnosis and the conditions of survival under the Survival Period definition have been met.

COVERAGE FOR CRITICAL ILLNESSES

If the Member receives the Diagnosis of a Critical Illness as such illness is defined in this Benefit, the Insurer will pay the Amount of Insurance specified in the Benefit Schedule.

However, if this Diagnosis was established after any Diagnosis of a Certain Illness or previous Critical Illness, for which benefit has been paid, benefit for this subsequent Diagnosis may only be claimed under the MULTIPLE OCCURRENCE COVERAGE section.

PARTIAL BENEFIT IN CASE OF CERTAIN ILLNESSES

If the Member receives the Diagnosis of one of the illnesses eligible under this section as defined hereunder, the Insurer will pay a benefit equal to 10% of the Amount of Insurance specified in the Benefit Schedule up to $25,000.

Only the Diagnosis of one of the following Certain Illnesses is eligible under this section. *Certain Illness* means:

1. *Coronary angioplasty* which 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. The procedure must be determined to be medically necessary by a Specialist.
2. *Ductal carcinoma in situ of the breast* which means the Diagnosis of non-invasive breast cancer originating in the ducts of the breast. The Diagnosis must be confirmed by biopsy.
3. *Stage A (T1a or T1b) prostate cancer* which means the Diagnosis of a clinically unapparent malignant tumour localized in the prostate that is neither palpable nor visible by imaging. The Diagnosis must be confirmed by pathological examination of prostate tissue.
4. *Stage 1A malignant melanoma* which means the Diagnosis of a melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or V invasion. The Diagnosis must be confirmed by biopsy.

Exclusion Period for Certain Illnesses described in 2), 3) and 4) above:

No benefit will be payable under the condition if the Diagnosis has been established within the first 90 days following the later of the date of Commencement of insurance or the effective date of last reinstatement of insurance under this Benefit.

If the Member has previously received a Diagnosis for a Critical Illness for which benefit has been paid, a claim may only be made under the MULTIPLE OCCURRENCE COVERAGE section.

Only one benefit may be paid in the Member's lifetime under this section.

CANCER RECURRENCE BENEFIT

The Insurer will pay the Amount of Insurance specified in the Benefit Schedule if the Member receives a Cancer (life-threatening) Diagnosis subsequent to receiving a previous cancer diagnosis if:

1. more than 60 months have passed since the previous cancer diagnosis; and
2. no treatment relating directly or indirectly to cancer has been received within that 60 month period (treatment does not include preventative medications and follow up visits to the Physician).

The subsequent Diagnosis must be established while coverage is in force.

MULTIPLE OCCURRENCE COVERAGE

1. If the Member has received the Diagnosis for a Certain or Critical Illness for which benefit has been paid and subsequently receives a Diagnosis for an eligible Critical Illness, the Insurer will pay the Amount of Insurance specified in the Benefit Schedule.

   For the benefit to be paid, the Diagnosis must be established at least 90 days after the date of the most recent claim settlement payment made for the Diagnosis of a Certain or Critical Illness.

   However, when the Member has received the Diagnosis of a Certain Illness for which benefit has been paid, and the following Diagnosis received by this Member is a Critical Illness Diagnosis which was made less than 90 days after the most recent payment made for the settlement of said benefit, the Insurer will pay a benefit equivalent to the Amount of Insurance specified in the Benefit Schedule less the amount paid for the Diagnosis of the Certain Illness.

2. If the Member has received a Diagnosis of a Critical Illness for which benefit has been paid, and subsequently receives the Diagnosis of a Certain Illness, the Insurer will pay a benefit equal to 10% of the Amount of Insurance specified in the Benefit Schedule up to $25,000.

   For the benefit to be paid, the Diagnosis must be established at least 90 days after the date of the most recent claim settlement payment made for the Diagnosis of a Critical Illness.

Payment of any benefit under this section is subject to the restrictions specified in the RE-ENTRY EXCLUSIONS section.

RE-ENTRY EXCLUSIONS

If the Member receives a benefit for the Diagnosis of a Certain or Critical Illness, insurance will automatically continue provided payment of premium is continued. The Member can claim a subsequent benefit for another eligible Critical Illness, subject to the following restrictions:

1. Following an Alzheimer's Disease claim, the Member cannot claim for Alzheimer's Disease or Loss of Independent Existence.
2. Following an Aortic Surgery claim, the Member cannot claim for Alzheimer's Disease, Aortic Surgery, Coma, Coronary Angioplasty, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke or Liver Failure of Advanced Stage.
3. Following an Aplastic Anemia claim, the Member cannot claim for Aplastic Anemia, Cancer (life-threatening), Ductal carcinoma in situ of the breast, Loss of Independent Existence, Stage A (T1a or T1b) prostate cancer or Stage 1A malignant melanoma.
4. Following a Bacterial Meningitis claim, the Member cannot claim for Bacterial Meningitis, Blindness, Coma, Deafness, Loss of Independent Existence, Loss of Speech, Paralysis or Stroke.
5. Following a Benign Brain Tumour claim, the Member cannot claim for Bacterial Meningitis, Benign Brain Tumour, Blindness, Coma, Deafness, Loss of Independent Existence, Loss of Speech, Paralysis or Stroke.
6. Following a Blindness claim, the Member cannot claim for Blindness or Loss of Independent Existence.

7. Following a Cancer (life-threatening) claim, the Member cannot claim for Aplastic Anemia, Cancer (life-threatening) unless all the requirements in the CANCER RECURRENCE BENEFIT section have been met, for Ductal carcinoma in situ of the breast, Loss of Independent Existence, Stage A (T1a or T1b) prostate cancer, Stage 1A malignant melanoma or Liver Failure of Advanced Stage.
8. Following a Coma claim, the Member cannot claim for Blindness, Coma, Deafness, Loss of Independent Existence, Loss of Speech, Paralysis or Stroke.
9. Following a Coronary Artery Bypass Surgery claim, the Member cannot claim for Alzheimer's Disease, Aortic Surgery, Coma, Coronary Angioplasty, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke or Liver Failure of Advanced Stage.
10. Following a Deafness claim, the Member cannot claim for Deafness or Loss of Independent Existence.
11. Following a Dilated Cardiomyopathy claim, the Member cannot claim for Alzheimer's Disease, Aortic Surgery, Coma, Coronary Angioplasty, Coronary Artery Bypass Surgery, Dilated Cardiomyopathy, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke or Liver Failure of Advanced Stage.
12. Following a Fulminant Viral Hepatitis claim, the Member cannot claim for Cancer (life-threatening), Ductal carcinoma in situ of the breast, Fulminant Viral Hepatitis, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stage A (T1a or T1b) prostate cancer, Stage 1A malignant melanoma or Liver Failure of Advanced Stage.
13. Following a Heart Attack claim, the Member cannot claim for Alzheimer's Disease, Aortic Surgery, Coronary Angioplasty, Coronary Artery Bypass Surgery, Coma, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke or Liver Failure of Advanced Stage.
14. Following a Heart Valve Replacement claim, the Member cannot claim for Alzheimer's Disease, Aortic Surgery, Coronary Angioplasty, Coronary Artery Bypass Surgery, Coma, Heart Valve Replacement, Heart Attack, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke or Liver Failure of Advanced Stage.
15. Following a Kidney Failure claim, the Member cannot claim for Coma, Heart Attack, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke or Liver Failure of Advanced Stage.
16. Following a Liver Failure of Advanced Stage claim, the Member cannot claim for Coma, Heart Attack, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke or Liver Failure of Advanced Stage.
17. Following a Loss of Independent Existence claim, the Member can no longer claim. Insurance under this Benefit terminates.
18. Following a Loss of Limbs claim, the Member cannot claim for Loss of Independent Existence or Loss of Limbs.
19. Following a Loss of Speech claim, the Member cannot claim for Loss of Independent Existence or Loss of Speech.
20. Following a Major Organ Failure on Waiting List claim, the Member cannot claim for Aplastic Anemia, Cancer (life-threatening), Coma, Ductal carcinoma in situ of the breast, Heart Attack, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ

Transplant, Stage A (T1a or T1b) prostate cancer, Stage 1A malignant melanoma, Stroke or Liver Failure of Advanced Stage.

21. Following a Major Organ Transplant claim, the Member cannot claim for Aplastic Anemia, Cancer (life-threatening), Coma, Ductal carcinoma in situ of the breast, Heart Attack, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stage A (T1a or T1b) prostate cancer, Stage 1A malignant melanoma, Stroke or Liver Failure of Advanced Stage.
22. Following a Motor Neuron Disease claim, the Member cannot claim for Blindness, Coma, Deafness, Heart Attack, Loss of Independent Existence, Loss of Speech, Motor Neuron Disease, Paralysis or Stroke.
23. Following a Multiple Sclerosis claim, the Member cannot claim for Blindness, Coma, Deafness, Kidney Failure, Loss of Independent Existence, Loss of Speech, Multiple Sclerosis, Paralysis or Stroke.
24. Following a Muscular Dystrophy claim, the Member cannot claim for Blindness, Coma, Deafness, Dilated Cardiomyopathy, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Loss of Speech, Major Organ Failure on Waiting List, Major Organ Transplant, Muscular Dystrophy, Paralysis, Stroke or Liver Failure of Advanced Stage.
25. Following an Occupational HIV Infection claim, the Member cannot claim for Blindness, Cancer (life-threatening), Coma, Deafness, Ductal carcinoma in situ of the breast, Kidney Failure, Loss of Independent Existence, Loss of Speech, Occupational HIV Infection, Paralysis, Stage A (T1a or T1b) prostate cancer, Stage 1A malignant melanoma, Stroke or Liver Failure of Advanced Stage.
26. Following a Paralysis claim, the Member cannot claim for Coma, Loss of Independent Existence, Loss of Speech or Paralysis.
27. Following a Parkinson's Disease claim, the Member cannot claim for Coma, Loss of Independent Existence, Loss of Speech, Paralysis or Parkinson's Disease.
28. Following a Primary Pulmonary Hypertension claim, the Member cannot claim for Aortic Surgery, Coma, Coronary Angioplasty, Coronary Artery Bypass Surgery, Dilated Cardiomyopathy, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Primary Pulmonary Hypertension, or Stroke.
29. Following a Progressive Systemic Sclerosis claim, the Member cannot claim for Progressive Systemic Sclerosis, Aortic Surgery, Blindness, Coma, Coronary Angioplasty, Coronary Artery Bypass Surgery, Cancer (life-threatening), Ductal carcinoma in situ of the breast, Heart Attack, Kidney Failure, Liver Failure of Advanced Stage, Loss of Independent Existence, Multiple Sclerosis, Paralysis, Stage 1A malignant melanoma, Stage A (T1a or T1b) prostate cancer, Stroke, Major Organ Failure on Waiting List or Major Organ Transplant.
30. Following a Severe Burns claim, the Member cannot claim for Loss of Independent Existence, Paralysis or Severe Burns.
31. Following a Stroke (cerebrovascular accident) claim, the Member cannot claim for Alzheimer's Disease, Aortic Surgery, Coma, Coronary Angioplasty, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Major Organ Failure on Waiting List, Major Organ Transplant, Stroke or Liver Failure of Advanced Stage.

RESTRICTIONS, EXCLUSIONS AND LIMITATIONS

No benefit is payable for:

1. any Certain or Critical Illness resulting directly or indirectly from any of the following:

a. intentionally self-inflicted injury, voluntary exposure to an illness or attempted suicide while sane or insane;
b. war, whether war be declared or not, or active service in the armed forces of any country, or participation in a riot, insurrection or civil commotion;
c. committing, or attempting to commit a criminal offence;
d. alcohol abuse;
e. the use of any medication, narcotic, intoxicant or any other harmful substance, except when taken as prescribed or recommended by a Physician.

2. any cancer that manifests itself prior to the date of Commencement of insurance when the same cancer either recurs or metastasizes after the date of Commencement of insurance, unless all the requirements in the CANCER RECURRENCE BENEFIT section have been met;

3. any Certain or Critical Illness resulting directly or indirectly from a Pre-existing Condition.

This Pre-existing Condition exclusion applies only to amounts equal to or below the Non-Evidence Maximum of Insurability Schedule.

However, if the Member has been continuously insured for more than 24 months or has submitted evidence of insurability satisfactory to the Insurer for an amount in excess of the amount specified in the Benefit Schedule as the Non-Evidence Maximum of Insurability, this Pre-existing Condition exclusion will not apply to any amount of coverage.

If this Critical Illness Benefit directly replaces a comparable benefit under the Policyholder's previous group insurance policy, a Member who has satisfied a period of time for the pre-existing conditions limitations or exclusions under that previous coverage will be deemed to have satisfied the same period of time for the Pre-existing Condition exclusion under this Benefit.

GEOGRAPHIC LIMITATIONS

If a Certain or Critical Illness is diagnosed outside Canada following an Accident or Illness, the Insurer will only assess the claim once the Member, having returned to Canada, has obtained a medical assessment of the diagnosis made previously.

BENEFIT TERMINATION

This Benefit terminates on the earliest of the following dates:

1. the date the Member attains the Age Limit specified in the Benefit Schedule,
2. the earliest of the dates indicated in the TERMINATION OF MEMBER INSURANCE provision,
3. the date on which the Insurer pays the amount applicable to Loss of Independent Existence under this Benefit.

CONVERSION PRIVILEGE

If a Member loses coverage under this Benefit due to:

1. termination of the Member's employment,
2. cessation of eligibility for insurance under the policy,
3. cessation of a period of Total Disability after which the Member did not return to work for the policyholder, and has not reached Age 65, then the Member may make a written application to the Insurer to convert their coverage within 31 days of cessation or termination. The Insurer will,

without evidence of insurability, issue to the Member an individual critical illness policy of a type offered by the Insurer for such conversions, on the 31st day following the cessation or termination. This privilege does not apply where loss of coverage is due to termination of the policy or benefit.

The amount of insurance that may be converted cannot exceed the Member's Amount of Insurance in effect on the date of cessation or termination or a total aggregate of $200,000 for all Critical Illness coverage conversions with the Insurer.

EXTENSION OF BENEFIT AFTER TERMINATION

The Insurer will pay a benefit if the Member receives the Diagnosis of a Certain or Critical Illness within 31 days of the termination of the Member's insurance. The Amount of Insurance from which the benefit is calculated is that which the Member could have converted under this benefit.

NOTICE AND PROOF OF CLAIM

Before settling any claim under this Benefit, the Insurer will require satisfactory written proof of the existence of a Certain or Critical Illness and of the eligibility for benefits at the time Diagnosis was made. A written initial notice of claim must be submitted to the Insurer within 30 days of the event.

The Insurer reserves the right to verify the Diagnosis with the attending Specialist(s) and to require any Member for whom a claim has been submitted to be examined at the Insurer's expense.


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