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Trustees reserve the right to change premiums and benefits at any time for all insured members, including retirees.

GENERAL INFORMATION

The group insurance plans discussed in these sections and their respective underwriters are:

Plan	Underwriter
Compulsory Life Insurance	Sun Life Assurance Company – Policy #71299.
Basic Life Insurance	Sun Life Assurance Company – Policy #71300.
Dependent Life Insurance	Sun Life Assurance Company – Policy #71300.
Optional Life Insurance	Sun Life Assurance Company – Policy #71300.
Retiree Life Insurance	Sun Life Assurance Company – Policy #71300.
Long Term Disability	Sun Life Assurance Company – Policy #71330.
Compulsory Accidental Death and Dismemberment Insuranc	SSQ Financial Group – Policy #9213871
Basic Accidental Death and Dismemberment Insurance	SSQ Financial Group – Policy #6994843.
Voluntary Accidental Death and Dismemberment Insuranc	SSQ Financial Group – Policy #9200725.
Hospital / Health Insurance	Medavie Blue Cross – Policy #12255.
Retiree Hospital / Health Insurance	Medavie Blue Cross – Policy #12256 and Policy #12656.
Dental Plan	Medavie Blue Cross – Policy #12255.
Critical Illness Plan	Manulife Financial – Policy # G0039089

ELIGIBILITY – PEITF GROUP INSURANCE PLAN

Any P.E.I. Teachers' Federation active member, employees of the P.E.I. Teachers' Federation, Board-based supervisory and non-supervisory personnel who are not affiliated with a union, associate members employed at a Department of National Defense school, or employed at Lennox Island School.

An Insured Person who is on an approved leave of absence may retain his / her insurance for a period of two (2) years (12 months for Long Term Disability). Extensions beyond two (2) years must be approved by The PEITF and The Insurer.

For the purposes of eligibility, "Board-based" shall mean those individuals whose normal place of work is an office of a Regional School Board as opposed to those individuals who are based at a school(s).

NOTE: Board-based non-supervisory personnel who are not affiliated with a union are not eligible for Long Term Disability.

You may obtain coverage for your eligible dependents under the Dependent Life, Health, Dental, Optional Life, Optional Critical Illness and Voluntary Accidental Death and Dismemberment Insurance plans. The plans contain a provision which will allow you to designate a person as your spouse, provided a common-law relationship exists and you have lived in a spousal relationship for at least the last year.

Please refer to the appropriate Plan Description of this booklet for further information in this regard.

NOTE: Whenever used in this booklet, the term "member" shall include employees of the PEITF and Board-based eligible employees.

WHEN CAN I JOIN PLANS FOR WHICH I AM NOT AUTOMATICALLY ENROLLED?

(a) New members who commence work between June 1 and October 31, may apply at any time from the day school opens until November 30.

(b) New members who commence work between November 1 and May 31 may enroll within 31 days of commencing work.

(c) The above time limits do not apply to Optional Plans.

WHEN DOES COVERAGE BECOME EFFECTIVE?

The effective date of coverage is the first of the month following payroll deduction of your premium for all options except Home and Auto and Voluntary Accidental Death and Dismemberment. Coverage for Home and Auto is arranged through Johnson Inc. For the effective date of Voluntary Accidental Death and Dismemberment coverage, see page 20.
Eligible members who do not apply within the initial enrollment period and who later wish to enroll will be required to provide satisfactory evidence of insurability and be approved by the Insurer.

NOTE: The member must be actively at work on the effective date or coverage will not take effect until return to active full-time employment.

TERMINATION FOR RETIREES.

Members who retire effective June 30th in any year will have their coverage continued until September 30th of that year. This clause applies to Life Insurance, Health and Dental Benefits and Accidental Death and Dismemberment coverage. The only exception for this clause is Long Term Disability. The Long Term Disability Benefit terminates on the date that the member retires. The Basic Critical Illness will terminate upon retirement and there are limitations on the amount of Optional Critical Illness coverage one can maintain in retirement. Please see the Critical Illness Plan section on page 54 for more details.

SUMMARY OF BENEFIT COVERAGE

THE COMPULSORY PLAN

All eligible members are insured under this plan. Your employer pays the full cost of this insurance.

TERM LIFE INSURANCE: $50,000

ACCIDENTAL DEATH AND
DISMEMBERMENT INSURANCE: $50,000 (Principal Sum)

AUTOMATIC ENROLLMENT

Effective October 1, 1993, each year new teachers will be enrolled automatically for the benefits outlined below.

You are entitled to decline coverage by completing an "Opting Out Form" within 30 days of becoming eligible for coverage. New teachers opting out and who later wish to enroll will be required to provide satisfactory evidence of insurability and be approved by The Insurer.

NOTE: Fixed Term Teachers with a contract for a full school year are automatically enrolled for the following benefits: Single Basic Life and Accidental Death and Dismemberment insurance, Single Health insurance and Long Term Disability, and Basic Critical Illness summarized below. Members may opt out of these coverages within 30 days of becoming eligible. They are eligible to apply for Dental, family Basic Life, Health, Voluntary AD&D and Optional Life and are asked to contact Johnson Inc. regarding enrolment and/or application. Basic Life is either single (member only) or family (member/spouse/dependent children).

Fixed Term Teachers hired for less than the full school year are automatically enrolled for Compulsory Life/AD&D only. If the contract is for 4 months or more (but less than 1 year), fixed term teachers may apply for all other benefits, except Dental and Long Term Disability.

The PEITF Group Insurance Trustees hope that you will seriously consider the benefits provided by this automatic enrollment.

Premiums are cost-shared 50% / 50% with your employer, with the exception of Long Term Disability and Basic Critical Illness which are 100% member paid.

BASIC LIFE INSURANCE:	$100,000
BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE:	$100,000 (Principal Sum)
DEPENDENT LIFE INSURANCE	
• Spouse:	$10,000
• Each Dependent Child:	$5,000
HOSPITAL / HEALTH INSURANCE	
• Hospital Benefits:	100% of reasonable and customary charges for: - private room accommodation - out-patient hospital services not covered by provincial plan.
• Ambulance Service:	Professional ambulance service to or from nearest hospital able to provide care required.
• Extended Health Benefits:	80% reimbursement of eligible expenses (some benefit maximums apply). Vision Care reimbursement at 80% to a maximum eligible expense of $250 (maximum reimbursement $200) once in every 24 consecutive months for adults and once in any 12 consecutive months for each dependent child less than 18 years of age. Prescription Drugs: - co-payment of 20% of the prescription amount to a maximum of $10 per prescription. Travel Health – Out-of-Province: - 100% of eligible expenses for unseen illness or accidental injury occurring while you are travelling.

BASIC CRITICAL ILLNESS: $10,000

LONG TERM DISABILITY

- Waiting Period: None.
- Elimination Period: Greater of 120 calendar days or accumulated sick leave credits.
- Integration / Offset: Primary Canada Pension Plan benefit, disability pension under the Teachers' Superannuation Act, Workers' Compensation Act, Section 17:02(g) of the Memorandum of Agreement.
- Scheduled Monthly Benefit: 60% of gross income
- Maximum Monthly Benefit: $8,000
- Cost of Living Adjustment: LTD payments will be increased by 1% each January 1st
- Age Limit: To age 60
- Own Occupation Period: 24 months
- Maximum Benefit Period: To age 60, except that if total disability occurs on or after age 59, but before 59½, benefits will be payable for the period of disability subject to a maximum of 12 months.
- Tax Status: Benefits are non-taxable.

OPTIONAL PLANS

You may elect coverage under these plans. You pay the entire cost of any Optional Life, Voluntary Accidental Death and Dismemberment and Optional Critical Illness Insurance you may elect. Evidence of insurability is required for any amounts of Optional Life Insurance and for amounts of Optional Critical Illness over $50,000 and Retirees must apply for Optional Critical Illness amounts over $20,000. The Dental plan premium is cost shared 50% / 50 % with your employer. Quotations and cost comparisons for Home and Auto insurance are provided without obligation.

OPTIONAL LIFE INSURANCE:	You must be enrolled in the Basic Life Insurance Plan. Available in units of $5,000 to a maximum of $100,000 per member. Coverage on your spouse available at 25% of the amount of Optional Life coverage on the member.
VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE:	(a) Available in units of $10,000 to a maximum of $300,000. (b) You may add coverage on your spouse and dependent children. (i) Your Spouse will be insured for 50% of the benefit you elect for yourself if you have dependent children or 60% if you do not. (ii) Each dependent child will be insured for 10% of your benefit if you have a spouse or 20% if you do not.
OPTIONAL CRITICAL ILLNESS	Units of $10,000 up to a maximum of $300,000. Dependent child benefit of $10,000.
DENTAL PLAN:	Basic Dental: Reimbursed at 80% of eligible expenses to maximum payment of $2,000 per person each calendar year. Major Restorative: Reimbursed at 50% of eligible expenses to maximum payment of $1,000 per person each calendar year. Orthodontics: Reimbursed at 50% of eligible expenses to maximum payment of $3,000 per person per lifetime.
AUTOMOBILE INSURANCE / HOME INSURANCE:	Premiums by payroll deduction with no interest or service charge.

LIFE INSURANCE

COMPULSORY LIFE INSURANCE

Compulsory Life Insurance covers your death from any cause and the benefit is payable in a lump sum to your beneficiary or to your estate if no beneficiary is designated.

Coverage terminates at age 70 or earlier retirement.

BASIC LIFE INSURANCE

Basic Life Insurance covers your death from any cause and the benefit is payable in a lump sum to your beneficiary or to your estate if no beneficiary is designated.

For active employees, the Basic Life Coverage will reduce by 50% at age 65 and terminate at age 70.

RETIREE LIFE INSURANCE

For retired members prior to age 65, Basic Life Insurance coverage may remain in force with no reduction until age 65. Insurance will then reduce to $15,000 for retirees who attain age 65 on or after March 5, 1986.

All currently insured retirees who are on reduced benefit amounts prior to July 1, 1985 will have their amounts of insurance then in force frozen at July 1, 1985 with no further reductions.

For retired members prior to age 65, Optional Life coverage may remain in force with no reduction, until attainment of age 65 at which time it ceases.

DEPENDENT LIFE INSURANCE

For the purposes of this plan, a dependent child is unmarried and under 22 years, or under age 25 if a full-time student.

As an active teacher, Insurance for your dependents terminates upon your attainment of age 70 or upon termination of your Basic Life coverage.

As a retired teacher the Dependent Life will terminate at age 65.

OPTIONAL LIFE INSURANCE

Member

All members insured under the Basic Life Insurance plan are eligible to apply for an additional twenty units of Group Life Insurance of $5,000 a unit.

Optional Life Insurance terminates at age 70.

Spouse

Each member enrolled for the Optional Life Insurance on his or her own life is eligible for additional insurance on the life of their spouse. The amount of insurance on the spouse is 25% of the amount of additional coverage on the member.

Benefit Reduction: 50% of the amount of coverage at age 65 up to and including age 69, with further reduction equal to 25% of the pre-65 amount of coverage at age 70. All coverage ceases upon the employee's 70th birthday.

When an individual is insured on a member basis, he/she may also be insured as a spouse where his/her spouse is also a member of the PEITF.

WAIVER OF PREMIUM

Should you become totally disabled prior to age 60, your Life Insurance coverages will remain in force without payment of premiums. Satisfactory proof of total disability must be submitted to the Insurance Company at least once a year.

LONG TERM DISABILITY

Definitions

The following definitions are essential for a complete understanding of your benefits:

Net Income means your gross income less the amount of tax payable on it, based on your province of residence and any personal exemptions claimed in the most recent personal tax credit return on record.

Earnings mean the gross monthly earnings including Administrative Allowance.

Pre-disability Income means gross income if your benefit is taxable and net income if your benefit is non-taxable.

Elimination Period is the initial period of disability which must be completed before benefits are payable. The start date of the elimination period is the later of the first day of total disability or the first day when medical treatment is given for it. If there is no interruption, the elimination period lasts for the greater of 120 calendar days or accumulated sick leave credits.

Interrupted Disability

Interrupted periods of total disability are treated as one single period of disability under certain circumstances.

Interrupted periods of total disability can be accumulated to complete the elimination period, after the initial 30 days of total disability have been fulfilled without interruption, if:

- no interruption lasts longer than 30 days
- each period of disability is due to the same or related causes and lasts for at least 10 working days; and
- the several periods of disability being accumulated occur within 12 months of the start date of the elimination period or as approved by Sun Life in advance, if the elimination period is 365 days or more.

If either the group policy or the salary continuance benefit are terminated, the interrupted disability provision no longer applies. The elimination period must be satisfied with continuous absence from work after the policy, or benefit, termination date.

After the elimination period is completed, interrupted periods of total disability are treated as one single period, if:

- no interruption is longer than 180 days, and
- the disabilities are due to the same related causes.

If either the group policy or the salary continuance benefit are terminated, Sun Life has no liability if the disability reoccurs after an interruption of 180 days or more.

Total Disability Benefit

After the elimination period has been completed, you qualify for a total disability benefit while you continue to satisfy the following definition:

- During the own occupation period of 24 months you are unable, solely because of an accident or sickness, to perform the essential duties of your own occupation AND are not gainfully employed, except as permitted for partial disability or rehabilitation.

- During any subsequent period for which benefits are payable, you are unable, solely because of an accident or sickness, to engage in any occupation for which you are qualified or may become qualified by reason of training, education or experience, AND are not gainfully employed, except as permitted for partial disability or rehabilitation.

Own occupation means the usual and customary occupation which you performed on a regular and continuing basis before becoming disabled. It is determined at the beginning of a period of disability and takes into account professionally recognized specialties. The own occupation period will be 12 months for any disability that begins when insurance is continued:
- because of a severance of employment, or
- under the extended protection provision, if any.

The monthly total disability benefit is described in the Summary of Benefit Coverage.

Total disability benefits are paid until the earliest of the following:
- you are no longer totally disabled;
- you fail to take part in a recommended rehabilitation program;
- the benefit period expires;
- the age limit specified is reached;
- death.

Cost of Living Adjustment

Your Long Term Disability payment will be increased by 1% each January 1st.

Loss of Permit/License

If you need to hold a government license or permit in order to perform your own occupation, and if it is withdrawn for health reasons, then you are automatically treated as disabled under the own occupation definition of total disability. This status is maintained for the first 12 months after the completion of the elimination period. You must not be gainfully employed, unless this is permitted for partial disability or rehabilitation.

Transplant Donors

If you undergo surgery to donate a body part to another person and are disabled, as a result, this condition qualifies as any other sickness that leads to disability.

Partial Disability Benefits after the Elimination Period

This benefit provision allows you, after becoming totally disabled, to engage in your own or any other occupation and still be eligible for benefits.

Partial disability benefits replace the total disability benefit once the elimination period has been completed, and while you are within the own occupation period if you:

- continue to satisfy the criteria of total disability, but return to work on a reduced basis at your own occupation.
- Return to work on a reduced basis means that you are unable to perform one or more of the essential duties of the occupation or are unable to perform these duties for the length of time normally required,
  OR
  return to work at any other occupation.

The partial monthly disability benefit payable is the monthly benefit shown in the Summary of Benefit Coverage determined at the beginning of the disability reduced by:

- any amounts applicable under the plan's integration provision, and
- 50% of any monthly income actually earned so that the total of the partial disability benefit paid, the income from all integration sources and the actual income earned does not exceed 100% of your monthly pre-disability income.

Partial Disability benefits are paid until the earliest of the following:

- you no longer satisfy the conditions required for the partial disability benefit;
- you fail to take part in a recommended rehabilitation program;
- the age limit specified is reached;
- the end of the own occupation period;
- death.

Rehabilitation Benefit

This benefit provision allows you, after becoming totally disabled, to resume work or to be retrained and still be eligible for benefits. Participation in an approved rehabilitation program is permitted during the elimination period although rehabilitation benefits become payable only after the elimination period has been completed.

The rehabilitation program may consist of medical treatment, vocational training or a combination, designed to return you to the workforce.

Rehabilitation benefits are payable only if the program:

- is approved by Sun Life in all respects, including the duration, and
- is carried out while you continue to receive medical treatment for the disability.

Return to a gainful occupation may be approved by Sun Life as part of the rehabilitation program if you:

- return to your own occupation that has been significantly modified to take into account your disability, or
- return to any other occupation during the own occupation period specified in the plan.

The amount payable is the monthly benefit shown in the Summary of Benefit Coverage, determined at the beginning of the disability, reduced by:

- any amount applicable under the plan's integration provision.
- 50% of any income earned from rehabilitation, so that the total of the rehabilitation benefit paid, the income from all integration sources and any income earned from the rehabilitation program does not exceed 100% of your monthly pre-disability income.

Rehabilitation benefits are paid until the earliest of the following;

- you are no longer totally disabled;
- you qualify for other long term disability benefits (total or partial disability);
- the rehabilitation program is completed, or discontinued;
- Sun Life withdraws its approval of the program;
- the age limit is reached;
- death.

Employer Subsidy

If an approved rehabilitation program consists of a gainful occupation, Sun Life will also pay 50% of your monthly income from the occupation for a period of up to three (3) months, by adding the amount directly to your monthly rehabilitation benefit. This subsidy allows your employer to reduce your monthly income by an equal amount.

Rehabilitation Plus

To encourage your efforts to re-enter the workforce, Sun Life will consider requests for payments over and above the rehabilitation benefit payable. The request must be directly related to the program and contribute to its success. Sun Life retains full responsibility for approving any such request and for deciding who is to receive the payments.

Integration of Benefits

Your scheduled monthly benefit is reduced by any of the following sources which apply on the basis of the integration method shown in the Summary of Benefit Coverage:

- Benefits for the same or related disability payable under any government plan to the extent permitted by law, such as the Canada/Quebec Pension Plan (primary only) and Workers Compensation.
- A disability pension under the Teacher's Superannuation Act and benefits from any retirement plan that includes employer contributions.
- Benefits for the same or related disability payable under any other plan underwritten on a group basis.
- Payments of any kind made by an employer during the period of disability including leave with pay as a result of a disability incurred while the insured is performing Board approved duties (Section 17.02 (G)) of the Memorandum of Agreement.

Only benefits which begin on or after the commencement of total disability are taken into account. Automatic cost of living increases to government plans that occur after disability payments by Sun Life have started, are not taken into account.

You must make reasonable efforts to obtain all benefits that might be available in connection with your disability.

LIMITATIONS

Medical Treatment

You must receive appropriate medical treatment beginning with the onset of the condition involved and continuing throughout the elimination period and any subsequent benefit period. This means treatment that involves more than examination or testing. It must be reasonable and customary, performed or prescribed by a physician or whenever considered necessary by Sun Life, a medical specialist, and be carried out as frequently as the condition requires.

If treatment is for substance abuse, you must be satisfactorily participating in a Sun Life approved withdrawal program.

Sun Life is entitled to and will pay reasonable charges for examinations by a physician or physicians of its choice at reasonable intervals while a claim is outstanding.

Continuation of Insurance

If your employment is temporarily interrupted, the plan permits your employer to continue coverage on a premium paying basis. Please contact Johnson Inc. to determine your options in the following circumstances:

Leave of Absence - coverage can be continued for up to 12 months during a leave of absence elected by you for:

(a) further education
(b) employment as a teacher with the Department of National Defense, or
(c) employment as a teacher overseas under the External Aid Program of the Canadian Government.

with your employer's agreement. Prior to beginning the leave, you and your employer must agree to schedule start and finish dates which are mutually acceptable.

Maternity leaves and non-maternity leaves are treated equally, but the following additional guidelines are used for maternity leaves, whenever necessary:

1. A maternity leave is deemed to begin on the date the employer requires you to leave work because, in the opinion of the employer, you are no longer able to perform your job due to pregnancy.

2. If you leave work because of a premature delivery which occurs prior to the start of a scheduled maternity leave, your leave begins on the date of delivery.

3. If you leave work because of pregnancy, but without having scheduled a maternity leave, your leave begins on the date of delivery.

Temporary Lay-Off, Strike, Lock-Out – coverage can be continued until the end of the month following the month in which employment is interrupted.

Severance of Employment – Coverage can be continued until the end of any minimum notice period given by the employer in accordance with federal/provincial requirements.

Accident/Sickness – coverage can be continued while you are unable to work due to accident and sickness.

Paid Vacation, Statutory Holidays – coverage can be continued while you are on a paid vacation or statutory holiday.

Limitation

Coverage cannot be continued for more than 12 months after the date on which you were last actively at work in the circumstances described above, unless the Company gives its prior agreement in writing.

A continuation during accident or sickness is not subject to the limitation unless it occurs before you have returned to active employment following a previous continuation.

Leave of Absence (Maternity and Non-Maternity)

Benefits are not payable during a leave of absence. Benefits are payable up to the scheduled date of commencement for the leave. Subsequent to the leave, benefits are payable for the later of the date on which the elimination period is completed or the scheduled date of return to work.

This limitation does not affect the completion of the elimination period.

Exclusions

No benefits are payable for a disability that results, directly or indirectly from:

- war, insurrection, rebellion, participation in a riot, or an act of civil disobedience
- intentionally self inflicted injury.

What is not covered

No benefits are payable for any period:

- you are absent from Canada longer than 4 months due to any reason, unless Sun Life agrees in writing in advance to pay benefits during the period.

- you are serving a prison sentence or are confined in a similar Institution

No benefits are payable for total disability resulting from:

- participation in a criminal offence.

Claims

To permit prompt assessment, initial notice of claim should be submitted to Sun Life no later than 90 days after your disability starts.

Written proof will be required within 90 days after completion of your elimination period. Obtain a claim form from Johnson Inc. Complete the Employee's Statement and have your doctor complete the Physician's Statement. Return the form to Johnson Inc. who will complete the Employer's Statement and send it to Sun Life for you.

When Sun Life assesses your claim, the amount of your benefit is also established. In some circumstances, this amount may have to be re-established later. However, if you have been underpaid, Sun Life will be responsible for the difference. Similarly, you will be responsible for any overpayment.

If your claim is denied:

- You have one (1) year to request reassessment. The request must be in writing and must include a copy of any additional information you wish to have considered.

- You can wait for at least 60 days after submitting written proof as required (but no more than 1 year), and then start a legal action.

Changes

Changes in coverage normally take place automatically when they are based on changes in salary. However, you must be actively at work to qualify for an increase in coverage.

Terminations

Your coverage under the plan is scheduled to terminate in any of the following events:

- when you are no longer eligible for coverage;
- when you are no longer actively employed;
- when you do not pay your part of the premium, if required;
- when the age limit would prevent you from qualifying for benefits.

Further coverage terminates if the plan is discontinued.

Should your active employment be temporarily interrupted due to vacation, leave of absence, lay-off, strike or lock-out, please consult the Administrator to determine the status of your coverage under the plan.

Guaranteed Benefits

Your right to benefits will not be prejudiced because the plan terminates during your elimination period or while benefits are payable.

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

COMPULSORY ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

All active members are covered under this plan. Coverage terminates at age 70 or earlier retirement.

The terms and conditions of this plan match those of the Basic Accidental Death and Dismemberment Insurance.

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

You are automatically insured under this Plan on the same date that your Basic Life Insurance becomes effective.

Beneficiary

Your Accidental Death benefit will be paid to the beneficiary(ies) designated under your appropriate Group Life Plan. If there is no such beneficiary designation, it will be paid to your estate. All other indemnities payable will payable to you, with the exception of indemnities payable under the following sections: "Repatriation"; "Education"; "Day-Care"; "Workplace Modification and Accommodation"; "Spousal Retraining"; "Family Transportation"; and "Identification".

Benefits

The "Schedule of Losses" is the same as the Voluntary Accidental Death and Dismemberment Plan. In addition, you are insured for the following benefits as outlined in the Voluntary Accidental Death and Dismemberment Plans set out below:

- Repatriation
- Funeral Expense Benefit
- Education
- Day Care
- Rehabilitation
- Workplace Modification and Accommodation Benefit
- Spousal Retraining
- Child Enhancement
- Permanent Total Disability
- Family Transportation
- Identification
- Common Disaster
- Escalation
- Seat Belt
- Home Alteration and Vehicle Modification
- Hospital Indemnity
- Aircraft Coverage
- Exposure and Disappearance

Miscellaneous Clauses

Please refer to the Voluntary Accidental Death and Dismemberment for further information on When Insurance Stops, Waiver of Premium, Cosmetic Disfigurement Benefit, Comatose Benefit, Continuation of Coverage during approved Leaves, Retirement, Extension of Family Coverage, Business Venture Benefit, Home-maker Weekly Indemnity, Conversion privilege, and Exclusions.

NOTE: Dependents are not insured under Compulsory and Basic Accidental Death and Dismemberment Insurance plans, but they may receive benefits.

VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

"It couldn't happen to me"

No one expects to be involved in a serious accident; yet, chances are that you know at least one person who has.

Accidents are the number one killer of Canadians under age 45 and the third leading cause of death overall.

Auto accidents account for almost 50% of these deaths.

If you survive a serious accident, you could be faced with great and immediate financial problems. Loss of limbs, eyesight, speech or hearing can occur.

Paralysis or the loss of use of hands, feet, arms or legs also cause major financial setbacks in a person's life.

"I don't want to think about it"

A common response when faced with the possibility. Unfortunately, no one has control over the fact that an accident may happen. You do, however, have a measure of control over the financial outcome of such an event.

By taking a few minutes to consider this program, you will allow yourself the freedom of knowing that you and your family will be prepared financially should a major accident occur.

"Why should I participate in this program?"

5 good reasons!

1. The PEITF has arranged the opportunity for you and your family to obtain extensive coverage at a very low monthly cost.

2. This group Accidental Death and Dismemberment Plan offers far more extensive coverage at a fraction of the cost of an individual plan.

3. Most other coverages will not pay lump sum benefits if you survive an accident.

4. This is a great, low cost way to supplement your Life Insurance.

5. Most people don't foresee losing their health during their prime years, but will agree that an accident is beyond their control.

Details of the Plan

The rising incidence of accidents plus the increasing travelling habits of our modern society have led to the development of a broad new type of insurance.

The following is an explanation of the voluntary personal accident plan available to you and your family.

Please give it full consideration as it may provide an inexpensive way to supplement your personal financial planning.

You are given the opportunity to purchase additional Accidental Death and Dismemberment insurance at a very low cost through payroll deductions.

Eligibility

All active members under age 64 may enrol in the plan. In addition, coverage may be added for spouses and eligible dependent children.

"Spouse" means an individual:

a) to whom you are legally married,
b) with whom you have continuously cohabited and who has been publicly represented as your spouse for a minimum of one year immediately before a Loss is incurred under the program.

NOTE: Only one individual will qualify as a spouse. If you are legally married but are also cohabiting with an individual as described under (b) above, the spouse will be the individual to whom you are legally married.

Dependent Children are either your legitimate or illegitimate children, adopted children, step-children or children who are in a parent-child relationship with you. The children are dependent upon you for maintenance and support and:

a) under 22 years of age and unmarried, or
b) under 25 years of age and unmarried and in attendance at an institution of higher learning, or

c) by reason of mental or physical infirmity, are incapable of self-sustaining employment and are totally dependent upon the employee for support within the terms of the Income Tax Act.

The Dependent Child will be covered from birth provided such child is born alive.

"Institution of higher learning" includes any university, college, CEGEP or trade school.

Coverage

Any accident resulting in death, dismemberment, paralysis, loss of use of limbs, loss of sight, speech or hearing - anywhere in the world - 24 hours a day - on or off the job.

Enrollment Procedures / Effective Date of Insurance

You may apply for coverage by completing an application card, which can be obtained by contacting Johnson Inc.

If you are presently insured under the plan, you may increase your insurance and/or add the Family Option by completing an application card and returning it to Johnson Inc.

Insurance will be effective on the date of receipt of the signed application card by Johnson Inc. However, if you are absent from active work for any reason other than vacation, coverage will only begin when you return to active work.

How do I increase, decrease, change plan or cancel my insurance?

You may increase or decrease your coverage or change your plan by making application to Johnson Inc.

You may cancel your coverage by advising Johnson Inc. in writing. Coverage will change or cease on the date your notification is received.

Beneficiary

Your accidental death benefit will be paid to the beneficiary(ies) designated on your application or revision card. If there is no such beneficiary designation, the benefit will be paid to your Estate. All other indemnities payable, will be payable to the Insured Person (including those payable for the dependents), with the exception of indemnities payable under the following sections: “Repatriation”; “Education”; “Day-Care”; “Workplace Modification and Accommodation”; “Spousal Retraining”; “Family Transportation”; and “Identification”.

Definitions

Wherever used in this Booklet:

“You” and “Your” means the eligible employee or member who has purchased this insurance.

“Plan” means the appropriate Group Policy (see page 2 of this booklet for policy number), which is on file with The PEITF.

"Injury" means bodily Injury caused by an accident occurring while your coverage is in force under the Plan, and resulting directly and independently of all other causes in Loss covered by the Policy, 24 hours a day, anywhere in the world.

"Principal Sum", when referring to you, means the amount indicated on the Application Card, which you have completed and filed with Johnson Inc.

"Principal Sum", when referring to your insured dependent(s) means the percentages outlined in this section.

"Accident" means any unlooked for mishap or untoward event which is not expected or designed.

"Sickness" means an impairment of normal physiological function and includes illness and infections.

"Disease" means any unhealthy condition of the body or any part thereof.

"Insured Person" means a member or his / her dependent(s) insured under the Plan.

“Insurer” means SSQ Financial Group General Assurance Company.

"Loss of Life" means the death of the Insured Person.

"Loss" as used with reference to hand or foot means complete severance through 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 through or above the elbow or knee joint; as used with reference to thumb means the complete severance of one entire phalanx of the thumb; as used with reference to finger means the complete severance of two entire phalanges of the finger; as used with reference to toes mean the 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.

"Loss" as used with reference to speech means complete and irrecoverable loss of the ability to utter intelligible sounds; as used

with reference to hearing means complete and irrecoverable loss of hearing.

"Loss" as used with reference to loss of use means the total and irrecoverable loss of use, provided the loss is continuous for 12 consecutive months and such loss of use is determined to be permanent at the end of such period.

“Paralysis” means the loss of ability to move all or part of the body.

“Quadriplegia” means the permanent Paralysis and functional loss of use of both upper and lower limbs.

“Paraplegia” means the permanent Paralysis and functional loss of use of both lower limbs.

“Hemiplegia” means the permanent Paralysis and functional loss of use of upper and lower limbs on the same side of the body.

"Hospital" means an institution licensed as a hospital, which is open at all times for the care and treatment of sick and injured persons, has a staff of one or more Physicians available at all times and which continuously provides 24 hour nursing service by graduate registered nurses. It provides organized facilities for diagnostics and surgery, is an active treatment hospital and not primarily a clinic, rest home, nursing home, convalescent hospital or similar establishment. For the purposes of this definition, hospital will include a facility or part of a facility used for rehabilitative care.

"Regular Care and attendance" means observation and treatment to the extent necessary under existing standards of medical practice for the condition causing the confinement.

"Physician" means a doctor of medicine (other than the Insured Person or a Member of the Immediate Family) who is licensed to practice medicine by:

1) a recognized medical licensing organization in the locale where the treatment is rendered, provided he is a member in good standing of such licensing body, or

2) a governmental agency having jurisdiction over such licensing in the locale where the treatment is rendered.

"Immediate Family Member" means a person at least eighteen (18) years of age, who is the son, daughter, father, mother, brother, sister, son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, sister-in-law, (all of the above include natural, adopted or step relationship), spouse, grandson, granddaughter, grandfather or grandmother of the Insured Person.

“Motorized Vehicle” means a passenger car, station wagon, van, jeep-type automobile or truck, ambulance or any type of motorized vehicle used by municipal, provincial or federal police forces.

“Seat Belt” means those belts that form a restraint system and includes infant and child restraint systems when properly used with a Seat Belt, and the restraining belts, which are part of a stretcher, used in the transportation of sick or injured persons by ambulance.

"Accommodation" means lodging in the vicinity of the Hospital where the Insured Person is confined.

The male pronoun will be construed as the feminine when the person is a female.

Schedule of Losses

When Injury results in any of the following losses within 365 days after the date of the Accident, the Insurer will pay:

For Loss of

Life	100%
Entire sight of both eyes	100%
Speech and hearing in both ears	100%
Entire sight of one eye	100%
Entire sight of one eye and one hand	100%
Entire sight of one eye and one foot	100%
Speech	100%
Hearing in both ears	100%
Hearing in one ear	66.66%
All toes of one foot	33.33%

For Loss or Loss of Use of

Both hands	100%
Both feet	100%
One hand and one foot	100%
One arm	100%
One leg	100%
One hand	100%
One foot	100%
Thumb and index finger of same hand	66.66%
Four fingers of one hand	66.66%

For Paralysis of

Both upper & lower limbs (Quadriplegia)	200%
Both lower limbs (Paraplegia)	200%
Upper and lower limbs of one side of the body (Hemiplegia)	200%

Indemnity provided under this section for all Losses sustained by any one insured person as the result of any one accident will not exceed the following:

a) With the exception of quadriplegia, paraplegia and hemiplegia, the Principal Sum.

b) 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 section exceed, in the aggregate, Two Times the Principal Sum as the result of the same accident.

Repatriation* (Basic and Voluntary Programs)

If you or your Insured Dependent(s) sustain accidental Loss of Life not less than 50 kilometers from your or your Insured Dependent(s) normal place of residence and indemnity for such Loss becomes payable under the program, we will pay the reasonable and customary expenses actually incurred for the transportation of the body to the first resting place (including but not limited to a funeral home or the place of interment) in proximity to you or your Insured Dependent(s) normal place of residence. The repatriation benefit up to $20,000 will be paid for expenses incurred for the return home of the body (including charges for the preparation of the body for such transportation).

Funeral Expense Benefit* (Basic and Voluntary Programs)

In the event Accidental Loss of Life is sustained by you or your Insured Dependent(s), the Insurer will pay the following expenses:

- Casket, Professional Funeral Services, plus use of Funeral Home (unit Price);
- Professional Funeral Service;
- Funeral Home facilities and equipment;
- Automotive equipment;
- Casket as selected;
- Outside enclosure;
- Health services Tax;
- Cremation: Urn, Cremation Charges.

Additional expenses or cash advances:
- Transportation;
- Cemetery;
- Guest register;
- Organist;
- Clergy Honorarium;
- Other Funeral Home charges (when the services of a second funeral home are required).

Reimbursement for such charges will not exceed $5,000 for all services with respect to any one deceased, less any charges for preparation of the remains for travel which are reimbursed under the section entitled "Repatriation Benefit".

Education (Basic and Voluntary Programs)**

If you sustain accidental loss of life and indemnity for such loss becomes payable in accordance with the terms of this Program, we will pay the Education Benefit stated below for each of your Dependent Children for education expenses provided the child is:

(1) Already enrolled full-time in an institution of higher learning above the secondary school level as defined in the province, territory or country of residence; or
(2) At a secondary school level but will enrol, as a full-time student in an institution of higher learning program within 365 days of your accidental death.

This benefit is equal to the reasonable and necessary expenses actually incurred for each Dependent Child, subject to a maximum of 5% of your Principal Sum or $5,000, whichever is less, for up to 4 consecutive years.

This benefit will be paid each year immediately upon receipt of satisfactory proof that your child is enrolled as a full-time student in an institution for higher learning, but payment will not be made for expenses incurred prior to your death, nor for room, board or other ordinary living, travelling or clothing expenses.

If your Dependent Child satisfies the above requirements, any benefits payable will be paid to such child.
"Institution for higher learning" includes any university, college, CEGEP or trade school.

Day-Care (Basic and Voluntary Programs)**

If you or your Insured Spouse sustain Accidental Loss of Life and indemnity for such Loss becomes payable in accordance with the terms of this Program, we will pay the Day-Care Benefit stated below for each of the Dependent Children who:

(1) Are enrolled in a Day-Care Centre on the date of such Loss; or
(2) Will enrol in a Day-Care Centre within 365 days after the date of your death.

This benefit is equal to the reasonable and necessary expenses actually incurred, subject to a maximum of 5% of your Principal Sum or $5,000, whichever is less, for each year your Dependent Child is enrolled in a Day-Care Centre, but not to exceed 4 years, which must run consecutively, with respect to any one Dependent Child.

This benefit will be paid each year immediately upon receipt of satisfactory proof that your child is enrolled in a Day-Care Centre, but payment will not be made for expenses incurred prior to your death, nor for room, board or other ordinary living, travelling or clothing expenses.

In the event that your Dependent Child does satisfy the requirements indicated above, the Day-Care Benefit will be payable to your surviving Spouse if your Spouse has custody of the child. If there is no surviving Spouse or your child does not reside

with your Spouse, benefits payable under this provision will then be paid to your child's guardian who has been legally appointed to manage the person of the child.

If none of your Dependent Children satisfy the requirements as shown under either the section entitled “Education Benefit” or this section, we will pay an amount equal to 5% of your Principal Sum or $2,500, whichever is less, under one of the policies issued to your Employer by AXA to your beneficiary.
The following definitions are applicable only to this benefit:

"Day-Care Centre" means a facility which is operated according to law, including laws and regulations applicable to day-care facilities and which provides care and supervision for children in a group setting on a regular basis. Day-Care Centre will neither include a hospital, the child's home, care provided during normal school hours while a child is attending grades 1 through 12.

"Dependent Child" means a natural child, adopted child, stepchild or a child who is in a parent-child relationship with the insured Member. The child is unmarried, under the age of 13 years of age and dependent upon the insured Member for maintenance and support.

Rehabilitation* (Basic and Voluntary Programs)

If you sustain an injury which results in a Loss payable under the section entitled “Specific Loss Accident Indemnity” under this program and such injury requires that you participate in a rehabilitation program in order to be qualified to engage in an occupation in which you would not have engaged except for such injury, the Insurer will pay the reasonable and necessary expenses actually incurred within 3 years from the date of loss to a maximum of $20,000. No payment will be made for room, board or other ordinary living, travelling or clothing expenses.

Workplace Modification and Accommodation Benefit (Basic and Voluntary Programs)

If you sustain a specific loss for which an amount of Principal Sum becomes payable under this program and you require special adaptive equipment and/or workplace modification in order to accommodate your active full-time work with the Employer, this benefit will reimburse the Employer for the actual expenses actually incurred up to $10,000.

Spousal Retraining* (Basic &Voluntary Programs)

If you sustain accidental loss of Life and indemnity for such loss becomes payable in accordance with the terms of this program, we will pay the reasonable and necessary expenses actually incurred, within 3 years from the date of your accidental death, 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 your spouse, would not otherwise have sufficient qualifications, up to a maximum of $20,000 for all such

expenses. No payment will be made for room, board or other ordinary living, travelling or clothing expenses. If your spouse satisfies the requirements stated above, it is presumed that your spouse is the beneficiary.

Child Enhancement (Voluntary Program)

With the exception of Loss of Life, the benefit amounts shown under the Specific Loss Accident Indemnity are doubled with respect to your Insured Dependent Children, subject to a maximum of $240,000. This provision is not applicable if Loss of Life occurs within 90 days after the date of the accident.

Permanent Total Disability (Basic & Voluntary Programs)

The Principal Sum is payable in a lump sum, less any other amounts paid or payable under the Specific Loss Accident Indemnity as a result of the same accident, if you become totally disabled and the following conditions are met:

1) The disability results from an Injury occurring prior to age 70
2) The disability commences within 365 days of the accident.
3) The disability prevents you from engaging in each and every occupation or employment for compensation or profit for which you are reasonably qualified by education, training or experience.
4) The disability has continued for 12 consecutive months, remains total and is deemed to be permanent at the end of such period.

Family Transportation* (Basic and Voluntary Programs)

If any Specific Loss covered under the "Specific Loss Accident Indemnity" confines you or your Insured Dependent(s) as an inpatient in a hospital or if any other Injury confines you or your Insured Dependent(s) to a hospital for at least 4 days and such hospital is located at least 150 kilometres from your or your Insured Dependent(s) residence, this benefit will refund expenses incurred by any Member(s) of the Immediate Family for hotel accommodation and transportation (via the most direct route) to you or your Insured Dependent(s) bedside, to a maximum of $15,000. Private transportation expenses are limited to $0.35 per kilometre travelled. Payment is not made for board or other ordinary living, travelling or clothing expenses.

Identification* (Basic & Voluntary Programs)

If you or an Insured Dependent sustain accidental Loss of Life, and the police require the identification of the body by a Member of the Immediate Family, and indemnity for Loss of Life subsequently becomes payable under the Policy, we will refund expenses incurred by such family member for:

1) Lodging and board (up to a maximum of 3 consecutive nights) while en route and/or during the stay in the city or town where the body is located, and

2) Transportation via the most direct route to this location, provided this location is not less than 150 km from the family member's usual residence.

Private transportation expenses are limited to $0.35 per km travelled and the total maximum refundable for all expenses is limited to $15,000. Payment will not be made for ordinary living, travelling or clothing expenses other than stated above.

Common Disaster (Voluntary Program)

If you and your Insured Spouse both sustain accidental Loss of Life which becomes payable under the program as the result of a "Common Accident", your Spouse's amount of coverage will be increased to the same level as yours to a combined program maximum of $1,000,000.

"Common Accident" means the same accident or separate accidents occurring within the same 24 hour period.

Escalation (Voluntary Program)

In the event you sustain an Injury which results in the benefit being payable under either Specific Loss Accident Indemnity or Permanent Total Disability, the Insurer will pay an Escalation benefit which is equal to 3% of the amount of benefit payable, for each year your insurance remains in force without interruption, subject to a maximum of 15%.

For benefit calculation purposes, the anniversary date (December 10, 1988) of this benefit or your effective date of insurance, whichever occurs last, is used and each subsequent anniversary date thereafter.

If you discontinue your coverage and subsequently re-apply, you are considered as a person becoming insured for the 1st time in the year you re-apply for coverage.

Seat Belt (Basic and Voluntary Programs)**

If you or your Insured dependent(s) is driving or riding in a Vehicle and wearing a properly fastened Seat Belt at the time of the accident, and a Loss becomes payable under the "Specific Loss Schedule" section of the Policy, AXA will pay an additional sum equal to 25% of the applicable amount payable under the "Specific Loss Schedule" section.

The driver of the Vehicle must hold a current and valid driver's license and is not intoxicated nor under the influence of drugs, unless such drugs are taken as prescribed by a Physician, at the time of the accident.

"Intoxicated" and "under the influence of drugs" are as defined by the jurisdiction where the accident occurs.

Home Alteration and/or Vehicle Modification* (Basic and Voluntary Programs)

If you or your Insured Dependent(s) sustain the Loss of or Loss of Use of Both Feet or Legs or becomes Quadriplegic, Paraplegic or Hemiplegic, for which indemnity becomes payable under the Policy, and you or your Insured Dependent(s) subsequently require the use of a wheelchair to be ambulatory, We will refund the reasonable and necessary expenses actually incurred during the 3 year period following the accident, to a maximum of $20,000 per accident;

(a) For the cost of alterations to you or your Insured Dependent(s) principal residence for the purpose of making it accessible and/or;
(b) The cost of modifications to 1 motor vehicle utilized by yourself or your Insured Dependent(s), when such modifications are approved by licensing authorities where required, for the purpose of adapting it to your or your Insured Dependent(s) needs.

The amount payable under this section will be coordinated with any amount paid or payable under any other insurance plan providing the same or similar benefit.

Hospital Indemnity (Basic and Voluntary Programs)**

If any Loss covered under the "Specific Loss Schedule" section of the Policy confines you or your Insured dependent(s) to a Hospital and such person is under the Regular Care and Attendance of a Physician, you or your Insured Dependent(s) will receive a daily benefit of 1/30th of 1% of your Principal Sum from the 1st day of hospitalization, up to a maximum of $2,500 per month and for a maximum duration of 365 days per accident.

Hospitalization required for treatment of any Injury other than for a Specific Loss is also covered in accordance with the above terms, provided such hospitalization begins within 365 days of the date of the accident which caused the Injury and insurance is in force. The daily benefit is payable from the 1st day of hospitalization if the Insured Person is hospitalized for at least 4 days.

Hospitalization is either a single uninterrupted confinement in a Hospital or several successive confinements in a Hospital as a result of the same accident, provided each such confinement is separated by a period of less than 90 consecutive days. All confinements must occur within 730 days of the date of the accident.

Only one hospitalization, as defined above, will be payable for all Injuries sustained by the Insured Person as the result of the same accident.

NOTE: Benefits marked with an asterisk (*) are only payable under one of the policies issued to the Employer by AXA.

Benefits marked with 2 asterisks (**) are payable under all other policies with similar benefits issued to the Employer by AXA subject to the maximum amount stated in the policies.

Aircraft Coverage (Basic and Voluntary Programs)

An Insured Person is covered while riding as a passenger, but not as a pilot, operator or member of the crew, in any aircraft provided the aircraft has a current and valid certificate of airworthiness and is flown by a licensed pilot, except any aircraft that is owned, operated, leased or chartered by or on behalf of the Policyholder. An Insured Person is also covered while flying as a passenger in any military aircraft and when boarding or alighting from or struck by any aircraft.

Exposure and Disappearance (Basic and Voluntary Programs)

If, by reason of an accident covered by this program, an Insured Person is unavoidably exposed to the elements and such exposure results in a covered Loss, such Loss will be covered.

If an Insured person is not found within one year of the disappearance, sinking or wrecking of a conveyance in which they were riding at the time of the accident, it will be presumed they have suffered Loss of Life resulting from bodily Injury caused by an accident.

Waiver of premium (Basic and Voluntary Programs)

Provided you have been approved for Waiver of Premium and remain eligible for such under the terms and conditions of the Policyholder's Compulsory Group Life Insurance Program, or your Basic Group Life Insurance Program, you need not pay any further premiums under the Policy for yourself, your Insured Spouse and/or Insured Dependent Children, while you remain disabled, until the earliest of the following dates:

(1) The Policy terminates;
(2) You reach age 65;
(3) You cease to be totally disabled.

All terms and provisions of the Policy apply during the period premiums are waived, including provisions relating to reductions in amounts of insurance.

Notwithstanding anything contained to the contrary in the Policy, benefits payable for any Loss which occurs while this clause is in effect cannot exceed the amount of insurance payable on the commencement date of your disability.

Cosmetic Disfigurement Benefit (Basic and Voluntary Programs)

When, as a direct result of participating in the Covered Activities as described in the definition of "Injury", you or your Insured Dependent(s) suffer cosmetic disfigurement due to a burn, the Insurer will pay the Cosmetic Disfigurement Benefit, provided that such burn is classified as a 3rd degree burn.

The amount of benefit payable under this section is based on the percentage of the Principal Sum, as shown in the Cosmetic Burn Schedule below, which is determined by the Area Classification Factor times the percentage of body surface actually burned.

The Maximum Allowable Percentage for Body Surface Burned, as shown in the following Cosmetic Burn Schedule, is based on 100% of the specific body part that was burned. The attending Physician will determine the actual percentage applicable to each burn.

If you or your Insured Dependent(s) suffer burns to more than one body part as a result of any one accident, benefits payable for all such burns will not exceed 100% of the Principal Sum.

Cosmetic Burn Schedule

Body Part	Maximum allowable % for body surface burned	Body Part	Maximum % of Principal Sum Payable
Face, neck, Head	9.0	Face, neck, Head	99.9
Hand & Forearm (right)	4.5	Hand & Forearm (right)	22.5
Hand & Forearm (left)	4.5	Hand & Forearm (left)	22.5
Upper Arm (right)	4.5	Upper Arm (right)	13.5
Upper Arm (left)	4.5	Upper Arm (left)	13.5
Torso (front)	18.0	Torso (front)	36.0
Torso (back)	18.0	Torso (back)	36.0
Thigh (right)	9.0	Thigh (right)	9.0
Thigh (left)	9.0	Thigh (left)	9.0
Lower Leg – below knee (right)	9.0	Lower Leg – below knee (right)	27.0
Lower Leg – below knee (left)	9.0	Lower Leg – below knee (left)	27.0

In the event benefits are payable under this section and the sections entitled "Specific Loss Accident Indemnity" or "Permanent Total Disability Indemnity", the total benefits payable will not exceed 100% of the Principal Sum (or 200% for Paralysis).

Comatose Benefit (Basic and Voluntary Programs)

When, as a result of Injury, you or your Insured Dependent(s) become Comatose, SSQ Financial Group will pay the Principal Sum less any other amount paid or payable under the Schedule of Losses, as the result of the same accident, provided:

1. You or your Insured Dependent(s) become Comatose within 365 days after the date of the accident; and
2. You or your Insured Dependent(s) has been Comatose for 60 consecutive days.

“Comatose” means being in a state of total unconsciousness from which the person cannot be aroused. Such person is unresponsive to any external stimuli or internal needs and continuously requires the use of life support systems.

Continuation of Coverage during approved Leaves (Basic Program)

If, under your Compulsory Group Life Insurance Program, or your Basic Group Life Insurance Program, your life insurance is continued during a strike or any approved leave of absence, temporary lay-off, maternity leave, or disability leave, coverage under this program will also be continued, provided payment of premium is continued.

All terms and provisions of the Policy apply during the period of the leave, including provisions relating to reductions in amounts of insurance.

Notwithstanding anything contained to the contrary in the Policy, benefits payable for any Loss which occurs while this clause is in effect cannot exceed the amount of insurance payable on the commencement date of your leave.

Continuation of Coverage during approved Leaves (Voluntary Program)

Subject to payment of premium, coverage will be continued for 31 days with respect to strike or for a period of up to 12 months during any approved leave of absence, temporary lay-off or maternity leave. For disability leave, coverage provided under this section will terminate when you reach age 65, qualify for a Waiver of Premium clause or when you return to work, whichever is earliest.

All terms and provisions of the Policy apply during the period of the leave, including provisions relating to reductions in amounts of insurance.

Notwithstanding anything contained to the contrary in the Policy, benefits payable for any Loss which occurs while this clause is in

effect cannot exceed the amount of insurance payable on the commencement date of your leave.

Extension of Family Coverage (Voluntary Program)

In the event of your death from any cause, the coverage will be continued for your insured Spouse and your insured Dependent Children for a period of 6 months without payment of premiums.

All terms and provisions of the program will apply during the period coverage is continued, including provisions relating to reductions in amounts of insurance.

Business Venture Benefit (Voluntary Program)
You will qualify for coverage under this section if you sustain an Injury which results in a Loss payable under the section entitled "Specific Loss Accident Indemnity ".

The Business Venture Benefit covers the Initial Costs applicable to the development of a new independent business enterprise in Canada.

The Initial Costs must be incurred by you within the 2nd year following the date Total Disability begins, and are subject to the lesser of a maximum of 20% of your Principal Sum or $ 50,000.

The Initial Costs will not include more than your equitable share of the expenses of facilities if you operate your business in a partnership, or in accordance with an agreement hereunder any facilities for such operation or practice are shared by more than one person.

To qualify for benefits under this section, you must:
(1) Be unable to perform your Own Occupation as a result of Total Disability beginning within 365 days following the date of Injury;
(2) Remain totally disabled for a continuous period of 1 year;
(3) Provide due proof of disability to the Insurer within said 1 year period; and
(4) Submit to the Insurer a Business Plan at the end of said 1 year period.

"Initial Costs" includes land, buildings, fixtures; machinery, supplies, vehicles, pre-opening expenses, but excludes Daily Operating Costs.

"Daily Operating Costs" means expenses incurred in the operation of your business for rent, electricity, heat, water, laundry, depreciation, your salaries and other fixed expenses arising out of the conduct and operation of such business.

"Total Disability" means the inability of yourself due to Injury, to perform each and every duty of your Own Occupation.

"Own Occupation" means each and every occupation or employment you are engaged in prior to the date of Injury.

"Business Plan" means a report which includes cash flow forecasts, a statement of personal assets and liabilities and market research results.

Home-maker Weekly Indemnity (Voluntary Program)

When an Insured Spouse who is neither gainfully employed nor receiving employment insurance benefits sustains an Injury and, as a result of such Injury and commencing within 30 days from the date of the Accident, becomes totally and continuously disabled and is prevented from performing any and all of his regular household and/or child-caring duties, SSQ Financial Group will pay $150 dollars, provided that the disability has continued for a period of 7 consecutive days, for the period the Insured Person is so disabled, including the 7 day period, while under the Regular Care and Attendance of a Physician, subject to a maximum period payable of 26 weeks or to age 70, whichever first occurs.

Conversion privilege

If, with the exception of policy termination, your insurance is terminated due to

(1) Termination of employment,
(2) Cessation of eligibility for insurance under the Policy, or
(3) Cessation of total disability after which You did not return to work for the Policyholder, and the Policy is still in effect, you may convert your own insurance (but not your Spouse's and/or Dependent Children's), without evidence of insurability, into an individual accident policy.

You must apply prior to attainment of age 70 and within 60 days of the termination of your insurance.

The benefits provided are a Specific Loss schedule available from SSQ Financial Group at the date of conversion. The amount of insurance that may be converted cannot exceed the lesser of the amount then in effect on the date of termination or $300,000. The premium is calculated at SSQ Financial Group' manual premium rates in force at the date of conversion.

Premiums are payable annually in advance. The individual accident policy takes effect at the latest 60 days after the termination of coverage under the Policy and is issued on an annually renewable basis.

If you sustain Loss of Life resulting from Injury within the 60 day period during which conversion is available, SSQ Financial Group pays your beneficiary a death benefit equal to the maximum you were entitled to apply for under this provision.

When does Insurance coverage stop?

Your insurance coverage will stop on the earliest of the following dates:

- on the date the policy is terminated;
- on the premium due date if premium is not paid, except as the result of an inadvertent error;
- at the end of the month in which you give notice of cancellation;
- at the end of the month in which you reach age 70;
- at the end of the month in which you cease to be an eligible member or employee, except as provided under Continuation of Coverage and Waiver of Premium.

The insurance coverage of your dependent(s), if any, will stop on the earlier of:

- the date your insurance coverage stops;
- at the end of the month in which your dependent(s) cease to be eligible.

If your insurance and/or the insurance of your dependent(s) should stop, you can still file a claim under the Plan for Losses arising from an accident, which occurred prior to the termination date.

Continuation of Coverage

Provided you continue to pay premiums and your coverage is continued under your Basic Group Life insurance plan, coverage under this Plan may be continued for you and your insured dependent(s) for any approved leave of absence. Coverage will terminate at the end of the month in which your Basic Group Life Insurance terminates.

No increase in coverage is allowed after you cease work.

Retirement (Basic Program)

If you retire prior to age 65 you may remain insured under this policy, subject to payment of premiums at regular premium rate, until the end of the month coincident with or next following the date you reach your 65th birthday.

The amount of Principal Sum applicable after retirement shall be an amount equal to the amount under your Basic Group Life Insurance Program.

Retirement (Voluntary Program)

If you retire prior to age 65, you may choose to remain insured under the Voluntary Plan, by payment of premiums at regular premium rate, until the end of the month in which you reach age 65.

Subject to payment of premiums, coverage may be continued after
you reach your 65th birthday, subject to the following:

1) Your Principal Sum will be limited to a maximum of $100,000;

2) Paralysis benefits will not exceed 100% of the Principal Sum; and

3) Your coverage will terminate when you reach your 75th birthday.

Note: Your insurance cannot be increased after the date you retire, and indemnity is not payable for Permanent Total Disability on or after that date.

Exclusions (Basic and Voluntary Programs)

The program does not cover any Loss, fatal or non-fatal, caused or contributed to by:

(1) Suicide or intentionally self-inflicted Injury;
(2) War, whether declared or not;
(3) Participation in a riot, insurrection, civil commotion or disturbance;
(4) Active full-time, part-time or temporary service in the armed forces of any country;
(5) Riding as a passenger or otherwise in any vehicle or device for aerial navigation, other than as provided in the section entitled "Aircraft Coverage";
(6) Medical treatment or surgery, except if the medical treatment or surgery was needed because of an Accident.

Critical Illness benefit (Basic and Compulsory only)

In the event you are diagnosed with a heart attack, stroke, life threatening cancer, or undergo coronary bypass surgery, a lump sum payment of $2,000 may be available under specific and limited conditions.

Definitions

“Heart Attack” means the Diagnosis of the death of a portion of the heart muscles, resulting from the blockage of one or more coronary arteries due to atherosclerotic heart disease. The Diagnosis must be based on all of the following criteria occurring at the same time: a) new episode of typical chest pain or equivalent symptoms, b) new electro-cardiographic (ECG) changes indicative of an acute myocardial infarction and c) biochemical evidence of myocardial necrosis (heart muscle death) including elevated cardiac enzymes and/or troponin. Lesser acute coronary syndromes including unstable angina and acute coronary insufficiency are specifically excluded.

“Coronary Artery Bypass Surgery” means the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts. The surgery must be recommended by a cardiologist licensed and practicing in Canada.

Non-surgical techniques NOT covered by this definition include:

- Balloon angioplasty;
- Laser embolectomy; or
- Other non-bypass techniques.

"Stroke" means the unequivocal Diagnosis by a neurologist of the death of brain tissue caused by thrombosis, embolism or hemorrhage. The Diagnosis must be based on all of the following: a) sudden onset of new neurological symptoms, b) new objective neurological deficits on clinical examinations persisting continuously for at least thirty (30) days following the Diagnosis of the stroke and c) new findings on CT scan or MRI, if done, consistent with the clinical diagnosis. This definition specifically excludes Transient Ischemic Attacks (TIA's).

"Life Threatening Cancer" means the Diagnosis of a malignancy, which is characterized by the uncontrolled growth of cancer cells with invasion of tissue. The following conditions are excluded under this definition:

- Early prostate cancer, Diagnosed as T1A N0 M0 and T1B N0 M0 or equivalent staging;
- Non-invasive cancer (in situ);
- Pre-malignant lesions, benign tumours or polyps;
- Any skin cancer other than invasive malignant melanoma greater than 0.75 mm.
- Any tumour in the presence of any Human Immunodeficiency Virus (HIV).

There shall be no coverage under this definition if within ninety (90) days following the effective date of coverage: a) a Diagnosis of Cancer is made or b) any symptoms or medical problems commenced and initiated investigations leading to the subsequent Diagnosis of any cancer.

"Principal Sum": $2,000

"Diagnosis" means the certified diagnosis of a Critical Illness by a medical practitioner or specialist who is licensed and practicing medicine in Canada, other than yourself, your business associate or your relative.

"Survival Period" means thirty (30) days following the date of Diagnosis of the Coronary Artery Bypass Surgery.

"Pre-existing condition" means: a) the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within a twenty-four (24) month period preceding the effective date of coverage, or b) an illness or condition for which you, during twenty-four (24) months prior to the effective date of coverage incurred medical expenses, received medical treatment, took prescribed drugs or medicine or consulted a physician.

Conditions for Payment

When you are Diagnosed with a Critical Illness while the policy is in force in the case your Critical Illness is the basis of claim, the

Insurer shall pay the Principal Sum subject that you survive the Survival Period.

Exclusions
The $2,000 benefit will not be paid if a Critical Illness results directly or indirectly from any one or more of the following causes:

1. Within ninety (90) days following the effective date of coverage a) Diagnosis of Cancer is made, or b) any symptoms or medical problems commenced and initiated investigations leading to the subsequent Diagnosis of Cancer.
2. Any Cancer that manifests itself prior to the effective date of insurance coverage when the same Cancer either recurs or metastasizes after such effective date unless all the requirements in the "Cancer Recurrence Benefit" section have been met.
3. An intentionally self-inflicted injury or sickness, whether you are sane or insane.
4. The use of illicit drugs other than as prescribed and administered by or in accordance with the instruction of a legally licensed medical practitioner.
5. From a Pre-existing Condition except if such Critical Illness is diagnosed twenty-four (24) months after the effective date of coverage.

Terminations
Your insurance coverage will stop on the earliest of the following dates:

- on the date this policy is terminated;
- on the date you reach 65 years of age;
- on the date you cease to be an active Member of the Policyholder on account of resignation, dismissal or retirement;
- on the date the Principal Sum payment has been paid.

Claims Procedure

You or your beneficiary must notify Johnson Inc.

In the case of claim, written notice of Injury must be given to SSQ Financial Group within 30 days after the date of the accident and written proof of loss must be furnished to them within 90 days after the date of such Loss. Forms on which to make a claim may be obtained from Johnson Inc., 111 Kent Street, Charlottetown, PEI, C1A 1N3.

Failure to furnish such notice or proof within such time shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to furnish such notice or proof and that such notice or proof was furnished as soon as was reasonably possible,
but in no event later than one year after the date of the accident.

HOSPITAL / HEALTH INSURANCE

GENERAL INFORMATION

Eligible dependents include:

1. Your legal spouse.

2. The person publicly acknowledged by you as your spouse who has cohabited with you continuously for a period of at least 12 months.

3. A stepchild, legally adopted child, or natural child of yourself or your spouse, (excluding a foster child) who is under 21 years of age and not employed on a full-time basis.

4. Unmarried children under 25 years of age while attending college, university, or other accredited educational institution as full-time students, provided there is no mandatory student program in effect or available offering the same or similar coverage.

5. A child 21 years of age or older who by reason of mental or physical disability is incapable of self-sustaining employment and is totally dependent upon you for support and provided such child was covered under this policy prior to age 21.

NOTE: At no time will coverage be provided for more than one spouse under the same policy.

Employees not actively at work or dependents (other than new-borns) in hospital at the time of enrollment are not entitled to coverage. Coverage will commence when an employee is actively at work, or in the case of a hospitalized dependent, when discharged from hospital.

NOTE: For continuation of Health and Dental coverage, student dependents age 21 or over must be registered with Medavie Blue Cross each September. It is the responsibility of the member to notify Johnson Inc.

HOSPITAL BENEFITS

This benefit is designed to supplement your Government Hospital Insurance Plan, which provides coverage at the standard ward level only. The following services are covered at 100% under your Medavie Blue Cross plan.

Private / Semi-Private Accommodation – charges for the difference between the normal charges for public ward accommodation in the hospital and the normal charges for private / semi-private accommodation actually occupied in that hospital when the participant becomes confined in that hospital on the

advice of a physician and such confinement is medically necessary.

The Following Are Not Covered:

- Charges for hospital accommodation incurred during any time the participant is not under the active treatment and care of a physician.

- Charges for chronic, convalescent, respite or custodial care, regardless of whether such care is provided in a chronic care bed or active treatment bed of a hospital.

- Charges for services provided in a nursing or convalescent home or special institution for the treatment of alcoholism or drug addiction.

- Charges for any period beyond the date which the participant can be medically discharged from the hospital as determined by the attending physician.

Out-Patient Hospital Services – the plan pays for any out-patient services not covered by your Government plan.

Licensed Nursing Home – charges for room and board up to $20 (maximum reimbursement $16) per day. This benefit is applicable to active teachers only.

Professional Ambulance Service – charges for licensed professional ground ambulance transportation to or from the nearest hospital able to provide the care required when, due to the medical condition of the participant, no other form of transportation can be utilized. Charges for transportation to and from scheduled appointments are not covered.

EXTENDED HEALTH BENEFITS

This benefit provides comprehensive protection against the cost of health services and supplies not covered by government programs. The plan reimburses you for the following covered expenses, when ordered by the attending physician. Part I benefits, covered at **80%**, are provided for expenses incurred either in or outside the province of residence. Part II benefits, covered at **100%**, are provided for expenses incurred outside the province of residence.

PART I

Nursing Services - Charges not exceeding $6,000 (maximum reimbursement $4,800) in a calendar year for the services of a Registered Nurse, Certified Nursing Assistant, or a Victorian Order Nurse who is not a resident of the participant's home or related to the participant's family, for medically necessary care

provided in the participant's home. Services must constitute the practice of nursing as determined by Medavie Blue Cross and must be pre-approved, with such approval being subject to periodic reassessment. Custodial, personal or respite care, or other services that can be performed by a person of lesser qualifications are not covered.

Medical Equipment - Charges not exceeding $15,000 (maximum reimbursement $12,000) per lifetime, for rental of a standard manual wheelchair (non-powered), standard hospital bed, medication compressor or other durable medical equipment required for therapeutic use. Charges must be pre-approved by Johnson Inc., with such approval being subject to periodic reassessment. The purchase of equipment is an option of Johnson Inc. Before considering the purchase of any medical equipment, Medavie Blue Cross must receive a physician's referral and two independent price quotations for the medical equipment. Charges for maintenance of any medical equipment are not covered.

Medical Prosthesis

- Charges for the purchase, repair, adjustment, or maintenance of prosthetic limbs (excluding myoelectric prostheses) and prosthetic eyes.

- Charges for 1 breast prosthesis, except in the event of a bilateral mastectomy, in any period of 24 consecutive months.

- Charges for 2 surgical brassieres in any period of 12 consecutive months.

- Charges not exceeding $600 (maximum reimbursement $120) in any period of 12 consecutive months for wig prostheses when required as a result of alopecia totallis or loss of hair resulting from chemotherapy or radiation therapy.

- Charges for repair, adjustment or maintenance are included up to $50 (maximum reimbursement $40) in any period of 12 consecutive months.

- Replacements are covered only in the event of pathological change.

Medical Supplies – Charges for:

- ostomy appliances, irrigating sets and pouches, but not including deodorants, pads, adhesives, skin creams or other supplies.

- urinary collection and retention systems including catheter tubes and pouches but not including other supplies.

- diabetic supplies including needles, syringes and testing materials.

- continuous glucose monitoring supplies (sensor) to a maximum of $2,280 per calendar year.

- continuous glucose monitoring transmitter to a maximum of $200 per calendar year.

- special garments for treatment of burns.

- elastic stockings.

- enuresis detection devices.

- intra-uterine contraceptive devices limited to one in any period of 12 consecutive months.

- an insulin pump to a maximum of $5,600 once every five consecutive calendar years when prescribed by a licensed physician.

- the rental of a compression pump to a maximum of $3000 once every five calendar years. If, due to extended illness or disability, it is felt that the need for these items will be long term, the purchase of this item may be approved. Compression sleeves to be used in conjunction with the compression pump are limited to two per consecutive calendar year.

- the purchase of oxygen and rental of equipment required for its administration. Equipment may be purchased at the option of Medavie Blue Cross.

Supports - Charges for cervical collars, splints, trusses and traction devices. Charges for custom fitted braces of rigid construction. Such purchase must be pre-approved by Johnson Inc.

Orthotics - Charges for custom molded foot supports (orthotics) as prescribed by the attending physician up to $200 (maximum reimbursement $160) in any period of 12 consecutive months. Orthotics must be fitted by and purchased from an orthopaedic foot care provider approved by Medavie Blue Cross. Charges for off-the-shelf retail items are not covered.

Orthopaedic shoes and modification - Charges for orthopaedic shoes one (1) pair in any period of 12 consecutive months. Orthopaedic shoes must be custom fitted and designed to accommodate, relieve or remedy mechanical foot defects or abnormalities, and must be fitted by and purchased from an orthopaedic shoe provider approved by Medavie Blue Cross. Charges for orthopaedic shoes and permanent modifications to orthopaedic or regular shoes including sole build-ups, lifts, wedges, steel plates, caliper plates, stirrups to accommodate braces, and self-adhesive closures when prescribed by a

physician, up to $100 (maximum reimbursement $80) in any period of 12 consecutive months. Shoes purchased only to accommodate orthotics, or comfortable walking shoes such as Nike, Berkenstock, Brooks, Rockport, etc., are not covered.

Emergency Transportation - Charges for emergency transportation by air, rail or water from an area not serviced by regular licensed professional ground ambulance to the nearest hospital or medical facility able to provide the required care when the urgency of the situation requires that only such form of transportation will be adequate. Includes the cost of return transportation for a Registered Nurse when it is medically necessary for a Registered Nurse to accompany the participant. Charges up to $500 (maximum reimbursement $400) per participant for any one emergency illness or accident shall be considered covered expenses.

Dental Services, Accidental Injury - Charges for the services of a dentist or dental specialist for the repair or replacement of natural vital teeth required as a result of an accidental injury caused by an external blow or force. Charges will be limited to the general practice level of the current edition of the Dental Association Fee Schedule of the province of residence. An accident report must be submitted before claims will be considered for payment. Services must be completed within 12 months of the date of accident.

When a planned course of treatment is expected to be in excess of $500 (other than on an immediate emergency basis), Johnson Inc. must receive an estimate of the proposed treatment and charges, and dental x-rays where applicable. Johnson Inc. will confirm the amount approved and whether or not payment will be limited.

Charges for Bite Planes up to a lifetime maximum of $50 (maximum reimbursement $40).

Private Practice Paramedical Services - Charges for active treatment provided by private practice paramedical practitioners who are duly licensed, certified or registered to practice, up to $70 per treatment (maximum reimbursement $56) and a maximum of 20 treatments per 12 consecutive month period by any one type of practitioner.

Paramedical practitioners shall be limited to speech therapists, occupational therapists, chiropractors, osteopaths, massage therapists, homeopaths / naturopaths, acupuncturists, chiropodists, podiatrists and counselling therapists.

For counselling therapist claims, the recognized governing and licensing body is the College of Counselling Therapists PEI.

Charges for active treatment provided by private practice psychologists who are duly licensed, certified or registered to practice, and counselling services provided by social workers with a master's degree up to a maximum of $125 per treatment

(maximum reimbursement $100) and a maximum of 20 treatments per 12 consecutive month period.

Charges for counselling services provided by individuals with a Masters Degree in Social Work up to a maximum of $125 per treatment (maximum reimbursement $100) and a maximum of 20 treatments per 12 consecutive month period.

Physiotherapy - Charges for active treatment provided by private practice physiotherapists who are duly licensed, certified or registered to practice. The maximum Eligible Expense is $70 (maximum reimbursement $56) per visit.

Hearing and Speech Aids - Charges for hearing aids for each ear not exceeding $1200 (maximum reimbursement $960) in any period of 5 consecutive years when purchased from an otolaryngologist or clinical audiologist. Charges for hearing tests, maintenance, batteries or ear molds are not covered.

Charges for a Phonic Ear Auditory System when required by a child for language development or classroom use to a maximum of $1,000 (maximum reimbursement $800) per lifetime.

Charges for speech aid equipment for a participant who does not have oral communication ability to a maximum of $1,000 (maximum reimbursement $800) per lifetime.

Pharmacogenetic testing – Charges for the analysis of a Participant's genetic makeup to determine how they will respond or metabolize certain prescribed drugs. The analysis must be provided by a laboratory approved by Medavie Blue Cross. The maximum will be limited to $500 (maximum reimbursement $400) per lifetime.

Diagnostic X-ray or Laboratory Tests - Charges for x-ray or laboratory tests carried out by a hospital, government or other laboratory qualified to render such services except when an in-patient of a hospital.

X-ray Therapy - Charges for x-ray therapy, radium and radioactive isotope.

Vision Care Services - Charges for one eye refraction per benefit period by a licensed optometrist or ophthalmologist up to the reasonable and customary amount as determined by Medavie Blue Cross.

An eye refraction for adults will be eligible for reimbursement every 12 consecutive months if medically necessary. A statement from the licensed optometrist or ophthalmologist will be required.

Charges for corrective eyeglasses, including lenses, frames, contact lenses but excluding safety glasses or glasses/contacts for cosmetic purposes up to $250 (maximum reimbursement $200).

Charges for contact lenses and professional fitting services up to $200 (maximum reimbursement $160) for non-elective, medically necessary conditions. There are several conditions which facilitate payment ***in lieu of*** frames and prescription lenses, or prescription contact lenses. The list of conditions is available upon request.

Charges for laser eye surgery up to $1,500 (maximum reimbursement of $1,200) per person per lifetime.

Vision Training and Remedial Eye Exercises limited to $150 per lifetime (maximum reimbursement $120) when performed by a licensed optometrist or ophthalmologist.

The benefit period for vision care services is a period of 24 consecutive months for adults and 12 consecutive months for persons under the age of 18.

Your Vision Care Benefit Does Not Cover:

- Refractions required by an employer, government body or other third party;
- Safety glasses or goggles;
- Replacement of lost, stolen or broken lenses or frames;
- Duplicate or spare eyeglasses;
- Intra-ocular lens implants;
- Non-prescription sunglasses.

TRAVEL HEALTH BENEFITS - OUT OF PROVINCE / OUT OF COUNTRY

PART II

Eligibility
Coverage for Travel Health Benefits is available to you and your eligible dependents.

Pre-Existing Condition
"Pre-existing condition" means any medical condition including illness, sickness, injury or symptoms, that required consultation, diagnosis, treatment and/or investigation in the 90 day period prior to departure from the province of residence, or for which a new medication was prescribed or a change was made in the dosage of a medication in the 90 days prior to departure from the province of residence.

Medavie Blue Cross will pay for the following services when they are:

- medically necessary;
- incurred on an urgent basis as a result of unforeseen illness or accidental injury occurring while you are travelling outside your province of residence or outside Canada;
- not covered or eligible for coverage by any government plan or program;
- non-elective services or services obtained on a referral basis.

Benefits are subject to all limitations, exclusions and maximum benefit limits.

Hospital In-Patient - Charges for in-patient care in a public general hospital up to the private room rate in excess of allowances provided under government medical insurance at the usual and customary fee of the hospital.

Hospital Out-Patient - Charges for out-patient care in a public general hospital in excess of allowances provided under government medical insurance at the usual and customary fee of the hospital.

Physicians' Services - Charges for the services of a Physician in excess of allowances provided under government medical insurance at the usual and customary fee for the area where the service is rendered.

Nursing Service - Charges for services of a Registered Nurse for private duty nursing care provided in a hospital or a temporary residence, when medically necessary and ordered by the attending physician. Coverage is not included for nursing service provided by a relative of the participant.

Diagnostic Services - Charges for diagnostic services including laboratory tests and/or x-rays in a private laboratory or diagnostic clinic when ordered by a physician in excess of allowances provided under government medical insurance.

Transportation Expenses

The Transportation Expense Benefit covers only expenses in excess of the level of expense a person would normally have incurred had no injury or illness occurred.

Charges for economy air transport from the place where emergency illness or injury occurred to the home city in Canada on a scheduled commercial air carrier including:

- Fare for transportation by stretcher including, when medically necessary, the return fare and approved professional charge of an accompanying Registered Nurse or other qualified medical attendant who is not a relative of the participant, when ordered by the attending physician.

- Charges in excess of booked fare or prearranged charter fare that are incurred as a result of a change in the planned schedule, including additional fare of an eligible participant covered under this plan who was travelling with the sick or injured participant.

- Return fare for transporting a member of the immediate family (spouse, parent, child) to attend at the side of a participant who was travelling unaccompanied by an adult family member, following critical injury or illness necessitating in-patient hospitalization. Attendance and return must occur within 10 days of discharge from hospital.

- Licensed air ambulance transportation to the participant's home departure point, when such transportation is medically necessary and is approved in advance and arranged by Medavie Blue Cross.

Boarding and Lodging - Charges for board and lodging or similar expenses up to a maximum of $700 for costs incurred by a participant or by a travelling companion remaining with the participant, when related to a period of in-patient hospitalization of the participant. Includes expenses incurred for a period of up to 10 days following insured hospitalization. Original itemized receipts must be provided for all expenses incurred.

Return of Vehicle Expense - Charges up to a maximum of $1,000 for the return of a private or rental vehicle by a commercial agency to the participant's place of residence or rental agency when a participant, during travel by automobile or other motorized vehicle, becomes totally disabled and is unable to drive the vehicle.

Repatriation Expense - Charges up to a maximum of $3,000 for transportation to return a deceased participant to the home community in Canada.

Your Travel Health Benefit Does Not Cover:

- Services, supplies and equipment related to all pre-existing conditions;

- Non-emergency services to monitor, stabilize or continue treatment of any existing medical condition;

- Services, supplies or equipment received by a participant who travelled outside the home province for the purpose of obtaining hospital treatment, medical treatment or advice;

- Services, supplies or equipment that were obtained outside the province of residence at a participant's election, including surgery or other treatment known to be required, that could be deferred until return to Canada;

- Cardiac surgery, angioplasty or other cardiac procedures, unless approved by Medavie Blue Cross prior to being performed, except when such procedures are performed immediately following admission to hospital, on an emergency basis, to preserve life, when a delay in treatment would threaten life;

- Surgery for removal of cataracts;

- Services, supplies or equipment provided to a participant in relation to pregnancy, other than services related to a naturally occurring miscarriage or to a premature delivery occurring before two months of the expected date of birth;

- Services, supplies or equipment related to any malignant medical condition originally diagnosed or treated prior to departure from the usual province of residence, or the progression of such condition, are excluded, except that the initial diagnostic services and transportation expenses related to such condition will be covered if approved in advance by Medavie Blue Cross and the medical condition has been stable for 12 months prior to departure.

- Expenses in excess of $2 million Canadian per covered Participant, per incidence outside the province of residence.

Travel Health Benefits are available on the assumption that a participant is entitled to all benefits provided under government insurance plans for out-of-province services. Benefits are supplemental to government insurance and will not duplicate or substitute benefits available under government insurance plans. Medavie Blue Cross will not pay any Travel Health benefits unless the participant is covered by a government insurance plan for out-of-province services.

In the event that services are necessary, or to establish a claim, the participant must call the assistance provider named on the reverse of the subscriber's identification card**.** As a condition of coverage under this plan, notification of any hospitalization must be made within 24 hours for verification of eligibility and coverage.

If following diagnosis or a period of treatment, it is determined, through appropriate medical evaluation, which a participant is able to return to Canada for such treatment, Medavie Blue Cross has the right to have the participant returned to Canada. If such determination is made and the participant or family member is duly informed and elects to obtain treatment outside Canada, the charges for such treatment will not be covered.

PRESCRIPTION DRUG BENEFIT

Medavie Blue Cross's drug plan covers the cost of prescription drugs including oral contraceptives and eligible "Over-the-Counter" drugs.

Medavie Blue Cross's drug plan features a mandatory generic drug substitution. Where an approved therapy exists, the pharmacist will provide the lowest cost version of the drug prescribed unless the physician indicates "no substitution" on the patient's prescription.

Convenient Service Card Feature

When you are enrolled under the plan, you are issued a subscriber identification card. It will entitle you and your eligible dependents to obtain prescription drugs, subject to a co-payment of **20% to a maximum of $10.00** towards the cost of each prescription. Present your card to your pharmacist who will submit the claim to Medavie Blue Cross. Payment for insured benefits will be forwarded directly from Medavie Blue Cross to the pharmacy.

After your pharmacist deducts the amount of Medavie Blue Cross's payment, you will be advised of any amount payable by yourself which may include a deductible, co-payment, or any other amount not covered by your drug benefit.

Vaccines, sera and injectables are subject to a maximum of $500 per person per calendar year.

Emergency kits for treatment of anaphylactic shock and Epi-pens are limited to a combined frequency of six kits in a calendar year.

Weight loss treatments are subject to a maximum of $1,600 per calendar year.

Sexual dysfunction drugs are subject to a maximum of $500 per person per calendar year.

The Prescription Drug Benefit Does Not Cover:

- Proprietary and patent medicines and other preparations routinely purchased without prescription;
- Any drug that is not dispensed in compliance with federal or provincial legislation governing the prescribing and dispensing of drugs;
- Biologicals and immunological products including allergy serums compounded in a lab and not bearing a Drug Identification Number (DIN);
- Experimental drugs, research drugs, or drugs available through the Emergency Drug Release Program;
- Smoking cessation products;

- Drugs administered or dispensed by a hospital or Specialized Care facility for use as an in-patient or out-patient, or drugs provided for by a qualified home care program;
- Any prescription drug that is determined by Medavie Blue Cross to be non-therapeutic, not cost effective relative to drugs used for the same or similar conditions, or not medically necessary;
- Drugs dispensed by a physician, dentist or clinic;
- Homeopathic and naturopathic medications, nutritional supplements or herbal remedies;
- Dietary supplements, infant formulas, total parenteral nutrition solutions (TPN) and food products;
- Charges for delivery service, completion of forms, or other ancillary services.

Prescription Quantities

The quantity of each separate prescription order or refill for maintenance drugs is limited to a maximum of 100 days supply, unless written authorization is obtained by Medavie Blue Cross. Other preparations are limited to 34 days supply. Coverage is not included for an additional supply of a prescription drug, either as an original prescription or refill, during any period covered by a previously dispensed prescription for the same drug, unless necessitated by a change in dosage.

CONVERSION

Following termination of coverage under the plan, a member may apply for non-group coverage. Application must be made within 30 days following termination from the plan. Benefits and premiums will be in accordance with those applicable at the time of application.

CLAIM PROCEDURE

Hospital Services – There are no claim forms to complete in order to obtain hospital services. Presentation of your Drug Claim Card assures credit at the hospital. The hospital will submit directly to Johnson Inc.

Extended Health Benefits – You must pay for all services at the time that they are rendered. You should be sure to obtain an official receipt clearly showing the name of the patient, an itemized list of services provided, dates of the services and the amounts charged. On submission of the receipt(s) and a claim form to Johnson Inc., you will be reimbursed in accordance with the policy. Johnson Inc.'s address: Johnson Inc., 111 Kent Street, Charlottetown, PEI, C1A 1N3.

COORDINATION OF BENEFITS

The "Coordination of Benefits" (COB) provision limits the financial responsibility of Medavie Blue Cross when you are also insured under another plan. Benefits will be coordinated so that the amount payable under both policies does not exceed 100% of the actual eligible expenses incurred.

If you are the person named on the subscriber identification card, submit your claim to Johnson Inc. Once the claim has been processed, any balance can be claimed with the other insurance company under which you are covered.

If the claim is for your spouse, and he or she has coverage elsewhere, submit the claim to that insurance company first. If your plan also covers your spouse, you can claim the remaining balance from Johnson Inc. Claims for dependent children who are covered under both policies should be submitted **first** to the insurance company of the parent whose birth date is earlier in the calendar year.

Johnson Inc. requires a copy of the payment statement or summary from the other insurance company and a copy of your receipt in order to pay any eligible balance.

RETIREE HEALTH BENEFITS

All members of the P.E.I. Retired Teachers' Association who are insured for Hospital / Health benefits prior to retirement are eligible to continue their medical coverage. There is no age limit.

If you cease to become a member of the P.E.I. Teachers' Association, you are no longer eligible for coverage under this group plan. You are, however, entitled to coverage under Medavie Blue Cross's non-group plan provided you make application within one (1) month following termination. Benefits and premium rates for the non-group plan will be those applicable at the time of application.

DENTAL PLAN

Your Medavie Blue Cross Comprehensive Dental Plan provides benefits for dental services based on reasonable and customary charges, up to the amounts specified in the Provincial Dental Association Fee Schedule for specialist dentists.

Members who enrol in the Dental Insurance plan will not be able to cancel their coverage unless they have been enrolled in the Dental plan for at least 12 Consecutive Months from the effective date of their coverage.

Dental Fee Guide - General Practitioners and Specialists Dental Fee Guide or the minimum fee specified in the Denturist Fee Guide of your province of residence.

Benefit Percentage (Co-insurance)

80% for Basic expenses

50% for Major restorative expenses

50% for Orthodontic expenses

Benefit Maximums

- $2,000 annual maximum for Basic Services
- Major restorative ($1,000 annual maximum for Crowns, Bridges and Dentures)
- $3,000 lifetime for Orthodontics

Part I – Basic Services

Diagnostic - Includes necessary procedures to assist the dentist in evaluating existing conditions and the dental care required. Includes visits, examinations, diagnosis, consultation, necessary x-rays, and services or appliances for space regaining, bite correction or habit control.

Complete oral examinations are limited to one during any 24 consecutive months.

Recall examinations are limited to two during any 12 consecutive months.

Complete mouth x-rays or panographic x-rays are limited to one during any 24 consecutive months.

Bite-wing x-rays are limited to two sets during any 12 consecutive months.

Preventive - Includes necessary procedures to prevent the occurrence of dental abnormalities or disease. Included under this benefit are polishing and scaling, application of fluoride solutions to retard dental decay, pit and fissure sealants and space maintainers for missing primary teeth.

Polishing and fluoride treatments are covered twice during any 12 consecutive months. Scaling is limited to 2 time units (a unit of time is based on increments of 15 minutes) in any 12 consecutive month period in conjunction with recall services when no periodontal coverage is included. Pit and fissure sealants are limited to restoration free occlusal surfaces of permanent posterior teeth for children up to the age of 18.

Coverage is not included for oral hygiene instruction, nutritional counselling or mouth guards.

Note: When periodontal services are included as a benefit, then scaling is limited to 8 time units in any 12 consecutive months.

Oral Surgery - Includes simple extractions and surgical extractions of teeth, removal of roots, surgical incision or excision and other oral surgical procedures including preoperative and postoperative care.

Minor Restorative - Includes sedative dressings, temporary restorations, amalgam, acrylic, composite resin, silicate restorations and retentive pins.

Coverage is not included for crowns and veneers (including repair), inlays and onlays (including repair), gold foil restorations or post (including core) and post removal.

Adjunctive Dental Services

Coverage is included for:

- emergency treatment not classified elsewhere in the dental Fee Schedule
- conscious sedation (includes intravenous or nitrous oxide)
- professional consultation

Coverage is **not** provided for:

- separate charges for local anaesthesia administered in conjunction with procedures
- general anaesthesia unless the patient's medical condition prevents conscious sedation
- electronic anaesthesia
- hypnosis
- acupuncture

Endodontics - Includes root canal therapy (including treatment planning, clinical procedures and appropriate radiographs), pulpal therapy and periapical services.

Coverage is not included for the bleaching of vital teeth.

Periodontics - Includes the necessary services for detecting and eliminating diseases affecting supporting structures of the teeth. Includes gingivectomy, gingivoplasty, curettage and other surgical periodontal procedures, periodontal scaling and root planing, and non-surgical periodontal services including appliance therapy.

Periodontal scaling and root planing is limited to 8 time units in 12 consecutive months. More frequent service may be allowed on an independent consideration basis for cases of severe periodontal conditions, and a treatment plan must be submitted prior to the service being rendered.

Prosthodontic Maintenance - Includes repair of partial or complete dentures, relining and rebasing of dentures, and recementing of crowns, inlays, onlays and bridgework.

Relining or rebasing is limited to once in any period of 36 consecutive months.

Repair of partial or complete dentures and recementing of crowns, inlays, onlays and bridgework is covered after a period of 6 months following installation.

This benefit covers maintenance services to existing, permanent placements only.

Pre-Determination of Benefits - When a planned course of treatment is expected to exceed $500 or more, Johnson Inc. must receive a description of the proposed treatment, an estimate of the charges, and dental x-rays where applicable, from the dentist or dentist specialist prior to the services being rendered.

Part II - Major Restorative Services

Prior approval is required by submitting a pre-treatment plan including x-rays. Contact the claims department for more information.

Inlays (1 per 5 calendar year, per tooth)

- Tooth coloured or amalgam core, in conjunction with crown
- Prefabricated, metal(permanent teeth)
- Prefabricated, plastic (permanent teeth)
- Veneer application
- Metal inlay (three surfaces)

- Composite inlay
- Porcelain/Ceramic inlay

Onlays

- Metal onlay (per tooth)
- Composite onlay
- Porcelain/Ceramic onlay
- Retentive pins for inlays, onlays and crowns
- Posts, cast metal
- Posts, prefabricated

Crowns (1 per 5 calendar years, per tooth. Includes inlays, onlays and crowns combined)

- Plastics
- Plastic, transitional
- Porcelain/Ceramic
- Metal (full cast)
- Metal (3/4 cast) partial veneer
- Crown, made to existing denture

Prosthodontic Services:

- Complete denture
- Immediate complete denture
- Temporary complete denture
- Complete overdenture
- Immediate complete overdenture (inclusive)
- Temporary partial denture
- Immediate partial denture
- Partial overdenture (plastic)
- Partial free end
- Immediate partial free end
- Partial tooth borne
- Immediate partial tooth borne
- Partial opposing arch
- Partial overdenture (cast)

- Immediate partial overdenture (cast)
- Remake
- Pontics
- Bridges

Retainers - Crowns:

- Plastic/Acrylic
- Porcelain/Ceramic
- Metal cast

Retainers - Inlays and Onlays:

- Metal inlay
- Metal onlay
- Metal onlay (acid etch bonded)
- Abutment preparation
- Retentive pins
- Transplantation of erupted tooth
- Alveoloplasty
- Removal of bone, exostosis
- Gingivoplasty
- Vestibuloplasty
- Surgical incision and drainage
- Fractures, Reductions, Alveolar
- Replantation, repositioning
- Repairs, lacerations
- Antral surgery
- Adjunctive Services - Drugs

Part III - Orthodontic Services

Prior approval is required by submitting a pre-treatment plan. Reimbursement is based on an initial deposit and monthly installments. Lump Sum reimbursements cannot be considered. Contact the claims department for more information.

- All necessary dental treatment which has as its objective the correction of malocclusion of the teeth.

Elective Services

If a participant elects a more expensive plan of treatment than is customarily provided, the plan will pay the applicable percentage of the lesser fee. The participant will be responsible for the balance of the dentist's fee.

How to Claim

Prior to receiving treatment you should inform your dentist of your membership under the plan. You will have an Identification Card showing your group and subscriber numbers.

Your dentist may elect to act as a "Participating Dentist" in which case he will bill Johnson Inc. directly and receive payment directly. You will be responsible for making payment to the dentist for any amount in excess of Plan Allowances.

If your dentist is a "Non-Participating Dentist" you must make settlement with the dentist for services rendered. A claim form completed by the dentist is required and following receipt of this form, payment will be made directly to you in accordance with the Plan Allowances.

Coordination of Benefits

The "Coordination of Benefits" (COB) provision for Dental Insurance works in a similar manner to that of the Health Insurance Coordination of Benefits, referenced at the end of the Health Insurance section.

The Benefit

If, while insured for this Benefit the Insured is diagnosed with one of the covered Critical Illness conditions ("Condition") shown below and more particularly defined in Covered Critical Illness Conditions Appendix, and survives for a period of thirty (30) days ("Survival Period") commencing on the date of the first diagnosis of such Condition or such longer Survival Period as is described in this Policy, the Benefit will become payable to the Member provided that the following conditions are met:

a) That Manulife Financial receives what it deems to be satisfactory evidence, including but not limited to medical evidence, documenting the Insured's diagnosis of a Condition, all of which must be provided at the Insured's expense, unless otherwise specified herein;

b) The diagnosis of any Condition is made by a Physician in Canada practicing in a specialty that is customarily consulted for diagnoses relating to the applicable Condition.

BASIC CRITICAL ILLNESS INSURANCE

Only available to active members, the comprehensive Basic Critical Illness Insurance Plan provides a lump sum benefit of $10,000 to you in the event that you are diagnosed with one of the listed critical illnesses (see below for the list of covered illnesses).

The benefit terminates at age 75, retirement, or Critical Illness benefit payout in each of the 4 Multiple Event Coverage Groups (see below for more details on the 4 Multiple Event Coverage Groups), whichever is earlier.

OPTIONAL CRITICAL ILLNESS INSURANCE

Available to Active and Retired members, the Optional Critical Illness Insurance Plan provides a lump sum benefit in the event that an eligible member, spouse or dependent child is diagnosed with a critical illness (listed on the table below).

Coverage is available for members and their spouses in increments of $10,000 (minimum) to $300,000 (maximum). Coverage is also available for eligible dependent children at a flat $10,000.

EVIDENCE OF INSURABILITY: Required for all amounts of Optional Critical Illness Insurance, however, evidence of insurability will be waived for amounts of $50,000 or less for Active members—and their eligible spouses; and $20,000 or less for Retired members—and their eligible spouses.

BENEFIT REDUCTION: The member's benefit amount is reduced by 50% on the member's 65th birthday to a maximum of $50,000 (minimum of $10,000). Similarly, the spouse's benefit is reduced by 50% on the spouse's 65th birthday to a maximum of $50,000.

TERMINATION: Member coverage terminates at the earlier of the following: at age 75, or critical illness benefit payout in each of the 4 Multiple Event Coverage Groups. Spousal coverage terminates at the earlier of member's or spouse's age 75, or Critical Illness benefit payout in each of the 4 Multiple Event Coverage Groups. Dependent Child coverage terminates at the earlier of the member's age 75, Child's limiting age (as specified below), or critical illness benefit payout.

CRITICAL ILLNESS DEFINITIONS

Accident: an unexpected or unforeseen happening or event involving an external force, causing loss or injury, independently of all other causes.

Actively at Work: at work for the Prince Edward Island Teachers' Federation on a Full-time basis at the Member's usual place of work. On weekends or holidays, or when on vacation, a Member is deemed to be Actively at Work if he was Actively at Work on his last normal working day or on his last scheduled shift.

Benefit: the Critical Illness benefit provided for under this Policy.

Child: a natural or legally adopted child, stepchild or foster child of the Member or of the Member's Spouse, who

a) is a resident of Canada

b) is unmarried;
c) is not employed on a full-time basis;
d) is not eligible for insurance as a Member under this or any other group policy;
e) relies on the Member for financial support;
f) is either under 21 years of age, or, if a full-time student at an accredited school, college or university, under 26 years of age; and
g) is defined as a dependent of the member, as per the Income Tax Act (Canada).

Immediate Family Member is a person who is:
a) the Member; or
b) the Member's Spouse or Child.

Insured: a person who is Member, or the Spouse or Child of the Member, and who meets all eligibility requirements for insurance under this Policy.

Leave of Absence: a period of absence from work for which the dates are fixed by legislation or by mutual agreement between the Policyholder and the Member. Leave of absence includes Maternity and Parental Leave of Absence.

Licensed, Certified, Registered: the status of a person who legally engages in the practice of an occupation or profession requiring a license or certificate issued by the appropriate authority, in the place where the service is provided.

Medically Necessary: broadly accepted and recognized by the Canadian medical profession as effective, appropriate and essential in the treatment of a sickness or injury, in accordance with Canadian medical standards.

Member is a person who:
a) for a non-retired Member:
i) is a Member of the Prince Edward Island Teachers' Federation,
ii) is compensated by the employer for services rendered in the normal course of the employer's business, and
iii) is a resident of Canada or the United States, or
b) is retired and is a resident of Canada or the United States.

Non-Evidence Limit: the Benefit Amount, as stated in this Policy, beyond which satisfactory medical evidence must be submitted to Manulife Financial in order for additional Benefit Amounts to be approved.

Physician: a doctor of medicine, licensed to practice medicine in the place in Canada where the services are provided.

Prior Plan: a previous Group Policy which insured all or some of the persons insured under this Policy, and which terminated within 31 days prior to the Effective Date of this Policy.

Spouse: a person, residing in Canada, who is the Member's legal Spouse, or the person who has, for at least 12 months, been continuously living with the Member in a role like that of a marriage partner, and publicly represented as such.

For greater certainty, Spouse shall not include:
a) a person divorced from the Member; or

b) a person separated from the Member where such separation is pursuant to a court order or a legal separation agreement, or the parties are living separate and apart without benefit of a court order or separation agreement; or
c) a person cohabiting with the Member without public representation of married status.

MULTIPLE EVENT COVERAGE BENEFIT
Not applicable to Child Critical Illness

This benefit is designed to provide a payout in the event that the Member or his Spouse is diagnosed with two or more of the Covered Critical Illness Conditions. Each condition is assigned to one of the four Multiple Event Coverage Groups specified below. The Member and Spouse may claim once for a Covered Critical Illness under each of the Multiple Event Coverage Groups. The Member and his Spouse may not claim more than once in any coverage group.

In order to be eligible for a Multiple Event Benefit payment, the Member or his Spouse must be:

a) for Active Members, declared stable and have been Actively at Work for a period of at least 60 consecutive calendar days following the date of diagnosis of the initial critical illness diagnosis; and
b) for Retired Members, declared stable for a period of at least 365 consecutive calendar days following the date of diagnosis of the initial critical illness diagnosis.

If the Member's Spouse is not employed, then he must not have any physical or mental conditions that would prevent him from being employed if he chose to engage in an occupation.

Multiple Event Coverage Groups
a) Cancer and Benign Brain Tumour

b) Stroke, Heart Attack, Coronary Artery Bypass Surgery, Heart Valve Replacement, Aortic Surgery, Dilated Cardiomyopathy, Loss of Speech, Coma, Paralysis, Motor Neuron Disease, Multiple Sclerosis, Parkinson's Disease, Alzheimer's Disease, Primary Pulmonary Hypertension, Loss of Independent Existence, Bacterial Meningitis and Muscular Dystrophy

c) Kidney Failure, Major Organ Transplant, Major Organ Failure on Waiting List, Aplastic Anemia, Blindness and Fulminant Viral Hepatitis

d) Deafness, Severe Burns, Loss of Limbs and Occupational HIV Infection
CONVERSION PRIVILEGE
If coverage terminates for a Member or a Spouse who is under age 65, the insured person may obtain Personal Critical Illness coverage.

Conditions for Conversion: The insured person must apply in writing on forms approved by Manulife Financial, within 31 days after insurance under the Group Policy terminates, to be eligible for Personal Critical Illness coverage.

Maximum Amount: The maximum amount that may be converted is the lesser of:

a) $150,000. or

b) the amount of insurance that terminated less the amount of insurance under any replacing Group Policy within 31 days of the termination.

The Maximum Amount refers to all amounts of Group Critical Illness coverage for which the Member is insured with Manulife Financial.

Plan of Insurance
The personal coverage will be the type issued by Manulife Financial under the Critical Illness conversion plan available at the time, and applies to Member, Spouse and Child coverage.

Issue of Personal Coverage
Manulife Financial will apply the following rules in issuing Personal Critical Illness coverage:

a) no evidence of insurability will be required;
b) the premium will be based upon Manulife Financial's conversion plan rates in effect at the time application is made;
c) no Waiver of Premium will be included;
d) the effective date of the personal coverage will be the 32nd day after the date of termination of the Group Insurance under this Benefit; and if the person elects to convert a lesser amount than that which he is entitled to convert, the personal coverage cannot be less than the current minimum for which Manulife Financial will issue the personal coverage.

Claim during Conversion Period
If a person is diagnosed with one of the covered Critical Illness conditions within 31 days of the date his Group Insurance terminates, and survives for a period of thirty (30) days, on receipt of due proof, Manulife Financial will pay the appropriate benefit for such loss under this Group Policy. This will be done even if the person did not apply for Personal Critical Illness coverage. If the person had applied for the personal coverage, any premium paid will be refunded.

Subsequent Eligibility Under this Policy
If a person obtains Personal Critical Illness coverage through this Privilege and later becomes eligible for insurance under this Group Policy, the amount for which he is eligible will be reduced by the amount of insurance remaining in force under the Personal Critical Illness Coverage.

Standard Exclusions
No Benefits are payable for any Condition directly or indirectly related to:
a) self-inflicted injuries or illnesses, whether the insured is sane or insane,

b) abuse of addictive substances, including but not limited to legal and illegal drugs and alcohol,

c) war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion,

d) the committing of or the attempt to commit an assault or criminal offence,

e) injuries sustained while operating a motor vehicle, either while under the influence of any intoxicant or if the Insured’s blood contained more than 80 milligrams of alcohol per 100 milliliters of blood at the time of the injury,

f) intentionally taking a poisonous substance or inhaling toxic gases or fumes,

g) any specific exclusions relating to any given Condition, as more particularly set out in Covered Critical Illness Conditions List.

PRE-EXISTING CONDITION EXCLUSION FOR NON-EVIDENTIARY INSURANCE AND CHILD INSURANCE

This section applies to any Insurance where Manulife Financial does not require the submission of medical evidence in support of an application for Insurance.

For ACTIVE Members:
A Pre-existing Condition is an illness or injury for which, during the 12 months prior to the Effective Date of Insurance or the latest date of reinstatement for this Benefit, the Insured person has exhibited signs or symptoms, received medical treatment, care or services (including diagnostic measures), consulted a Physician or has been prescribed medication; or where treatment would have been sought by a prudent individual during the 12 months prior to the Effective Date of Insurance or the latest date of reinstatement for this Benefit.

During the first 12 months of Insurance or the latest reinstatement of this Insurance, whichever is applicable, no Benefit is payable for a Condition that is directly or indirectly related to a Pre-existing Condition. This exclusion applies whether or not the Insured person was aware of his Pre-existing Condition or had received a diagnosis prior to the Effective Date of Insurance or the latest reinstatement of this Benefit, whichever is applicable.

For RETIRED Members:
A Pre-existing Condition is an illness or injury for which, during the 24 months prior to the Effective Date of Insurance or the latest date of reinstatement for this Benefit, the Insured person has exhibited signs or symptoms, received medical treatment, care or services (including diagnostic measures), consulted a Physician or has been prescribed medication; or where treatment would have been sought by a prudent individual during the 24 months prior to the Effective Date of Insurance or the latest date of reinstatement for this Benefit.

During the first 24 months of Insurance or the latest reinstatement of this Insurance, whichever is applicable, no Benefit is payable for a Condition that is directly or indirectly related to a Pre-existing Condition. This exclusion applies whether or not the Insured person was aware of his Pre-existing Condition or had received a diagnosis prior to the Effective Date of Insurance or the latest reinstatement of this Benefit, whichever is applicable.

MORATORIUM PERIOD EXCLUSION
No benefit will be payable in relation to Cancer or Benign Brain Tumour if, within the first 90 days following the later of:

a) the effective date of coverage, or
b)the effective date of last reinstatement of coverage,

the insured person has any of the following:
a) signs or symptoms that lead to a diagnosis of Cancer or Benign Brain Tumour, regardless of the date when the diagnosis is made, or
b) medical consultations, tests or any form of clinical evaluation, that lead to a diagnosis of Cancer or Benign Brain Tumour, regardless of when the diagnosis is made; or
c) a diagnosis of Cancer or Benign Brain Tumour.

Child Critical Illness Exclusion
Where a Child is born within ten months of the Effective Date of Child Insurance, and such Child is diagnosed with any Condition within those 10 months, no benefit shall be payable for such Condition.

ADULT COVERED CONDITIONS DEFINITIONS

Covered Conditions are those recognized within the medical profession as being of a critical nature. Advances in the medical knowledge and treatment of critical illnesses will evolve, and accordingly Manulife Financial reserves the right to change the contract definitions for Conditions covered under any given Plan. All claims under this Policy shall be adjudicated using the definition of any Condition(s) that is in effect at the time the claim is incurred. Accordingly, you must ensure that you have the most current version of this appendix at the time that you submit a claim under this Policy.

Alzheimer's Disease is defined as a definitive clinical diagnosis by a specialist in the diagnosis and treatment of Alzheimer's Disease, which is a progressive degenerative disease of the brain. The Insured must exhibit the loss of intellectual capacity involving impairment of memory and judgment, which results in a significant reduction in mental and social functioning, as to require continuous daily supervision.
Exclusion: All other organic brain disorders and psychiatric illnesses that result in dementia are specifically excluded.

Aortic Surgery is defined as 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.
Exclusion: Surgery for the diseases of the branches of the thoracic aorta or abdominal aorta is specifically excluded.

Aplastic Anemia is defined as a definite of a chronic persistent bone marrow failure, confirmed by biopsy, which results in anemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following:
a) marrow stimulating agents;
b) immunosuppressive agents;
c) bone marrow transplantation.
The diagnosis of Aplastic Anemia must be made by a specialist.

Bacterial Meningitis is defined as 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. The diagnosis of Bacterial Meningitis must be made by a Specialist.
Exclusion: No benefit will be payable under this condition for viral meningitis.

Benign Brain Tumour is defined as a non-malignant tumour arising from the brain or meninges. The histologic nature of the tumour must be confirmed by examination of tissue (biopsy or surgical excision).
Exclusion for Certain Tumours: Tumours of the bony cranium and pituitary microadenomas (less than 10 mm in diameter) are excluded.
Moratorium Period Exclusion: No benefit under this condition will be payable in relation to this condition if, within the first 90 days following the later of:
a) the effective date of coverage, or

b) the effective date of last reinstatement of coverage,

the insured person has any of the following:

a) signs or symptoms that lead to a diagnosis of Benign Brain Tumour, regardless of the date when the diagnosis is made, or

b)medical consultations, tests or any form of clinical evaluation, that lead to a diagnosis of Benign Brain Tumour, regardless of when the diagnosis is made; or

c) a diagnosis of Benign Brain Tumour.

This information must be reported to Manulife Financial within 6 months of the date of the first diagnosis. If this information is not so provided, Manulife Financial has the right to deny any claim for Benign Brain Tumour or any critical illness caused by Benign Brain Tumour or its treatment.

Blindness is defined as the total and irreversible loss of vision in both eyes as confirmed by an ophthalmologist, with the corrected visual acuity being 20/200 or less in each eye or the field of vision is less than 20 degrees in both eyes.

Cancer is defined as a tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue.
Exclusion for Certain Cancers. The following cancers are excluded from coverage:
a) carcinoma in situ
b) Stage 1A malignant melanoma (melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without level IV or V invasion)
c) any non-melanoma skin cancer that has not become metastatic (spread to distant organs)
d) stage A(T1a or T1b)prostate cancer
e) any tumour in the presence of any HIV

Moratorium Period Exclusion. No Benefit will be payable in relation to this condition if, within the first 90 days following the later of:
a) the effective date of coverage, or
b) the effective date of last reinstatement of coverage,
the insured person has any of the following:

a) signs or symptoms that lead to a diagnosis of cancer (covered or excluded under this Policy), regardless of the date when the diagnosis is made; or

b) medical consultations or tests that lead to a diagnosis of cancer (covered or excluded under this Policy), regardless of the date when the diagnosis is made; or

c) a diagnosis of cancer (covered or excluded under this Policy).

This information must be reported to Manulife Financial within 6 months of the date of the first diagnosis. If this information is not so provided, Manulife Financial has the right to deny any claim for cancer or, any critical illness caused by any cancer or its treatment.

Coma is defined as a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of four days. The Glasgow coma score must be four(4) or less, continuously during the four days.
Exclusions: Medically induced comas are specifically excluded.

Coronary Artery Bypass Surgery is defined as the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass grafts, excluding any non-surgical techniques such as balloon angioplasty or laser relief of an obstruction or other non-coronary artery bypass graft medical treatments.

Deafness is defined as 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 cycles per second.

Dilated Cardiomyopathy is defined as the unequivocal diagnosis by a cardiologist of Cardiomyopathy causing permanent impaired left ventricular function with an ejection fraction of less than 25% as measured using Canadian Cardiovascular Society approved imaging techniques.
The cardiomyopathy must result in severe functional limitations consistent with those described in Class IV of the Canadian Cardiovascular Society (CCS) Classification of Functional Impairment and this limitation must be sustained over at least one year while the claimant is treated according to current Canadian Cardiovascular Society treatment recommendations for heart failure.
Exclusion: Cardiomyopathy directly related to alcohol or drug misuse.
CCS Angina classification:
1. Class 0 Asymptomatic
2. Class I Ordinary physical activity, such as walking or climbing stairs does not cause angina. Angina with strenuous, rapid, or prolonged exertion at work or recreation.
3. Class II Slight limitation of ordinary activity. Walking or climbing stairs rapidly, walking uphill, walking or stair climbing after meals, or in cold or in wind or under emotional stress, or only during the few hours after awakening. Walking more than two blocks on the level or climbing more than one flight of ordinary stairs at a normal pace and under normal conditions.
4. Class III Marked limitation of ordinary physical activity. Walking one or two blocks on the level or climbing one flight of stairs in normal conditions and at a normal pace.
5. Class IV Inability to carry out any physical activity without discomfort - anginal syndrome may be present at rest.

Fulminant Viral Hepatitis is defined as a sub-massive to massive necrosis of the liver by any virus, leading precipitously to liver failure as diagnosed by a specialist.
This diagnosis must be supported by all of the following:
a) rapid decreasing of liver size;
b) necrosis involving entire lobules, leaving only a collapsed reticular framework;
c) rapid deterioration of liver function tests;
d) deepening jaundice; and
e) hepatic encephalopathy.
Slowly progressing liver failure as a result of a viral infection is explicitly excluded.

Heart Attack is defined as the death of a portion of heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis must be based on:
a) new electrocardiographic changes consisting of the development of Q waves and/or ST segment elevation not previously present or any other changes indicative of a myocardial infarction, and
b) elevation of cardiac biochemical markers to levels considered diagnostic for infarction.
Exclusion: Heart attack does not include and no Benefit shall be payable for an incidental finding of ECG changes suggesting a prior myocardial infarction, in the absence of a corroborating event.

Heart Valve Replacement is defined as the replacement of any heart valve with either a natural or mechanical valve.
Exclusion: Heart valve repair is specifically excluded.

Kidney Failure (End Stage Renal Disease) is defined as end stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular hemodialysis, peritoneal dialysis or renal transplantation is initiated.

Loss of Independent Existence is defined as a definite diagnosis of:
a) a total inability to perform, by oneself, at least 2 of the following 6 activities of daily living, or,
b) cognitive impairment as defined below, for a continuous period of at least 90 days with no reasonable chance of recovery. The diagnosis of Loss of Independence Existence must be made by a specialist.
Activities of daily living are:
a) Bathing - the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of equipment.
b) Dressing - the ability to put on and remove necessary clothing including braces, artificial limbs or other surgical appliances.
c) Toileting - the ability to get on and off the toilet and maintain personal hygiene.
d) Bladder and Bowel Continence - the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained.
e) Transferring - the ability to move in and out of a bed, chair or wheelchair, with or without the use of equipment.
f) Feeding - the ability to consume food or drink that already has been prepared and made available, with or without the use of adaptive utensils.

Cognitive Impairment is defined as "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 is defined as the irreversible severance of two or more limbs above the wrist or ankle joint as the result of an accident or medically required amputation.

Loss of Speech is defined as the total and irreversible loss of the ability to speak as the result of physical injury or disease which must be established for a continuous period of at least 180 days.
Exclusion: All psychiatric related causes are specifically excluded.

Major Organ Failure on Waiting List is defined as the diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow as a result of which transplantation must be medically necessary.
To qualify under Major Organ or Bone Marrow Failure on Waiting List the Insured must become enrolled as the recipient in an approved government organ or bone marrow transplant program in Canada or the U.S., for one or more of the organs or bone marrow specified in this provision. For the purposes of the

Survival Period, the date of diagnosis is the date your enrolment in such a transplant program takes effect.

Major Organ Transplant is defined as the diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow as a result of which transplantation is medically necessary.
To qualify under Major Organ or Bone Marrow Transplant the Insured must undergo surgery as the recipient for transplantation of a heart, lung, liver, kidney or bone marrow, and limited to these entities.
Exclusion: A transplantation that is not medically necessary is specifically excluded.

Motor Neuron Disease is defined as a definitive 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 entities.

Multiple Sclerosis is defined as a diagnosis that is made in accordance with one of the two methods outlined below, either of which will be acceptable to Manulife Financial:
a) A diagnosis by a neurologist of Multiple Sclerosis, characterized by well defined neurological abnormalities persisting for a continuous period of at least six months or with evidence of two separate clinically documented episodes. Multiple areas of demyelination must be confirmed by MRI scanning or imaging techniques generally used to diagnose multiple sclerosis; or
b) A diagnosis of Multiple Sclerosis by a neurologist ,in accordance with definitions established by the International Panelon MS Diagnostic Criteria.

Muscular Dystrophy is defined as a disease of the muscle causing progressive and permanent weakening of certain muscle groups. The diagnosis of muscular dystrophy must be made by a Neurologist, and confirmed with the appropriate laboratory, biochemical, histological, and electromyographic evidence. The disease must result in the total and permanent inability to perform, by oneself, at least 2 of the following 6

Activities of Daily Living as documented by an occupational therapist, physiotherapist, or rehabilitation specialist. Activities of Daily Living are defined as:
a) Bathing - the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of equipment.
b) Dressing - the ability to put on and remove necessary clothing including braces, artificial limbs or other surgical appliances.
c) Toileting - the ability to get on and off the toilet and maintain personal hygiene.
d) Bladder and Bowel Continence - the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained.
e) Transferring - the ability to move in and out of a bed, chair or wheelchair, with or without the use of equipment.
f) Feeding - the ability to consume food or drink that already has been prepared and made available, with or without the use of adaptive utensils.

Cognitive Impairment is defined as "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."

Table 1

INTERNATIONAL PANEL CRITERIA (2005 REVISIONS TO THE MCDONALD CRITERIA) FOR DIAGNOSIS OF MS

Clinical Presentation	Additional Data Needed for MS Diagnosis
Two or more attacks; objective clinical evidence of 2 or more lesions	None[a]
Two or more attacks; objective clinical evidence of 1 lesion	Dissemination in space, demonstrated by: • MRI[b] OR • 2 or more MRI-detected lesions consistent with MS plus positive CSF[c] OR • await further clinical attack implicating a different site
One attack; objective clinical evidence of 2 or more lesions	Dissemination in time, demonstrated by: • MRI[b] OR • Second clinical attack
One attack; objective clinical evidence of 1 lesion (monosymptomatic presentation; clinically isolated syndrome)	Dissemination in space, demonstrated by: • MRI[b] OR • 2 or more MRI-detected lesions consistent with MS plus positive CSF[c] AND Dissemination in time, demonstrated by: • MRI[b] OR • Second clinical attack
Insidious neurological progression suggestive of MS	One year of disease progression (retrospectively or prospectively determined) AND 2 out of the following 3: a. Positive brain MRI (9 T2 lesions or 4 or more T2 lesions with positive visual evoked potentials) b. Positive spinal cord MRI (2 or more focal T2 lesions) c. Positive CSF (isoelectric focusing evidence of OCB and/or elevated IgG index)

[a] Brain MRI is recommended to exclude other etiologies
[b] MRI criteria for dissemination in space or time are described in Table 2
[c] Positive CSF defined as oligoclonal bands different from those in serum, or raised IgG index

Table 2

MAGNETIC RESONANCE IMAGING CRITERIA FOR BRAIN ABNORMALITY: SPACE AND TIME DISSEMINATION

Magnetic Resonance Imaging Criteria to Demonstrate Dissemination of Lesions in Time (DIT)

There are two ways to show DIT using imaging:

a. Detecting gadolinium enhancement at least 3 months after the onset of the initial clinical event, if not at the site corresponding to the initial event.

b. Detecting a NEW T2 lesion if it appears at any time compared to a reference scan done at least 30 days after the onset of the initial clinical event.

Magnetic Resonance Imaging Criteria to Demonstrate Brain Abnormality and Demonstration of Dissemination in Space (DIS)

Three out of four of the following:

1. One gadolinium-enhancing lesion or nine T2 hyperintense lesions if there is no gadolinium-enhancing lesion
2. At least one infratentorial lesion
3. At least one juxtacortical lesion
4. At least three periventricular lesions

NOTE: A spinal cord lesion can be considered equivalent to a brain infratentorial lesion: an enhancing spinal cord lesion is considered to be equivalent to an enhancing brain lesion, and individual spinal cord lesions can contribute along with individual brain lesions to reach the required number of T2 lesions.

Occupational HIV Infection is defined as the diagnosis of Human Immunodeficiency Virus(HIV) resulting from accidental injury during the course of the Insured's normal occupation, which exposed the person to HIV contaminated body fluids.
Payment of the Benefit in relation to this condition requires satisfaction of all of the following criteria:
a) The accidental injury must be reported to the Policyholder within fourteen(14)days of the accidental injury;
b) An HIV test must be taken within fourteen (14) days of the accidental injury and the result must be negative;
c) An HIV test must be taken between ninety (90) days and one hundred eighty days(180)after the accidental injury and the result must be positive;
d) All HIV tests must be performed by licensed HIV testing facilities and personnel;
e) The accidental injury must have been reported, investigated and documented in accordance with current Canadian workplace guidelines.

Exclusions: No payment of this Benefit will be made if:
a) the Insured has elected not to take any available licensed vaccine or any other form of treatment offering protection against HIV;
b) a licensed cure for HIV infection has become available prior to the payment of the Benefit; or
c) HIV infection has occurred as a result of non-accidental injury (including, but not limited to, sexual transmission or intravenous (IV) drug use).

Paralysis is defined as the complete and permanent loss of use of two or more limbs for a continuous period of 90 days following the precipitating event, during which time there has been no sign of improvement.
Exclusion: All psychiatric related causes for paralysis are specifically excluded.

Parkinson's Disease is defined as a definitive diagnosis by a specialist of primary idiopathic Parkinson's Disease, which is characterized by a minimum of two or more of the following clinical manifestations: muscle rigidity, tremor, or bradykinesis (abnormal slowness of movement, sluggishness of physical and mental responses).The Insured must require substantial physical assistance from another adult to perform at least 2 of the following 6 Activities of Daily Living:
a) Bathing – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of equipment.
b) Dressing – the ability to put on and remove necessary clothing including braces, artificial limbs or other surgical appliances.
c) Toileting – the ability to get to and from the toilet and maintain personal hygiene.
d) Bladder and Bowel Continence – the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained.
e) Transferring – the ability to move in and out of a bed, chair or wheelchair, with or without the use of equipment.
f) Feeding – the ability to consume food or drink that already have been prepared and made available, with or without the use of adaptive utensils.
Exclusion: All types of Parkinsonism other than the type described in this section are specifically excluded.

Primary Pulmonary Hypertension is defined as a primary and unexplained increase in pulmonary artery pressure causing signs of right heart strain and failure. There must be permanent irreversible functional limitations consistent with those described in Class IV of the Canadian Cardiovascular Society (CCS) Classification of Functional Impairment. Secondary pulmonary hypertension associated with lung disease, chronic hypoventilation, pulmonary thromboembolic disease, diseases of the left side of the heart and congenital heart disease are specifically excluded.
The diagnosis of primary pulmonary hypertension needs to be made by a cardiologist or a specialist in respiratory medicine and needs to be supported by data provided at cardiac catherisation. The diagnosis must be supported by all three (3) of the following criteria:
1. Mean pulmonary artery pressure > 40 mmHG; and
2. Pulmonary vascular resistance > 3 (mmHg/L)/min; and
3. Normal pulmonary wedge pressure < 15 mmHg.

CCS Angina classification:
1. Class 0 Asymptomatic
2. Class I Ordinary physical activity, such as walking or climbing stairs does not cause angina. Angina with strenuous, rapid, or prolonged exertion at work or recreation.
3. Class II Slight limitation of ordinary activity. Walking or climbing stairs rapidly, walking uphill, walking or stair climbing after meals, or in cold or in wind or under emotional stress, or only during the few hours after awakening. Walking more than two blocks on the level or climbing more than one flight of ordinary stairs at a normal pace and under normal conditions.
4. Class III Marked limitation of ordinary physical activity. Walking one or two blocks on the level or climbing one flight of stairs in normal conditions and at a normal pace.
5. Class IV Inability to carry out any physical activity without discomfort - anginal syndrome may be present at rest.

Severe Burns is defined as third degree burns over at least 20% of the body surface.

Stroke (Cerebrovascular Accident) is defined as a cerebrovascular event producing neurological sequelae lasting more than 30 days and caused by intracranial thrombosis or hemorrhage, or embolism from an extra-cranial source. There must be evidence of measurable, objective neurological deficit. Exclusion: Transient Ischemic Attacks are specifically excluded.

CHILD COVERED CONDITIONS DEFINITIONS
Includes all of the adult covered conditions plus the following 7 conditions:
Autism is defined as an organic defect in brain development characterized by failure to develop communicative language or other forms of social communication, with the diagnosis confirmed either by a pediatric psychiatrist or a pediatrician before the Child's third birthday.

Cerebral Palsy is defined as a definitive diagnosis of definite Cerebral Palsy, a non-progressive neurological defect characterized by spasticity and in coordination of movements.

Congenital Heart Disease is defined as any one or more diagnosis(es) from the following lists of heart conditions:

List A
a) Total Anomalous Pulmonary Venous Connection
b) Transposition of The Great Vessels
c) Atresia of any heart valve
d) Coarctation of The Aorta
e) Single Ventricle
f) Hypoplastic Left Heart Syndrome
g) Double Outlet Left Ventricle
h) Truncus Arteriosus
i) Tetralogy of Fallot
j) Eisenmenger Syndrome
k) Double Inlet Ventricle
l) Hypoplastic Right Ventricle
m) Ebstein's Anomaly

The foregoing conditions shall be covered following the expiry of a 30 day Survival Period, commencing from the date of diagnosis or birth, whichever is the later of the two. The diagnosis of any of the conditions in List A must be made by a qualified pediatric cardiologist, and supported by appropriate cardiac imaging.

List B
a) Pulmonary Stenosis
b) Aortic Stenosis
c) Discrete Subvalvular Aortic Stenosis
d) Ventricular Septal Defect
e) Atrial Septal Defect

The foregoing conditions shall be covered only when open heart surgery is performed for correction of the condition and following the expiry of a 30 day survival period from the date of diagnosis or birth, whichever is the later of the two. The diagnosis of any of the conditions in this List B must be made by a qualified pediatric cardiologist and supported by appropriate cardiac imaging. The surgery must be recommended by a qualified pediatric cardiologist and performed by a cardiac surgeon in Canada.

List B Exclusion: Trans-catheter procedures such as balloon valvuloplasty or percutaneous Atrial Septal Defect closure are excluded.

General Exclusions: All other congenital cardiac conditions, not specifically listed herein, are excluded.

Cystic Fibrosis is defined as a definitive diagnosis of Cystic Fibrosis with evidence of chronic lung disease and pancreatic insufficiency.

Down's Syndrome is defined as a definitive diagnosis of Down's Syndrome supported by chromosomal evidence of Trisomy 21.

Muscular Dystrophy is defined as a definitive diagnosis of Muscular Dystrophy, characterized by well defined neurological abnormalities, confirmed by electromyography and muscle biopsy.

Type 1 Diabetes Mellitus (Juvenile Diabetes) is defined as a diagnosis of type 1 diabetes mellitus, characterized by absolute insulin deficiency and continuous dependence on exogenous insulin for survival. The diagnosis must be made by a qualified pediatrician or endocrinologist licensed and practicing in Canada, and

there must be evidence of dependence on insulin for a minimum of three months.

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