THE Great-West Life ASSURANCE COMPANY

THE CATHOLIC INDEPENDENT SCHOOLS OF VANCOUVER ARCHDIOCESE

Short-Term Employees

BENEFIT DETAILS

Great-West Life is a leading Canadian life and health insurer. Great-West Life's financial security advisors work with our clients from coast to coast to help them secure their financial future. We provide a wide range of retirement savings and income plans; as well as life, disability and critical illness insurance for individuals and families. As a leading provider of employee benefits in Canada, we offer effective benefit solutions for large and small employee groups.

Great-West Life Online

Visit our website at www.greatwestlife.com for:

- information and details on Great-West Life's corporate profile and our products and services
- investor information
- news releases
- contact information
- claim forms and the ability to submit certain claims online

Great-West Life Online Services for Plan Members

As a Great-West Life plan member, you can also register for GroupNet™ for Plan Members at **www.greatwestlife.com**. To access this service, click on the GroupNet for Plan Members link. Follow the instructions to register. Make sure to have your plan and ID numbers available before accessing the website.

This service enables you to access the following and much more, within a user friendly environment twenty-four hours a day, seven days a week:

- your benefit details and claims history
- personalized claim forms and cards
- online claim submission for many of your claims, as outlined in the Health Care and Dental sections of this booklet
- extensive health and wellness content

Using our GroupNet Mobile app, you can access certain features of GroupNet for Plan Members to:

- submit many of your claims online – part of our industry-leading GroupNet online services
- access personalized coverage information about benefits, claims and more – quickly and easily, any time
- view card information
- locate the nearest provider who has access to Provider eClaims, through a built-in GPS mapping tool

In addition, by using GroupNet Text, you can get immediate information that is specific to your benefits. GroupNet Text allows you to use your mobile device to access detailed plan information, including:

- plan and member identification numbers
- coverage details (details available depend on your plan design)
- reimbursement amounts
- benefit maximums, balances and more

You can sign up for GroupNet Text on GroupNet for Plan Members under the Your Profile tab.

To use GroupNet Text, go to GroupNet for Plan Members and select the Your Profile tab, then text certain keywords to 204-289-1667. You will receive an instant text back providing information on your coverage. For a complete list of keywords, text Help. For a brief description of the type of information that a keyword provides, text Help along with the specific keyword.

Compatibility of GroupNet Text may vary by mobile device or operating system.

Great-West Life's Toll-Free Number

To contact a customer service representative at Great-West Life for assistance with your medical and dental coverage, please call 1-800-957-9777.

This booklet describes the principal features of the group benefit plan sponsored by your employer, but **Group Policy Nos. 335645** and **335646** and **Plan Document No. 56565** issued by Great-West Life **and Group Policy No. 100005769** issued to your employer by Industrial Alliance Pacific Insurance and Financial Services Inc. ("IAP") are the governing documents. If there are variations between the information in the booklet and the provisions of the policies or plan document, the policies or plan document will prevail.

This booklet contains important information and should be kept in a safe place known to you and your family.

The Plan is administered by

THE Great-West Life ASSURANCE COMPANY

and

Industrial Alliance Pacific Insurance and Financial Services Inc. ("IAP")

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Access to Documents

You have the right, upon request, to obtain a copy of the policy, your application and any written statements or other records you have provided to Great-West Life as evidence of insurability, subject to certain limitations.

Legal Actions

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act (for actions or proceedings governed by the laws of Alberta and British Columbia), The Insurance Act (for actions or proceedings governed by the laws of Manitoba), the *Limitations Act, 2002* (for actions or proceedings governed by the laws of Ontario), or other applicable legislation. For those actions or proceedings governed by the laws of Quebec, the prescriptive period is set out in the Quebec Civil Code.

Appeals

You have the right to appeal a denial of all or part of the insurance or benefits described in the contract as long as you do so within one year of the initial denial of the insurance or a benefit. An appeal must be in writing and must include your reasons for believing the denial to be incorrect.

Benefit Limitation for Overpayment

If benefits are paid that were not payable under the policy, you are responsible for repayment within 30 days after Great-West Life sends you a notice of the overpayment, or within a longer period if agreed to in writing by Great-West Life. If you fail to fulfil this responsibility, no further benefits are payable under the policy until the overpayment is recovered. This does not limit Great-West Life’s right to use other legal means to recover the overpayment.

Protecting Your Personal Information

At Great-West Life, we recognize and respect the importance of privacy. Personal information about you is kept in a confidential file at the offices of Great-West Life or the offices of an organization authorized by Great-West Life. Great-West Life may use service providers located within or outside Canada. We limit access to personal information in your file to Great-West Life staff or persons authorized by Great-West Life who require it to perform their duties, to persons to whom you have granted access, and to persons authorized by law. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

We use the personal information to administer the group benefits plan under which you are covered. This includes many tasks, such as:

- determining your eligibility for coverage under the plan
- enrolling you for coverage
- investigating and assessing your claims and providing you with payment
- managing your claims
- verifying and auditing eligibility and claims
- creating and maintaining records concerning our relationship
- underwriting activities, such as determining the cost of the plan, and analyzing the design options of the plan
- preparing regulatory reports, such as tax slips

Your employer has an agreement with Great-West Life in which your employer has financial responsibility for some or all of the benefits in the plan and we process claims on your employer's behalf. We may exchange personal information with your health care providers, your plan administrator, any insurance or reinsurance companies, administrators of government benefits or other benefit programs, other organizations, or service providers working with us or the above when relevant and necessary to administer the plan.

As plan member, you are responsible for the claims submitted. We may exchange personal information with you or a person acting on your behalf when relevant and necessary to confirm coverage and to manage the claims submitted.

You may request access or correction of the personal information in your file. A request for access or correction should be made in writing and may be sent to any of Great-West Life's offices or to our head office.

For a copy of our Privacy Guidelines, or if you have questions about our personal information policy and practices (including with respect to service providers), write to Great-West Life's Chief Compliance Officer or refer to **www.greatwestlife.com**.

Liability for Benefits

Your employer has entered into an agreement with The Great-West Life Assurance Company whereby your employer will have full liability for Dental benefits outlined in this booklet. This means your employer has agreed to fund these benefits and they are, therefore, uninsured. All claims will, however, be processed by Great-West Life.

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Welcome to Great-West Life!

Welcome to Great-West Life! Your employer and Great-West Life have worked together to develop a package of benefits to meet your needs. These benefits are an important part of the total compensation package from your employer.

Our goal is to make it easy for you and your family to have your questions answered. If you have any questions about your benefits, you can ask your employer or contact a customer service representative.

Why is this booklet important

This booklet outlines the benefits that are available under your employer's policy with Great-West Life. The section called "General Terms" includes facts about eligibility and enrolment. This is followed by a section on each of your benefits, containing benefit descriptions and the coverage that each benefit provides and what you are not covered for.

Definitions

Here are definitions for some of the terms in your employee booklet. You will find more definitions included in each section.

Actively at work

You are actively at work if you are carrying out your normal duties at:

- your employer's place of business; or
- some other location required by your employer's business.

You will also be considered actively at work if you are absent only due to a scheduled day off or vacation but otherwise able to carry out your normal duties.

Child

A child is your unmarried son or daughter. This includes a step-child and a common-law child. Common-law child means a child of your common-law spouse and another person. This child must be dependent on you and your common-law spouse for support and maintenance.

A child must be under age 22 and depend on you for support and maintenance. We will continue coverage while the child is under age 25 and attending an accredited college or university on a full-time basis. We must receive confirmation that the child is a full-time student and remains dependent on you for support and maintenance.

We will continue coverage beyond the maximum ages indicated above for a child who is physically or mentally handicapped as long as:

- the child became handicapped before reaching the applicable maximum age stated above, and
- we receive proof satisfactory to us that the child is not capable of self-support due to the handicap.

Contract Period

The contract period is the time period contained in the contract.

Covered person

Covered person means you or your dependent who is covered under the plan.

Dependent

A dependent is your spouse or child. Anyone who is in the armed forces full-time is not eligible to be a dependent.

Earnings

Earnings means your gross annual salary before any deductions, but does not include other compensation such as commissions, bonuses, dividends, overtime, profit sharing or car allowances.

Weekly earnings are annual earnings divided by the number of weeks you are expected to work. Example – Teachers (43 weeks), Principals (48 weeks), 12 month employees (52 weeks), etc.

Monthly earnings are annual earnings divided by 12.

Emergency

An emergency means any sudden, unexpected illness or injury for which the insured person needs immediate treatment.

Employee

Employee means you while working for your employer on a full year contract for at least 20 hours a week.

Family

You and all your dependents who are covered under the policy.

Illness

Illness means a sickness or disease of the mind or body, including conditions related to pregnancy.

Insured person

Insured person means you or your dependent who is covered under the policy.

Leave of absence

A leave of absence is a period of time that you are permitted to be absent from work. Your employer must have agreed to the leave of absence.

Pregnancy

Pregnancy means carrying a child within the womb, childbirth or miscarriage. It also means any complications resulting from a pregnancy.

Pregnancy leave of absence

Pregnancy leave of absence means a period of time you are permitted to be absent from work because of pregnancy. It can either be a pregnancy leave allowed by provincial or federal law or a leave that you and your employer agree to. It can also mean a pregnancy leave that your employer asks you to take, if allowed by law.

We consider that a pregnancy leave of absence begins on the earlier of the following dates:

- the date you or your employer choose as the beginning of the leave, or
- the date your child is born.

We consider that a pregnancy leave of absence ends on the earlier of the following dates:

- the day before the date you are scheduled to return to work, or
- the day before the date you return to work.

Proof of insurability

Proof of insurability is the additional information that we need about a person's health, job and leisure activities to decide if the requested coverage will be provided.

Reasonable Treatment

Reasonable treatment means treatment that is considered reasonable if it is accepted by the Canadian medical profession, it is proven to be effective, and it is a form, intensity, frequency and duration essential to diagnosis or management of an illness, injury or pregnancy.

Spouse

A spouse is a person to whom you are legally married.

Only one spouse can be covered at a time.

Waiting period for coverage

The waiting period for coverage is the time you must wait before coverage may begin.

Waiting periods for disability payments

The Short Term Disability waiting period is the time you must be absent from work due to disability before Short Term Disability payments may be made. Please refer to the "Short Term Disability coverage" section for details.

We, our and us

We, our and us mean The Great-West Life Assurance Company.

General Terms

Waiting period for coverage

There is no waiting period for coverage.

When your coverage begins

You must enrol to receive coverage. Your employer can provide you with the form to complete. This form must be signed and dated.

When you enrol

If you are not actively at work

If you are not actively at work on the date coverage would begin according to the following, your coverage will begin when you are actively at work.

If you enrol before the end of the waiting period for coverage

Coverage will begin on the day after the waiting period for coverage ends, if you are actively at work on that day.

If you enrol after the end of the waiting period for coverage

If you enrol within 31 days of the end of the waiting period for coverage, coverage will begin on the day after the waiting period for coverage ends, if you are actively at work on that day.

Evidence of good health is required if you enrol more than 31 days after the end of the waiting period for coverage. Coverage will begin on the date the evidence of good health is approved by us, if you are actively at work on that day.

When you enrol and apply for family coverage

If you enrol and apply for family coverage before the end of the waiting period for coverage

Coverage for a dependent who is not hospitalized will begin on the date your coverage begins.

If you enrol and apply for family coverage after the end of the waiting period for coverage

If you enrol within 31 days of the end of the waiting period for coverage, coverage for a dependent who is not hospitalized will begin on the date your coverage begins.

Evidence of good health is required if you enrol more than 31 days after the end of the waiting period for coverage. Coverage for a dependent who is not hospitalized will begin on the date the dependent's evidence of good health is approved by us or the date your coverage begins, whichever is later.

If your dependent is hospitalized

If your dependent other than a newborn child is hospitalized on the date coverage would otherwise begin, coverage for that dependent will begin on the first day after the dependent is discharged from the hospital.

Health and Dental coverage for a newborn child will begin at birth or the date dependent coverage would otherwise begin, whichever is later.

What changes to report to your employer

You must report the following changes immediately to your employer:

- changes in dependent coverage;
- adding or removing a dependent;
- change of spouse;
- change to your coverage;
- change of name;
- change of beneficiary, or
- change of banking information (if we are depositing your claim expenses directly into your bank account).

You report these changes by filling out the appropriate form that is available from your employer. You must sign and date all forms.

Any resulting change in your coverage will take effect on the date the above changes occur. You must be actively working for any increase in coverage to take effect.

When your coverage ends

This section applies to all benefits. Any additional terms that apply to a particular benefit have been included in that benefit section.

Your coverage ends

Your coverage will end on the earliest of the following dates:

- the date you no longer satisfy the definition of employee;
- the date you become a full-time member of the armed forces.

If you are absent from work due to a temporary lay-off, coverage may be continued until the last day of the month that follows the month the lay-off began unless the temporary lay-off is due to the end of the school year in which case coverage will continue until the beginning of the following school year.

Your dependent coverage ends

A dependent's coverage will end on the earliest of the following dates:

- the date your coverage ends;
- the date your dependent no longer satisfies the definition of dependent.

Beneficiary designation

You may make, alter or revoke a designation of beneficiary as permitted by law. You should review any beneficiary designation made under this policy from time to time to ensure that it reflects your current intentions. You may change the designation by completing a form available from your employer.

Medical examinations and autopsies

When you apply for coverage, we may ask for a medical examination by a physician of our choice, depending on the medical condition or the amount of coverage applied for. We will pay for this examination.

You will have to pay for this examination if the application is completed more than 31 days after the end of the waiting period for coverage.

When you submit a claim for payment, we may ask the covered person to have medical examinations by physicians of our choice. We will pay for these examinations. We will not make any claim payments if the covered person refuses to have these examinations.

If a death occurs, we can ask for an autopsy to be performed. We will pay for the autopsy.

Recovering damages from a third party

If another person or organization is responsible for causing a disability or a medical or dental condition, we will suspend payments and recover our payments from the amount you recover for loss of income or the medical or dental condition through legal action or an out-of-court settlement as we are entitled in law to do. We also reserve the right to recover our payments directly from the person or organization that caused the disability or condition. You shall co-operate with us in our attempt to recover our payments, including participation in a lawsuit. You must notify us of any planned legal action and when payments are received.

Incontestability

If a loss or disability occurs within the first two years of coverage or increased coverage, we will void coverage retroactive to the effective date of coverage or increased coverage, if the covered person made any false statements or withheld any information on the enrolment form, evidence of good health form or in any written statement.

If a loss or disability occurs two or more years after coverage begins or increases, we will void coverage retroactive to the effective date of coverage or increased coverage, if the covered person fraudulently either made any false statements or withheld any information on the enrolment form, evidence of good health form or in any written statement.

We can end coverage at any time if the covered person made any false statement about age.

Your Health Care coverage

What is Your Health Care coverage

We will pay for the usual cost of covered services and supplies that are medically necessary to treat an illness, injury or pregnancy.

We will only cover:

- The amount that is usually charged for the service or supplies in the area in which the charge is made.
- Services and supplies that are needed to diagnose or treat an illness, injury or pregnancy and that are recognized by the Canadian Medical Association as effective and appropriate and based on accepted standards of Canadian health care.
- Services and supplies that we are legally allowed by the government to cover. We will not cover any portion of services or supplies which the insured person is entitled to receive, or for which the insured person is entitled to a benefit or reimbursement, by law or under a plan that is legislated, funded, or administered in whole or in part by a government ("government plan"), without regard to whether coverage would have otherwise been available under this plan. In this limitation, government plan does not include a group plan for government employees.
- Charges for services and supplies that are incurred while the person is insured.

The coverage includes the following. Details of coverage can be found under "What you are covered for":

- Drugs
- Hospital accommodation
- Laser eye surgery, eye examinations, eyeglasses or contact lenses
- Medical services and equipment
- Paramedical services
- Referrals for medical treatment outside the insured person's home province
- Emergency out-of-province/country treatment

How much we will pay

We will pay a percentage of the covered medical costs, up to any maximum amounts stated in the description of the benefit. Before we pay a benefit under this coverage, you must pay the deductible amount if any.

The deductible is $25, each calendar year, unless otherwise shown below.

The following is an overview of what we will pay. Please see the "What you are covered for" section for specific details.

For covered drugs purchased in Quebec, 80% of the covered costs after the deductible is paid.

For covered drugs purchased outside Quebec:

- covered drugs purchased from Costco Wholesale Canada Ltd. or one of its affiliates using the drug card, 90% of the covered costs after the deductible is paid.
- covered drugs subject to Prior Authorization or Health Case Management and purchased from a provider designated by us (whether or not the insured person used the drug card), 90% of the covered costs after the deductible is paid.
- covered drugs purchased from another source or covered drugs purchased without the drug card, 80% of the covered costs after the deductible is paid.

For hospital expenses, 80% of the difference between the cost of a ward and a semi-private room in a hospital after the deductible is paid.

For laser eye surgery, eyeglasses and contact lenses, 80% of the covered costs up to $250 and $65 for eye examinations in any two consecutive calendar year period for an insured person age 21 and over and every calendar year for an insured person under age 21 after the deductible is paid.

For emergency out-of-province/country, 100% of the covered costs above the insured person's provincial health plan coverage with no deductible.

For all other expenses, 80% of the covered costs after the deductible is paid.

When your Health Care coverage ends

Please see "When your coverage ends" in the “General Terms” section for additional terms that apply to when your coverage ends.

Coverage for surviving dependents

If you die, Health Care coverage for your dependents may continue until your spouse remarries or until the second anniversary of your death, whichever is earlier.

If the insured person is totally disabled when your employment ends

Coverage will be continued for you or your dependent who is totally disabled on the date it would otherwise end because you are no longer employed. We will continue to pay covered costs that result from the total disability for 90 days, while the policy is in force.

For Health Care coverage, you are totally disabled while unable to perform the essential duties of any occupation for which you are reasonably suited by education, training or experience, for any employer.

For Health Care coverage, a dependent is totally disabled while:

- unable to perform the normal activities of a person of the same age and sex, and
- receiving treatment from a physician because of illness or injury.

What you are covered for

Drugs

We cover the cost of drugs that can only be obtained with a prescription and are prescribed by a person entitled by law to prescribe them and dispensed by a person entitled by law to dispense them. We will only pay for eligible drugs that are approved by the Canadian government for sale to the general public and that have a Drug Identification Number (DIN). This does not include experimental drugs. We also cover some life-supporting, non-prescription drugs approved by us as well as disposable needles, syringes, lancets and testing materials for monitoring diabetes.

We cover up to a 100 day supply for all drugs.

An insured person can use the drug card to purchase eligible drugs. Use of the drug card authorizes us, or our authorized agent, to inform pharmacists and physicians on patient safety issues for the insured person. We, or our authorized agent, are not legally liable for this information.

Use of the drug card authorizes us, or our authorized agent, to inform pharmacists and physicians on patient safety issues for the insured person. We, or our authorized agent, are not legally liable for this information.

You are responsible for the payment of all charges at the time of purchase. We will reimburse you on the earlier of the date (i) 30 days from the date of purchase and (ii) the date the covered drug costs are $75 or more.

A physician, dentist, clinic, hospital, or some pharmacies may not be able to process a claim using the insured person's card, but you can make a claim for the cost of eligible medicines by using a claim form and including the receipts. A receipt must show the prescription number and the name of the drug or Drug Identification Number (DIN).

If an insured person's drug card is lost or stolen, it must be reported immediately to the employer.

We will not pay for the following:

- alcohol
- bandages
- contraception, other than contraceptive drugs and products containing a contraceptive drug which are *not* used for contraception
- drugs used as abortifacients
- cosmetic items
- hair growth stimulants
- sunscreens
- cotton
- vitamins (except injectible), minerals, dietary supplements
- food substitutes, infant food or formula
- disinfectants
- fertility drugs
- homeopathic medicines
- immunizations and vaccines
- non-disposable insulin injectors
- products used to quit smoking
- spring loaded devices used to hold lancets
- products used to lose weight

Hospital accommodation

We will cover the difference between the cost of a ward and a semi-private room in a hospital. Room charges for outpatients will not be covered. The hospital stay must be because of illness, injury or pregnancy.

A hospital is a facility that is licensed to provide active, convalescent or chronic care treatment for sick or injured patients. It does not include nursing homes, homes for the aged, rest homes or any other facility that provides similar care.

Laser eye surgery, eye examinations, eyeglasses or contact lenses

We will cover the cost of laser eye surgery, contact lenses or eyeglasses, including sunglasses or safety glasses, prescribed by an ophthalmologist or optometrist, if they are prescribed to correct vision. We will pay up to the maximum amount shown in the "How much we will pay" section.

We will cover the cost of one eye examination (including eye refractions)

- every calendar year for an insured person under age 21, or
- every two calendar years for an insured person age 21 or over.

We will pay 50% of the cost of:

- visual training
- remedial exercises.

When you make a claim, make sure that the receipt includes the name of the person who was prescribed the eyeglasses or contact lenses, as well as the date on which they were received. Receipts for deposits are not acceptable. If you have a receipt for a deposit, send it along with the receipt for the balance when you make a claim.

Preferred Vision Services (PVS) Discount

Preferred Vision Services (PVS) is a service provided by Great-West Life to its customers through PVS which is a preferred provider network company.

PVS entitles you to a discount on a wide selection of quality eyewear and lens extras (scratch guarding, tints, etc.) when you purchase these items from a PVS network optician or optometrist. A discount on laser eye surgery can be obtained through an organization that is part of the PVS network.

PVS also entitles you to a discount on hearing aids (batteries, tubing, ear molds, etc.) when you purchase these items from a PVS network.

You can use the PVS network as often as you wish for yourself and your dependents.

Using PVS:

- Call the **PVS Information Hotline** at **1-800-668-6444** or visit the **PVS Web site** at **www.pvs.ca** for information about PVS locations and the program

- Arrange for a fitting, an eye examination, a hearing assessment or a hearing aid, if needed

- Present your group benefit plan identification card, to identify your preferred status as a PVS member through Great-West Life, at the time the eyewear or the hearing aid is purchased, or at the initial consultation for laser eye surgery

- Pay the reduced PVS price. If you have vision care coverage or hearing aids coverage for the product or service, obtain a receipt and submit it with a claim form to your insurance carrier in the usual manner.

Medical services and equipment

We will cover the cost of the following services and supplies if they are prescribed by a physician:

- services provided by a professional nurse. We must approve the services before we will cover the cost. These services must be provided in the insured person's home by a professional nurse who does not normally live with, is not related to, nor is a member of the insured person's immediate family.

  We will pay up to $10,000 per calendar year until the insured person reaches age 65. After age 65, we will pay up to $10,000 per calendar year with a lifetime maximum of $25,000. This change to a lifetime maximum takes place on the January 1st following the 65th birthday. If the birthday is January 1st, this $25,000 lifetime maximum begins on the 65th birthday.

  We will not cover the cost of a professional nurse if the care they provide is not the skilled duties that only they can provide. We will also not cover the cost of care from a professional nurse that is provided in a nursing home, rest home, home for the aged, hospital, or any facility that provides similar care.

  A professional nurse is a Registered Nurse or a Licensed Practical Nurse. If the insured person lives in Ontario, a professional nurse is a Registered Nurse or a Registered Practical Nurse.

- out-patient services and supplies from a hospital in the insured person's home province or from a surgical supply company.

- walkers, braces, artificial limbs and eyes, and other prosthetic devices that we approve. As the cost of these items varies greatly, we recommend that you contact us before purchasing a device. We will ask you for the written information that we require to determine how much of the cost we will cover based on the least expensive device that is medically adequate and, once it is provided, we will advise you of the amount we will cover.

- crutches and canes.

- initial pair of frames and one corrective lens, contact lens or prosthetic lens prescribed after cataract surgery and only for the eye that had the surgery. We will cover once per eye in the insured person's lifetime.

- breast prosthesis after a mastectomy, including replacement(s) every two calendar years, and two surgical bras in a calendar year.

- oxygen.

- custom-made orthopaedic shoes, prescribed by a physician, podiatrist or chiropodist, when no other method such as orthotics and/or off-the-shelf orthopaedic shoes can correct the problem. We will cover one pair each calendar year. We will not cover modifications to shoes.

- foot orthotics prescribed by a physician, podiatrist, or chiropodist, 2 pairs per two calendar years for an insured who is a dependent child under 19 years of age and 1 pair per two calendar years for all other insured. They must be determined as being necessary by a biomechanical examination and be custom-made. They must be required to carry out regular daily living activities, and not just for sports or recreation. We will pay up to $300 in any two calendar years.

- two pairs of surgical stockings each calendar year.

- wigs, up to $100 in the insured person's lifetime following chemotherapy or radiation treatment, and up to $250 in the insured person's lifetime for total hair loss from alopecia totalis, a medical condition where all of the hair is lost.

- certain diagnostic tests, radium treatments and x-rays performed in the insured person's province of residence when coverage is not available under the provincial government.

- services directly provided by a speech therapist. The speech therapist must be registered in the province where the service is given and cannot be a person who normally lives with the insured person nor be a person related to nor a member of the insured person's immediate family. We will pay up to $1,000 per insured person in a calendar year.

- services directly provided by a clinical psychologist. The psychologist must be registered in the province where the service is given and cannot be a person who normally lives with the insured person nor be a person related to nor a member of the insured person's immediate family. We will pay up to $1,000 per insured person in a calendar year.

- hearing aids and repairs, not including batteries. We will pay up to $500 in any period of four consecutive calendar years.

- rental charges for wheelchairs, hospital beds and other temporary therapeutic equipment that we approve. We may cover the cost of purchasing this equipment if we determine that it is more economical than renting. We must approve the purchase before it is made. We will pay for the least expensive device that is medically adequate.

The following is a list of examples of items that we will cover if prescribed by a physician and approved by us:

- aerochambers
- apnea monitor
- casts
- ostomy supplies
- compressors
- blood glucose monitor
- grab bars
- Mozes detector
- nebulizers to administer asthma medication
- oxygen equipment and
- T.E.N.S. machine (for chronic pain)

The following is a list of examples of items that we will not cover even if prescribed by a physician:

- air conditioners or purifiers
- blood pressure kits
- breast pumps
- Craftmatic, Ultramatic or other lifestyle beds
- exercise equipment, machines or programs
- home or car modifications (for example, ramps or lifts)
- humidifiers
- mattresses (except for standard mattresses with approved hospital beds)
- Obus Formes or orthopaedic pillows

Ambulance services

We will cover the cost of a licensed ambulance or other emergency service that transports the insured person to and from the nearest hospital that is able to give the necessary treatment. This covers travel between hospitals. If transportation is not provided by a licensed ambulance, we may also cover the cost of a person accompanying the insured person, if it is medically necessary.

Dental accident

If healthy, natural teeth are damaged or lost due to a sudden impact, we will cover the cost of the dental services required to repair or replace the teeth if the impact that caused the damage or loss happened while the insured person is covered under this provision. This does not include damage or loss caused by objects or food placed in the mouth.

The amount we will pay is based on the least expensive treatment that is adequate to correct the damage. We will not cover more than the fee stated in the current Dental Association General Practitioner's Fee Guide. This treatment must be completed within 12 months of the impact. If treatment is scheduled to occur more than 90 days after the impact, we must be given a treatment plan before the end of the 90-day period.

Orthodontic care must be for relocating teeth that are accidentally forced out of position or for splinting damaged teeth for stability. Dental procedures to correct existing crossbites, alignment of rotated teeth, closing of spaces, and uprighting teeth are not covered. Implants and treatment related to implants are also not covered.

Paramedical services

We will pay up to $500 in a calendar year for the services of each of the following:

- acupuncturists
- chiropodists or podiatrists
- chiropractors
- massage therapists
- naturopaths
- osteopaths
- physiotherapists

Costs for speech therapists and clinical psychologists are included in Health Care coverage. For details, please look under “Medical services and equipment.”

We will cover up to the usual charge for each service, up to the maximum charge set in the Schedule of Fees for the type of paramedical practitioner providing the service. If there is no Schedule of Fees, we will set a fee for the service.

We will cover the cost of laboratory tests and x-rays recommended by a licensed chiropractor, osteopath or podiatrist.

Where provincial registration exists, the paramedical practitioner must be registered in the province where the service is given, and the paramedical practitioner cannot be a person who normally lives with the insured person nor be a person related to nor a member of the insured person's immediate family.

Other Services and Supplies

We can, on such terms as we determine, cover services and supplies under this plan where the service or supply represents reasonable treatment.

Referrals for treatment outside your home province

If a physician in the insured person's home province gives a written referral for treatment that is not performed in that home province, we will cover the cost of the treatment as specified below, if it is provided in Canada or the United States.

The physician must give us full details of the treatment and we must approve it in advance. The insured person must apply and provide us with a statement from the provincial health plan that describes what it will cover.

We will pay up to $10,000 in the insured person's lifetime for the following:

- hospital room and board at the ward rate
- hospital services and supplies, and
- diagnosis and treatment by physicians

Emergency out-of-province/country coverage

The insured person must be eligible for benefits under a government health plan in Canada to qualify for emergency out-of-province/country coverage.

We will cover the cost of emergency treatment, described below, that is required while temporarily outside the home province, (including outside Canada) on business or vacation. We will not cover emergency treatment while travelling for health reasons. An emergency means any sudden, unexpected illness or injury which requires immediate treatment. We will pay up to $1,000,000 for each insured person for all the covered costs related to any one emergency under this emergency out-of-province/country coverage. When emergency treatment for a condition is completed, any ongoing treatment related to that condition is not covered.

If you are on an approved leave of absence, we will only cover the first 30 days of a trip, and we will pay up to $10,000 per year for each insured person. This limitation is not applicable to in-Canada emergency health care benefits.

Travelling outside Canada while pregnant: We will not cover any pregnancy related costs which are incurred outside of Canada within nine weeks of the expected delivery date. Costs associated with a child born outside Canada within nine weeks of the expected delivery date, or after the expected delivery date, are not covered.

When used under this emergency out-of-province/country section, hospital means a facility licensed to provide emergency treatment for sick or injured patients. It must have facilities for diagnosis and treatment. Physicians and registered nurses must be in attendance 24 hours a day. It does not include nursing homes, homes for the aged, rest homes, convalescent care facilities or any facility that provides similar care.

We will cover the charges for emergency treatment that are over the amount covered by the provincial health plan of the insured person's home province. This coverage includes the cost of:

- hospital room and board at the ward rate
- hospital services and supplies, and
- treatment by licensed physicians

In emergency out-of-province/country situations, other charges included under the Health Care coverage section of this policy are covered to the same extent that they would be in Canada. This includes coverage such as wheelchair rental, crutches and prescription drugs.

In the event of a medical emergency, you or someone acting on your behalf must contact the Travel Assistance Centre prior to seeking medical treatment. If it is not reasonably possible for you to contact the Travel Assistance Centre prior to seeking medical treatment due to the nature of the medical emergency, you must contact the Travel Assistance Centre as soon as possible. Failure to contact the Travel Assistance Centre as described will result in a reduction of benefits in the case of hospitalization of 40% of eligible costs. All costs for such emergency will be limited to your emergency out-of-province/country coverage maximum or $25,000, whichever is less.

If a physician or the Travel Assistance provider recommends you or your dependents be moved to a different facility at the destination, and you choose not to go, eligible costs for emergency coverage will in the case of hospitalization be reduced by 40% of eligible costs. All costs for such emergency will be limited to your emergency out-of-province/country coverage maximum or $25,000, whichever is less.

If a physician or the Travel Assistance provider recommends you or your dependent return to your home province, and you choose not to go, emergency coverage will end.

What is not covered for Emergency out-of-province/country treatment

We will not pay for any costs resulting directly or indirectly:

(a) from an accident occurring while you or your dependent was operating a vehicle, vessel or aircraft, if you or your dependent :
    i) were impaired by drugs or alcohol, or
    ii) had a blood alcohol level higher than 80 milligrams of alcohol per 100 millilitres of blood.
(b) from the abuse of illegal substances.

Please see "What you are not covered for under any Health Care coverage" section for additional terms that apply to emergency out-of-province/country and the Health Care coverage.

How to make an out-of-province/country claim

There are special rules for claiming the costs of emergency treatment outside of your home province or Canada.

For all medical expenses, complete the applicable forms, making sure all required information is included. Attach all initial receipts and forward to Great-West Life after the expense is incurred. This will enable Great-West Life to co-ordinate payment directly with the hospital and/or medical provider involved, providing the insured person gives approval to Great-West Life to co-ordinate payment with the Provincial Health Care plan. It is very important that you send your claims to the Great-West Life Out-of-Country Claims Department immediately as your Provincial Health Care Plan has very strict time limitations.

If a medical provider or hospital bills you directly, send the bill along with your claim form to Great-West Life Out-of-Country Claims Department.

What you are not covered for under any Health Care coverage

We can decline a claim for services or supplies that were purchased from a provider that is not approved by us.

We can limit the covered expense for a service or supply to that of a lower cost alternative service or supply that represents reasonable treatment.

We will not pay for the cost of:

- services or supplies associated with a covered service or supply, unless specifically listed as a covered service or supply determined by us to be a covered service or supply
- health care services or supplies that the insured person is eligible to claim under Workers' Compensation legislation in the insured person's province of residence
- health care services or supplies required due to intentionally self-inflicted injury
- health care services or supplies required as the result of war, rebellion, or hostilities of any kind, whether or not the insured person is a participant
- health care services or supplies required as the result of participation in a riot or civil disturbance
- health care services or supplies due to committing a criminal offence or provoking an assault
- services required by a court, the insured person's employer, a school or anyone other than the insured person's physician (For example, the insured person's employer requiring a doctor's note or a court requiring that the insured person receive psychological services.)
- drugs administered during treatment in an emergency room of a hospital, or as an in-patient in a hospital

Prior Authorization

In order to determine whether coverage is provided for certain services and supplies, we will maintain a limited list of services or supplies that require prior authorization.

These services and supplies, including a listing of the prior authorization drugs, can be found on the Great-West Life website as follows:
http://greatwestlife.com/001/Client_Services/Group_Plan_Members/Forms/Prior_Authorizations_Forms/index.htm

Prior authorization is intended to help ensure that a service or supply represents reasonable treatment.

If the use of a lower cost alternative service or supply represents reasonable treatment, an insured person may be required to provide medical evidence why the lower cost alternative service or supply cannot be used before coverage may be provided for the service or supply.

Health Case Management

If you or one of your dependents apply for prior authorization of certain supplies or services, Great-West Life may contact you to participate in health case management. Health case management is a program recommended or approved by Great-West Life that may include but is not limited to:

- consultation with you or your dependent and the attending physician to gain understanding of the treatment plan recommended by the attending physician;
- comparison with the attending physician, of the recommended treatment plan with alternatives, if any, that represent reasonable treatment;
- identification to the attending physician of opportunities for education and support; and
- monitoring your or your dependent’s adherence to the treatment plan recommended by the attending physician.

In determining whether to implement health case management, Great-West Life may assess such factors as the service or supply, the medical condition, and the existence of generally accepted medical guidelines for objectively measuring medical effectiveness of the treatment plan recommended by the attending physician.

Health Case Management Limitation

Great-West Life can, on such terms as it determines, limit the payment of benefits for a service or supply where:

- Great West Life has implemented health case management and you or your dependent do not participate or cooperate; or
- you or your dependent have not adhered to the treatment plan recommended by the attending physician with respect to the use of the service or supply.

Health Case Management Expense Benefit

Expenses associated with health case management may be paid for by Great-West Life at its discretion. Expenses claimed under this provision must be pre-authorized by Great-West Life.

Designated Provider Limitation

For a service or supply to which prior authorization applies or where we have recommended or approved Health Case Management, we can require that a new service or supply be purchased from or administered by a provider designated by us, and:

- limit the covered expenses for a service or supply that was not purchased from or administered by a provider designated by us to the cost of the service or supply had it been purchased from or administered by the provider designated by us; or
- decline a claim for a service or supply that was not purchased from or administered by a provider designated by us.

Patient Assistance Program

A patient assistance program may provide financial, educational or other assistance to you or your dependents with respect to certain services or supplies.

If you or your dependents are eligible for a patient assistance program, Great-West Life may require you or your dependents to apply to and participate in such a program. Where financial assistance is available from a patient assistance program that Great-West Life requires participation in, Great-West Life will reduce the amount of a covered expense for a service or supply by the amount of financial assistance you or your dependent are entitled to receive for that service or supply.

Co-ordination of benefits with your spouse's plan

Co-ordination with your spouse's plan is one of the advantages of the group policy. It may allow you to receive up to 100% of Health Care costs. First, you must have family coverage that includes Health Care coverage and have an eligible spouse and/or children. Second, your spouse must have the same type of coverage where they work.

Here are the procedures to follow:

Claiming your expenses

If you are claiming your expenses, the claim must be sent to us first. We will pay for the portion of the claim that is covered by us and send you an explanation of payment. Your spouse can then send a copy of the explanation and a copy of the receipts, along with a claim for the unpaid portion, to their group plan.

Claiming your spouse's expenses

If you are claiming your spouse's expenses, a claim must be sent to your spouse's plan first. Your spouse's plan will pay for the portion of the claim that is covered by them and send your spouse an explanation of payment. You can then send a copy of the explanation and a copy of the receipts, along with a claim for the unpaid portion, to us.

Claiming your child's expenses

If you are claiming expenses for your child, you must first claim from the plan of the parent with the earliest birthday (month and day) in the calendar year. For example, if your birthday is May 19th and your spouse's birthday is June 11th, your child will claim under your plan first. Then, the claim for the unpaid portion should be sent to your spouse's plan along with a copy of the explanation of payment and a copy of the receipts.

If you are separated or divorced, claims for your child's benefit must be co-ordinated based on the standard industry guidelines.

Submitting a claim

Claims for prescription drugs, paramedical services and visioncare may be submitted online. To use the online service you will need to be registered for GroupNet for Plan Members and signed up for direct deposit of claim payments with eDetails. For online claim submissions, your Explanation of Benefits will only be available online.

You must retain your receipt for 12 months from the date you submit your claim to Great-West Life as a record of the transaction, and you must submit it to Great-West Life on request.

For claims not submitted online, access GroupNet for Plan Members to obtain a personalized claim form or obtain a copy of the claim form that is available from your employer. Complete this form making sure it shows all the required information.

Make sure that your receipts include:

- the name of the person who received the service or supply
- the date the service or supply was received
- the type of service or supply and
- the cost

Your Dental coverage

What is Your Dental coverage

We pay for the covered dental care charges that are incurred while the person is covered and care was provided by a licensed dentist, denturist, dental hygienist entitled by law to practice independently, anaesthetist or specialist. When we use the term “dentist” in this provision, we intend it to include all of the above.

How much we will pay

The amount we will pay is based on the current Dental Association Fee Guide for General Practitioners or Dental Hygienist Fee Guide.

We base coverage on the cost of the least expensive treatment that could be used to treat or prevent the dental problem. If the cost of the dental work given is more than the cost of the least expensive treatment, we will only cover the cost of the least expensive treatment.

We will pay a percentage of the covered dental costs, up to any maximum amounts stated in the description of the benefit. Before we pay a benefit under this coverage, you must pay the deductible amount if any.

There is no deductible for covered dental costs.

The following is an overview of what we will pay. Please see the "What you are covered for" section for specific details.

Preventive coverage

100% of Preventive covered costs with no deductible.

Maintenance coverage

100% of Maintenance covered costs with no deductible.

The maximum we will pay for Preventive and Maintenance covered costs combined is unlimited.

Limitation

If you enrol more than 31 days after the end of the waiting period for coverage, the maximum amount payable to you for charges incurred during the first twelve months of coverage will be $250. The full coverage offered under this Dental coverage provision will begin after twelve months.

If you enrol for family coverage more than 31 days after the end of the waiting period for coverage or more than 31 days after first acquiring a dependent, the maximum amount payable for each dependent for charges incurred during the first twelve months of coverage will be $250. The full coverage offered under this Dental coverage provision will begin after twelve months.

Please refer to the “General Terms” section for details on the waiting period for coverage and enrolment procedures.

When your Dental coverage ends

Please see "When your coverage ends" in the “General Terms” section for additional terms that apply when your coverage ends.

Coverage for your surviving dependents

If you die, dental coverage for your dependents may continue until your spouse remarries or until the second anniversary of your death, whichever is earlier.

When your Dental treatment will cost more than $500

If the cost of any dental treatment will be more than $500, we recommend that you send us a "pre-determination" before the treatment is started. A pre-determination is a report describing the proposed treatment and cost. We will determine how much of the treatment is covered and give a written estimate of how much the covered person will be responsible to pay before the treatment begins.

We may also need the following information:

- a fully completed written estimate; and
- pre-operative x-rays, study models, and laboratory reports.

If we ask for the above information, we cannot process the pre-determination or pay any claim until we receive it.

What you are covered for

Dental coverage is made up of various types of coverage. We have included detailed descriptions of each type below.

Preventive coverage

These are procedures used to treat or help prevent basic dental problems. Some of the procedures are examinations, x-rays, fluoride treatment and fillings.

1. Examinations

A. Initial or Complete Examinations

A complete examination includes examination and charting of the teeth, gums and underlying bone, pulp vitality tests, recording the history of the patient's dental work and planning a treatment.

One complete examination is covered per lifetime, once per general practitioner.

B. Recall Examinations

A recall examination includes a complete examination of the teeth, gums and underlying bone, pulp vitality tests, checking occlusion and consulting with the patient.

One recall examination is covered every six months.

C. Specific Examinations

A specific examination may include an examination of the teeth or a specific tooth, gums and underlying bone, pulp vitality tests and checking occlusion.

One specific examination is covered once every six months.

D. Emergency Examinations

An emergency examination includes checking for pain or infection and pulp vitality tests.

E. Consultation

This is a visit to the covered person's dentist to discuss a serious dental problem and to agree on a treatment plan and is covered for up to $50 per consultation.

2. X-rays

A. Full Mouth Series X-rays

Full mouth x-rays are a series of at least 16 films including bitewings. One series is covered every 36 months.

B. Panorex X-rays

A panorex is one view of the entire mouth and is covered once every calendar year.

C. Periapical X-rays

Periapical x-rays are x-rays of single teeth. These are limited to the maximum amount payable for 13 films per covered person per calendar year.

D. Bitewing X-rays

A bitewing x-ray is used to detect decay in molar teeth. One set of bitewing x-rays are covered every 6 months.

E. Bite X-rays

Bite x-rays are x-rays of the chewing surface of the teeth. These x-rays show the fit between the upper and lower teeth when they are in contact. There is no limit to the number of bite x-rays the covered person is covered for.

3. Tests

A. Biopsy of Oral Tissue

A biopsy occurs when a small piece of tissue is removed and sent to a laboratory to be tested for disease. There are no limits.

B. Pulp Vitality Test

The pulp is the soft tissue inside a tooth. This test is performed to see if the pulp is healthy. One pulp vitality test per tooth is covered if the test is done more than 30 days prior to a root canal therapy.

4. Unmounted Study Models

These are diagnostic casts or models of the upper and lower teeth, each separate from the other. These are used for diagnostic ability or for construction of impression trays and temporary bridges and partial denture. These are limited to one set per calendar year.

5. Cavity Prevention

A. Polishing or Cleaning Teeth

One unit (15 minutes) is covered each visit and up to one treatment every six months.

B. Recall Scaling

One unit (15 minutes) is covered each visit and up to one visit every six months as part of the Recall Package. (For periodontal scaling, please see the "Treatment of gums" section.)

C. Fluoride

Fluoride is a substance which is applied to the teeth to strengthen the enamel and prevent decay in primary and permanent teeth. The covered person is covered for one treatment every six months.

D. Recall Package

Recall Package includes polishing, recall scaling and recall examinations. It may also include fluoride and is covered once every six months.

E. Pit and Fissure Sealants

This is a coating put on top of any pits or cracks in teeth to prevent cavities from forming. There is no limit to the number of treatments the covered person is covered for.

6. Space Maintainers

A. Space Maintainers

A space maintainer is an appliance that a dentist uses to maintain a space where a tooth has been removed.

B. Maintenance of space maintainers

Maintenance of a space maintainer means adjusting, recementing or repairing an appliance used to maintain a space where a tooth has been removed.

7. Fillings

Please note: These procedures may include local anaesthesia, removal of decay, pulp protection (a sedative used to protect the nerve) and bite adjustment (work done to make sure that the fit between the top and bottom teeth is correct). The cost of finishing or polishing is not covered.

All restoration done to the same tooth will be covered as a single visit to the dentist.

A. Amalgam Fillings

These are silver fillings that are used to restore teeth. If a bonded silver filling is installed, we will only cover the cost of a non-bonded silver filling.

B. Composite Fillings

These are white filling that are used to restore teeth.

C. Veneer Applications

Veneers are white facings put on a tooth's surface. Veneer applications that are done for cosmetic purposes are not covered.

D. Retentive Pins

These are pins used to make sure that a restoration or filling stays in place.

E. Pre-fabricated Posts

These are pre-made posts used for additional support to the tooth after root canal treatment.

F. Sedative Fillings for Caries, Trauma and Pain Control

Caries result from tooth decay. Trauma means a blow to the mouth or teeth resulting in injury. Severe wear may be considered a traumatic injury. Pain control includes temporary fillings and local anaesthesia to reduce pain before a permanent filling is installed.

Sedative fillings that are applied to reduce pain are covered. This procedure includes local anaesthesia, removal of decay and/or removal of existing restoration, bite adjustment (treatment to make sure that the fit between the top and bottom teeth is correct), pulp cap (a sedative placed on an exposed nerve to reduce pain and prevent infection) and placement of a sedative filling (a sedative placed under a filling to reduce pain).

G. Stainless Steel, Plastic and Polycarbonate Caps

This is a cap that is installed to cover the whole tooth or teeth. These are limited to once in 5 years.

8. Bite Adjustment/Equilibration

This is a procedure to correct the bite problem between the upper and lower teeth when they are in contact. Bite adjustments are covered for up to eight units every calendar year.

9. Minor Oral Surgery

Please note: These procedures may include local anaesthesia, appropriate x-rays, surgery and follow-up care.

A. Extractions

Extraction means removing a tooth, including an impacted tooth. There is no limit to the number of extractions per visit.

B. Residual Root Removal

Residual root removal means removing tooth roots left behind when a tooth is extracted. One root removal is covered per tooth in a lifetime.

What you are not covered for

We will not pay for:

- dental services or supplies that the covered person is eligible to claim under the Workers' Compensation legislation
- any dental charges not included in the current Dental Association Fee Guide for General Practitioners or Dental Hygienist Fee Guide
- cosmetic procedures
- charges for appointments that are not kept
- charges for completing claim forms
- treatment to correct temporomandibular joint dysfunction (The hinge joint of the jaw is called the temporomandibular joint.)
- any endodontic treatment which was started before the effective date of coverage
- the replacement of dental appliances that are lost, misplaced or stolen
- experimental treatment or testing

Co-ordination of benefits with your spouse's plan

Co-ordination with your spouse's plan is one of the advantages of your group policy. It may allow you to receive up to 100% of your Dental costs. First, you must have family coverage that includes Dental coverage and have an eligible spouse and/or children. Second, your spouse must have the same type of coverage where they work.

Here are the procedures to follow:

Claiming your expenses

If you are claiming your expenses, send the claim to us first. We will pay for the portion of the claim that is covered by us and send you an explanation of payment. Your spouse can then send a copy of the explanation and a copy of the receipts, along with a claim for the unpaid portion, to your spouse's group plan.

Claiming your spouse's expenses

If you are claiming your spouse's expenses, send a claim to your spouse's plan first. Your spouse's plan will pay for the portion of the claim that is covered by them and send your spouse an explanation of payment. You can then send a copy of the explanation and a copy of the receipts, along with a claim for the unpaid portion, to us.

Claiming your child's expenses

If you are claiming expenses for your child, you must first claim from the plan of the parent with the earliest birthday (month and day) in the calendar year. For example, if your birthday is May 19th and your spouse's birthday is June 11th, your child will claim under your plan first. Then, the claim for the unpaid portion should be sent to your spouse's plan along with a copy of the explanation of payment and a copy of the receipts.

If you are separated or divorced, claims for your child's benefit must be co-ordinated based on the standard industry guidelines.

Submitting a claim

For claims submitted online, access GroupNet for Plan Members to obtain a personalized claim form or obtain a copy of the claim form that is available from your employer and have your dental service provider complete the form. The completed claim form will contain the information necessary to enter the claim online. To use the online service you will need to be registered for GroupNet for Plan Members and signed up for direct deposit of claim payments with eDetails. For online claim submissions, your Explanation of Benefits will only be available online.

You must retain your receipt for 12 months from the date you submit your claim to Great-West Life as a record of the transaction, and you must submit it to Great-West Life on request.

For claims not submitted online, access GroupNet for Plan Members to obtain a personalized claim form or obtain a copy of the claim form that is available from your employer and have your dental service provider complete the form.

Your employer may have made arrangements to allow your dental service provider to send claims to us electronically. If so, you will not have to fill out a claim form and we will make the payment to the person designated. Once payment has been made, we will send an explanation of our payment.

We will pay benefits to you when we receive satisfactory proof of claim.

We must receive all claims by the earlier of the following dates:

- June 30th of the year following the treatment, or
- 90 days after the date the policy terminates

Your Short Term Disability coverage

In this section, you and your mean the employee.

What is Short Term disability coverage

If you become disabled while insured under this policy and suffer a loss of earnings as a result, you may be eligible for Short Term Disability payments subject to all of the terms of this coverage.

Short Term Disability premiums will not have to be paid while you are receiving Long Term Disability payments under the "Long Term Disability coverage" section of this policy provided this Short Term Disability coverage section remains in force.

What is the definition of disability

When used in this Short Term Disability section, disabled because of disease or injury, there is no combination of dutires you can perform that regularly took at least 60% of your time at work to complete. Disability is assessed on the basis of the duties regularly performed for your employer or any other employer before disability started. The availability of work is not considered when assessing disability.

How much we will pay

66.67% of weekly earnings, rounded to the next dollar, up to a maximum of $2,600 per week.

Proof of insurability must be provided by you and approved by us for any amount of coverage over $2,240 per week.

We will make Short Term Disability payments weekly in arrears.

We will calculate how much we will pay based on all of the following:

- the amount of coverage that is in effect at the start of your continuous period of disability
- less than half of one day will not be considered a day of disability
- the amount of coverage will be based on the lesser of your actual earnings and the level of earnings on which the premium for this coverage was paid
- the amount of the payment is the amount of your coverage reduced by any amount described in the "When we reduce your payments" section

If you are disabled for any part of a week, we will pay 1/5 of the amount of the weekly payment for each full day you are disabled.

A regular work day is any day you are scheduled to work or would be scheduled to work if it were not a holiday or vacation day.

Tax status

Payments are non-taxable.

Waiting period for payments

Accident

If you are disabled by an accident, there will be a waiting period of fourteen consecutive days. When used in this Short Term Disability section, accident means a bodily injury that occurs solely as a direct result of a sudden and unexpected action from an outside source.

Illness or injury

If you are disabled by an illness or injury, there will be a waiting period of fourteen consecutive days.

If you do not see a physician during the waiting period, you will only be eligible for payments from the date you saw a physician.

Start date of disability

Start date of disability means the first regular work day you are unable to work due to the disability.

If you become disabled while on a leave of absence, we will consider the scheduled return-to-work date as the start date of disability. If you have been designated by the employer as working only ten months of the year and become disabled during the period between the end of one school year and the start of another, we will consider the scheduled return-to-work date as the start date of disability. The waiting period for payments begins on that date.

If you become disabled while outside Canada and the United States, we will consider the date you return to Canada or the United States as the start date of disability. The waiting period for payments begins on that date.

When your Short Term Disability payments end

Short Term Disability payments will end on the earliest of the following dates:

- the date you no longer meet the definition of disability
- the date you do not supply us with appropriate medical documentation showing how the illness or injury prevents the performance of the essential duties of your occupation
- the date you engage in work for wages or profit (other than in an approved rehabilitation program)
- the date you have received 15 weeks of weekly payments for a continuous period of disability
- the date the school year ends if you have been designated by the employer as working only ten months of the year. If you continue to be disabled at the beginning of the following school year and have not received 15 weeks of weekly payments, payments will resume.
- the date the employee reaches the end of the Contract Period
- the date you die

When your Short Term Disability coverage ends

Please see "When your coverage ends" in the “General Terms” section for additional terms that apply to when your coverage ends.

What happens if a disability occurs again

If we stop making Short Term Disability payments because you are no longer disabled and you became disabled again within 14 consecutive days due to the same or a related condition, the new period of disability will be considered part of the same continuous period of disability. In such case:

- a new waiting period will not apply
- the payment will be the same as when the first claim ended, and
- payments will not be made beyond the maximum period shown under the “When your Short Term Disability payments end” section

You must re-apply for disability payments by filling out a new claim form.

When we reduce your payments

You may be eligible to apply for and receive benefits from other sources during the disability. For the purpose of any calculations under this provision, we will automatically reduce the disability payments by the full amount of any benefits you are eligible to apply for and receive, before any income tax and/or any other deductions, under:

- any Workers' Compensation Act or similar legislation
- the Canada/Quebec Pension Plan
- to the extent permitted by law, any automobile insurance plan that does not take income benefits under the Employment Insurance Act (Canada) into account when determining benefits

If you receive a lump sum payment from any of the above, we will divide the payment by the number of weeks for which you would have been eligible to receive the benefit and reduce each of our weekly payments by that amount.

If you have not applied for these other benefits, or if your application has not yet been approved, we may estimate the amount you may be eligible to receive and reduce your payments by that amount. If we are notified in writing that your application for these other benefits, or any appeal, has been declined and we determine that this decision should be subject to appeal, you must file an appeal and we may continue to reduce your payments until we are notified in writing that such appeal has been declined.

What you are not covered for

We will not make Short Term Disability payments if a disability results directly or indirectly from:

- self-inflicted injury
- substance abuse unless you are participating in a treatment program approved by us
- war, rebellion or hostilities of any kind whether or not you are a participant
- participation in a riot or a civil disturbance
- committing a criminal offence or provoking an assault
- an accident while you were operating a vehicle, vessel or aircraft, if you
  a) were impaired by drugs or alcohol, or
  b) had a blood alcohol level higher than 80 milligrams of alcohol per 100 millilitres of blood

We will not make Short Term Disability payments if you:

- are on a leave of absence, including maternity/parental leave
- are outside of Canada and the United States, unless we approve the absence
- are working or engaged in any business or occupation for wages or profit
- continue to receive a salary from any employer
- are not under the continuing care of a licensed physician or surgeon
- are not receiving treatment that we consider appropriate
- do not attend an examination by a physician of our choice
- are receiving severance pay, a damages award or other payment due to termination of the employment relationship. If any such payment or award is received in a lump sum, we will stop making Short Term Disability payments for a period equal to the number of weeks the lump sum amount represents relative to your pre-disability earnings

Submitting a claim

We must receive proof of claim within 90 days after the disability began, or 90 days after the plan terminates, whichever occurs earlier.

Life coverage

Your Life coverage

In this section, you and your mean the employee.

What is Your Life coverage

If you die while covered under the policy, we will pay the amount of Employee Life coverage to your named beneficiary. If you have not named a beneficiary or there is no surviving beneficiary at the time of your death, payment will be made to your estate. Your employer will explain the claim requirements to your beneficiary.

How much we will pay

Two times your annual earnings, rounded to the next $1,000, up to a maximum of $400,000. We will base the amount of coverage on your actual annual earnings or the amount of annual earnings that premiums have been paid on, whichever is less.

Reduction

When you reach age 65, the amount of your Employee Life coverage will be reduced by 50%.

When Your Employee Life coverage ends

When you reach age 70.

Please see “When your coverage ends” in the “General Terms” section for additional terms that apply when your coverage ends.

Your Employee Optional Life coverage

What is Employee Optional Life coverage

If you die while covered under this policy and you have chosen Employee Optional Life coverage, we will pay the amount of Employee Optional Life coverage to your named beneficiary. If you have not named a beneficiary or there is no surviving beneficiary at the time of your death, payment will be made to your estate. Your employer will explain the claim requirements to your beneficiary.

How much we will pay

Multiples of $10,000, as elected by you, to a maximum of $200,000. Proof of insurability must be provided by you and approved by us.

When Your Employee Optional Life coverage ends

When you reach age 65.

Please see "When your coverage ends" in the "General Terms" section for additional terms that apply when your coverage ends.

Additional Information on Life coverage

Waiver of Premium provision

What happens to the premiums if you become totally disabled

When you become disabled, prior to age 65, we will waive the premiums for your Employee Life and/or Employee Optional Life if you have been disabled for 6 continuous months or were disabled at the time of death. Waiving the premium means your amount of coverage that was in effect at the time of disability will continue without payment of premiums.

For the purposes of this coverage disabled means you are unable to perform the essential duties of any occupation for your employer or any other employer for which you are qualified because of education, training or experience.

Your Life coverage will continue under this provision as long as you remain disabled or you reach age 65, whichever occurs earlier.

Termination of the policy will have no effect on your coverage, while premiums are waived.

We must receive proof of disability within twelve months of the start date of your disability. We will require proof of the ongoing disability from time to time. This proof may be medical information from your physicians or a request to be examined by a physician of our choice. If you do not provide the proof of disability within three months of the date we requested it, premiums will no longer be waived.

If you are no longer disabled and you do not return to work with your employer, or you return to work with your employer but the policy has terminated, Life coverage will end. You may have the right to convert your Life coverage. Please refer to the "Converting your Life coverage" section.

Converting Your Life coverage

If you are under age 70 and your Employee Life coverage or your Employee Optional Life coverage under this policy ends for the following reasons:

- your employment ends
- you no longer qualify as an employee
- this policy ends
- your class is no longer covered

you may convert this coverage to individual insurance.

Written application must be made to us accompanied by the first premium within 31 days after coverage ends. This is called the 31-day conversion period. The Individual insurance will not begin until the end of this 31-day conversion period. If you die during the 31-day conversion period, we will pay the maximum amount of insurance you were entitled to apply for.

The premium rate for the individual insurance will be based on:

- the Individual Life and/or Group rates
- the amount of insurance, and
- the age of the person whose life is to be insured on the birthday closest to the date the policy starts.

The individual policy will be one of the standard life insurance conversion policies available by Great-West Life or any of its affiliates.

What you are not covered for

We will not pay any amount of Employee Optional Life coverage, if suicide is committed within two years of the date coverage begins and/or is increased.

Submitting a claim

We will pay benefits to you or your beneficiary when we receive satisfactory proof of claim.

Global Medical Assistance Program

This program provides medical assistance through a worldwide communications network which operates 24 hours a day. The network locates medical services and obtains Great-West Life's approval of covered services, when required as a result of a medical emergency arising while you or your dependent is travelling for vacation, business or education. Coverage for travel within Canada is limited to emergencies arising more than 500 kilometres from home. You must be covered by the government health plan in your home province to be eligible for global medical assistance benefits. The following services are covered, subject to Great-West Life's prior approval:

- On-site hospital payment when required for admission, to a maximum of $1,000

- If suitable local care is not available, medical evacuation to the nearest suitable hospital while travelling in Canada. If travel is outside Canada, transportation will be provided to a hospital in Canada or to the nearest hospital outside Canada equipped to provide treatment

  When services are covered under this provision, they are not covered under other provisions described in this booklet

- Transportation and lodging for one family member joining a patient hospitalized for more than 7 days while travelling alone. Benefits will be paid for moderate quality lodgings up to $1,500 and for a round trip economy class ticket

- If you or a dependent is hospitalized while travelling with a companion, extra costs for moderate quality lodgings for the companion when the return trip is delayed due to your or your dependent’s medical condition, to a maximum of $1,500

- The cost of comparable return transportation home for you or a dependent and one travelling companion if prearranged, prepaid return transportation is missed because you or your dependent is hospitalized. Coverage is provided only when the return fare is not refundable. A rental vehicle is not considered prearranged, prepaid return transportation

- In case of death, preparation and transportation of the deceased home

- Return transportation home for minor children travelling with you or a dependent who are left unaccompanied because of your or your dependent’s hospitalization or death. Return or round trip transportation for an escort for the children is also covered when considered necessary

- Costs of returning your or your dependent's vehicle home or to the nearest rental agency when illness or injury prevents you or your dependent from driving, to a maximum of $1,000. Benefits will not be paid for vehicle return if transportation reimbursement benefits are paid for the cost of comparable return transportation home

Benefits payable for moderate quality accommodation include telephone expenses as well as taxicab and car rental charges. Meal expenses are not covered.

CONTACT - Employee Assistance Program

The Contact employee assistance program provides you and your dependents with access to confidential counselling and information services.

The services provided under the Contact employee assistance program are available by dialing the toll-free number shown below. This toll-free number is staffed 24 hours a day, 7 days a week by intake counsellors who can provide immediate support and counselling, respond to crisis or emergency situations or schedule appointments.

For service in English:	1-800-387-4765
For service in French:	1-800-361-5676

For more information on the services available under the Contact employee assistance program, please see the employee assistance program brochure provided by your plan administrator or visit the employee assistance program: **www.shepellfgi.com**.

Basic Group Critical Illness Insurance Summary
(Underwritten by Industrial Alliance Pacific Insurance and Financial Services Inc. ("IAP") - Policy No. 100005769)

Policy No. 100005769 issued to Catholic Independent Schools of Vancouver Archdiocese (CISVA)

This Summary is designed to outline the benefits for which you are eligible to employees of Catholic Independent Schools of Vancouver Archdiocese ("CISVA") under Group Policy No. 100005769 issued by Industrial Alliance Insurance and Financial Services Inc. ("**the Company**"). In the event of any variation between this document and the provisions of the Group Policy, the latter will prevail. All rights with respect to the benefits of an Insured Employee will be governed solely by the Group Policy which may be amended from time to time.

Plan Description

Covered Condition Benefit

If an Insured Employee is diagnosed by a Specialist with a Covered Condition while his Basic Group Critical Illness Insurance is in force and survives for 30 days following the Date of Diagnosis or such longer period as described in certain Covered Conditions, the Company will pay to such Insured Employee the Benefit Amount in force with respect to such Insured Employee (the "**Covered Condition Benefit**"), subject to the terms and conditions of the Group Policy. The Date of Diagnosis must be later than the effective date or latest reinstatement date of the coverage. If the Insured Employee dies before the approved Covered Condition Benefit is paid, the Covered Condition Benefit will be paid to the estate of such Insured Employee. In the event an Insured Employee receives a simultaneous Diagnosis of multiple Covered Conditions, the Company will pay the Covered Condition Benefit for one Covered Condition only. The Covered Condition for which the Covered Condition Benefit is paid will be the Covered Condition which first appears in the lowest Multiple Event Coverage Benefit grouping (MEC Grouping) shown in the "**Multiple Event Coverage Benefit**" section, starting with MEC Grouping Group 1.

Multiple Event Coverage Benefit

If an Insured Employee receives a Covered Condition Benefit under the Group Policy, and thereafter the Employee is diagnosed with a different Covered Condition in a different Multiple Event Coverage Benefit grouping ("**MEC Grouping**"), the Company will pay to such Insured Employee the Benefit Amount in force with respect to such Insured Employee (the "**Multiple Event Coverage Benefit**"), subject to the terms and conditions of the Group Policy. The Insured Employee must survive for 30 days following the Date of Diagnosis or such longer survival period as described in certain Covered Conditions to qualify for this benefit. If the Insured Employee dies before the approved Multiple Event Coverage Benefit is paid, the Multiple Event Coverage Benefit will be paid to the estate of such Insured Employee.

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

MEC Grouping	**Covered Condition**
Group 1	Cancer (Life-Threatening)
Group 2	Aortic Surgery, Coronary Artery Bypass Surgery, Heart Attack, Heart Valve Replacement or Repair, Stroke
Group 3	Bacterial Meningitis, Benign Brain Tumour, Coma, Dementia including Alzheimer's Disease, Loss of Independent Existence, Loss of Speech, Motor Neuron Disease, Multiple Sclerosis, Paralysis, Parkinson's Disease and Specified Atypical Parkinsonian Disorders, Stroke
Group 4	Aplastic Anemia, Kidney Failure, Major Organ Failure On Waiting List, Major Organ Transplant
Group 5	Blindness
Group 6	Deafness
Group 7	Severe Burns
Group 8	Loss of Limbs
Group 9	Occupational HIV Infection

AdvanceCare Benefit

If an Insured Employee is diagnosed by a Specialist with an AdvanceCare Benefit Condition while his Basic Group Critical Illness Insurance is in force, the Company will pay to such Insured Employee a benefit equivalent to 10% of the Benefit Amount in force with respect to such Insured Employee (the "**AdvanceCare Benefit**"), subject to the terms and conditions of the Group Policy. The Date of Diagnosis must be later than the effective date or latest reinstatement date of the coverage. If the Insured Employee dies before the approved AdvanceCare Benefit is paid, the AdvanceCare Benefit will be paid to the estate of such Insured Employee. The AdvanceCare Benefit is a one-time benefit for which the Company will pay for one AdvanceCare Benefit Condition only. Payment of the AdvanceCare Benefit will not affect the amount of benefit payment under a Covered Condition Benefit or a Multiple Event Coverage Benefit. Basic Group Critical Illness Insurance for an Insured Employee will continue in force during the adjudication of an AdvanceCare Benefit and following the payment of an AdvanceCare Benefit providing premiums continue to be paid as required.

Limitations

An Insured Employee will not be entitled to a Covered Condition Benefit for Cancer (Life-Threatening) if, within 90 days following the issue date of an insured's Basic Group Critical Illness Insurance coverage:

- Such Employee has a diagnosis of Cancer (Life-Threatening), or has any signs, symptoms or investigations leading to the Diagnosis of Cancer (Life-Threatening), regardless of when the Diagnosis is actually made. In the event of any such Diagnosis, the Covered Condition Benefit will not be paid. If the Insured Employee continues to satisfy the Eligibility provisions for coverage under the Policy, Basic Group Critical Illness Insurance will remain in force but Cancer (Life-Threatening) will no longer be considered a Covered Condition for such Employee.

An Insured Employee will not be entitled to a Covered Condition Benefit for Benign Brain Tumour if, within 90 days following the issue date of an insured's Basic Group Critical Illness Insurance coverage:

- Such Employee has a diagnosis of Benign Brain Tumour, or has any signs, symptoms or investigations leading to the Diagnosis of Benign Brain Tumour, regardless of when the diagnosis is made. In the event of any such Diagnosis, the Covered Condition Benefit will not be paid. If the Insured Employee continues to satisfy the Eligibility provisions for coverage under the Policy, Basic Group Critical Illness Insurance will remain in force but Benign Brain Tumour and all other MEC Group 3 Covered Conditions will no longer be considered Covered Conditions for such Employee.

An Insured Employee will not be entitled to an AdvanceCare Benefit for Early Stage Cancer if, within 90 days following the issue date of an insured's Basic Group Critical Illness Insurance coverage:

- Such Employee has a diagnosis of Early Stage Cancer, or has any signs, symptoms or investigations leading to the diagnosis of Early Stage Cancer, regardless of when the Diagnosis is made. In the event of any such Diagnosis, Basic Group Critical Illness Insurance will remain in force but Early Stage Cancer will be removed as an AdvanceCare Benefit Condition for such Employee.

Exclusions

In addition to the exclusions included within the definition of certain Covered Conditions, the following exclusions also apply.

No benefit will be paid if a Covered Condition or AdvanceCare Benefit Condition results directly or indirectly from any one or more of the following:

a) attempted suicide;
b) taking poison or inhaling gas, whether voluntarily or involuntarily, not connected with the employment of the Insured Employee;
c) taking any drug other than as prescribed by a licensed physician;
d) participation in a criminal act or any attempt to commit a criminal offense, including but not limited to operating a motor vehicle while the concentration of alcohol in 100 millilitres of the Insured Employee's blood exceeds 80 milligrams;
e) intentionally self-inflicted injury, while sane or insane.

In addition, no benefit will be paid if the Insured Employee suffers Blindness, Coma, Deafness, Loss of Limb, Paralysis, Severe Burns or Stroke as a result, directly or indirectly, from amateur or professional boxing, bungee jumping, B.A.S.E. jumping, cliff diving, mountain climbing, motor vehicle racing or speed competition on land and/or water, parachuting or underwater activities, including scuba diving and snuba diving.

Policy Definitions

"**AdvanceCare Benefit Conditions**" are medical conditions for which an AdvanceCare Benefit is paid under the Group Policy with respect to an Insured Employee. These are Coronary Angioplasty or Early Stage Cancer as defined in this document.

"**Benefit Amount**" means the amount of Basic Group Critical Illness Insurance for which the Insured Person is covered, as indicated in the Group Insurance Certificate issued to the Employee.

"**Covered Conditions**" with respect to an Insured Employee are Aortic Surgery, Aplastic Anemia, Bacterial Meningitis, Benign Brain Tumour, Blindness, Cancer (Life-Threatening), Coma, Coronary Artery Bypass Surgery, Deafness, Dementia including Alzheimer's Disease, Heart Attack, Heart Valve Replacement or Repair, Kidney Failure, Loss of Independent Existence, Loss of Limbs, Loss of Speech, Major Organ Failure on Waiting List, Major Organ Transplant, Motor Neuron Disease, Multiple Sclerosis, Occupational HIV Infection, Paralysis, Parkinson's Disease and Specified Atypical Parkinsonian Disorders, Severe Burns and Stroke, as defined in the section titled Definitions of Covered Conditions.

"**Date of Diagnosis**" means the date on which a Specialist diagnoses the Insured Person with one of the Covered Conditions or one of the AdvanceCare Benefit Conditions.

"**Diagnosis**" means the certified diagnosis of the Insured Person with a Covered Condition or one of the AdvanceCare Benefit Conditions by a Specialist.

"**Employee**" means an employee as defined in the Group Policy.

"**Insured Employee**" means an Insured Person who is an eligible Employee.

"**Insured Person**" means an Employee who is insured under the Group Policy.

"**Specialist**" means a licensed medical practitioner who

- has been trained in the specific area of medicine relevant to the Covered Condition or AdvanceCare Benefit Condition for which a benefit is being claimed;
- has been certified by a specialty examining board; and
- Is currently practicing in their area of specialty in Canada or the United States of America

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

In the absence or unavailability of a Specialist, and as approved by the Company, a Covered Condition or AdvanceCare Benefit Condition may be diagnosed by a qualified medical practitioner practicing in Canada or the United States of America.

Definitions Of Covered Conditions

Aortic Surgery means the undergoing of surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta means the thoracic and abdominal aorta but not its branches. The Surgery must be determined to be medically necessary by a Specialist.

Exclusion: No benefit will be payable under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

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

- marrow stimulating agents
- immunosuppressive agents
- bone marrow transplantation

The Diagnosis of Aplastic Anemia must be made by a Specialist.

Bacterial Meningitis means a definite Diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least 90 days from the date of Diagnosis.

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 means a definite Diagnosis of a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgical or radiation treatment or cause irreversible objective neurological deficit(s). The Diagnosis of Benign Brain Tumour must be made by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition if, within the first 90 days following the later of the Issue Date of coverage, or the last reinstatement date of coverage, an insured has any of the following:

- signs, symptoms or investigations that lead to a Diagnosis of Benign Brain Tumour (covered or excluded under the Policy), regardless of when the Diagnosis is made; or
- a Diagnosis of Benign Brain Tumour (covered or excluded under the Policy).

Medical Information about the Diagnosis and any signs, symptoms or investigations leading to the Diagnosis must be reported to the Company within 6 months of the Date of Diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for Benign Brain Tumour or any Critical Illness caused by any Benign Brain Tumour or its treatment.

No benefit will be payable under this condition for pituitary adenomas less than 10mm.

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

- the corrected visual acuity being 20/200 or less in both eyes; or,
- the field of vision being less than 20 degrees in both eyes.

The Diagnosis of Blindness must be made by a Specialist.

Cancer (Life-Threatening) means a definite Diagnosis of a tumour, which must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. Types of cancer include carcinoma, melanoma, leukemia, lymphoma, and sarcoma. The Diagnosis of Cancer (Life Threatening) must be made by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition if, within the first 90 days following the later of the Issue Date of coverage, or the last reinstatement date of coverage, the insured has any of the following:

- signs, symptoms or investigations that lead to a Diagnosis of cancer (covered or excluded under the Policy), regardless of when the Diagnosis is made; or
- a Diagnosis of cancer (covered or excluded under the Policy).

Medical Information about the Diagnosis and any signs, symptoms or investigations leading to the Diagnosis must be reported to the Company within 6 months of the Date of Diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for Cancer (Life Threatening) or any Critical Illness caused by any cancer or its treatment.

No benefit will be payable for the following:

- lesions described as benign, pre-malignant, uncertain, borderline, non-invasive, carcinoma in-situ (Tis), or tumours classified as Ta;
- malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- any non-melanoma skin cancer, without lymph node or distant metastasis;
- prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;

- papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis;
- chronic lymphocytic leukemia classified less than Rai stage 1; or
- malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC Stage 2.

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

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

- a medically induced coma; or,
- a coma which results directly from alcohol or drug use; or,
- a diagnosis of brain death.

Coronary Artery Bypass Surgery means the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s). The Surgery must be determined to be medically necessary by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

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

The Diagnosis of Deafness must be made by a Specialist.

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

- aphasia (a disorder of speech)
- aphraxia (difficulty performing familiar tasks);
- agnosia (difficulty recognizing objects); or

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

The Insured Person must exhibit

- Dementia of at least moderate severity, which must be evidenced by a Mini Mental State Exam of 20/30 or less, or equivalent score on another generally medically accepted test or tests of cognitive function; and
- Evidence of progressive worsening in cognitive and daily functioning either by serial cognitive tests or by history over at least a 6 month period.

The Diagnosis of Dementia, including Alzheimer's Disease must be made by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition for affective or schizophrenic disorders, or delirium.

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

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

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

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

- elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty, in the absence of new Q waves, or
    - ECG changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as described above.

Heart Valve Replacement or Repair means the undergoing of Surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities. The Surgery must be determined to be medically necessary by a Specialist.

Exclusion: No benefit will be payable under this Covered Condition for angioplasty, inter-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

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

The Diagnosis of Kidney Failure must be made by a Specialist.

Loss of Independent Existence means a definite Diagnosis of the total inability to perform, by oneself, at least 2 of the following 6 Activities of Daily Living for a continuous period of at least 90 days with no reasonable chance of recovery. The Diagnosis of Loss of Independent Existence must be made by a Specialist.

Activities of Daily Living are:

- bathing – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of assistive devices;
- dressing – the ability to put on and remove necessary clothing, braces, artificial limbs or other surgical appliances with or without the aid of assistive devices;
- toileting – the ability to get on and off the toilet and maintain personal hygiene with or without the aid of assistive devices;
- 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;
- transferring – the ability to move in and out of a bed, chair or wheelchair, with or without the aid of assistive devices; and
- feeding – the ability to consume food or drink that already has been prepared and made available, with or without the use of assistive devices.

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

The Diagnosis of Loss of Limbs must be made by a Specialist.

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

The Diagnosis of Loss of Speech must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for all psychiatric related causes.

Major Organ Failure on Waiting List means a definite Diagnosis of the Irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Failure on Waiting List, the Insured Person must become enrolled as the recipient in a recognized transplant center in Canada or the United States of America that performs the required form of transplant surgery. For the purpose of the survival period, the Date of Diagnosis is the date of the Insured Person's enrolment in the transplant centre. The Diagnosis of the major organ failure must be made by a Specialist.

Major Organ Transplant means a definite Diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow and transplantation must be medically necessary. To qualify under Major Organ Transplant, the Insured Person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities.

The Diagnosis of the major organ failure must be made by a Specialist.

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

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

Multiple Sclerosis means a definite Diagnosis of at least one of the following:

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

The Diagnosis of Multiple Sclerosis must be made by a Specialist.

Occupational HIV Infection means a definite Diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Insured Person's normal occupation, which exposed the person to HIV contaminated body fluids. The accidental injury leading to the infection must have occurred after the effective date of such Insured Person's insurance coverage.

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

- The accidental injury must be reported to the Company within 14 days of the accidental injury;
- A serum HIV test must be taken within 14 days of the accidental injury and the result must be negative;
- A serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;
- All HIV tests must be performed by a duly licensed laboratory in Canada or the United States of America;
- The accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States of America workplace guidelines.

The Diagnosis of Occupational HIV Infection must be made by a Specialist.

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

- the Insured Person has elected not to take any available licensed vaccine offering protection against HIV; or,
- a licensed cure for HIV infection has become available prior to the accidental injury; or
- HIV infection has occurred as a result of non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use.

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

The Diagnosis of Paralysis must be made by a Specialist.

Parkinson's Disease and Specified Atypical Parkinsonian Disorders means a definite Diagnosis of either a) Parkinson's Disease or b) Specified Atypical Parkinsonian Disorders, as defined below.

a) "**Parkinson's Disease**" means a definite Diagnosis of primary Parkinson's disease, a permanent neurological condition which must be characterized by bradykinesia (slowness of movement) and at least one of the following: muscular rigidity or rest tremor. The Insured Person must exhibit objective signs of progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's Disease.
b) "**Specified Atypical Parkinson's Disorders**" means a definite Diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.

The Diagnosis of Parkinson's Disease or a Specified Atypical Parkinsonian Disorder must be made by a Specialist.

Exclusions: No benefit will be payable for Parkinson's Disease or Specified Atypical Parkinsonian Disorders if, within the first year following the later of the Issue Date or the latest reinstatement date of an Insured Person's coverage, such Insured Person has any of the following:

- signs, symptoms or investigations that lead to a Diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism, regardless of when the Diagnosis is made; or
- a Diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of Parkinsonism.

Medical information about the Diagnosis and any signs, symptoms or investigations leading to the Diagnosis must be reported to the Company within 6 months of the Date of Diagnosis. If this information is not provided within this period, the Company has the right to deny any claim for Parkinson's Disease or Specified Atypical Parkinsonian Disorders or its treatment.

No benefit will be payable under Parkinson's Disease and Specified Atypical Parkinsonian Disorders for any other type of Parkinsonism.

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

The Diagnosis of Severe Burns must be made by a Specialist.

Stroke (Cerebrovascular Accident) means a definite Diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism from an extra-cranial source with:

- acute onset of new neurological symptoms, and
- new objective neurological deficits on clinical examination,

persisting for more than 30 days following the Date of Diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging testing.

The Diagnosis of Stroke must be made by a Specialist.

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

- Transient Ischaemic Attacks; or
- Intracerebral vascular events due to trauma; or
- Lacunar infarcts which do not meet the definition of stroke as described above.

Definitions Of Advancecare Benefit Conditions

Coronary Angioplasty means the undergoing of an interventional procedure to unblock or widen a coronary artery that supplies blood to the heart to allow an uninterrupted flow of blood. The procedure must be determined to be medically necessary by a Specialist.

Early Stage Cancer refers to one of the following conditions:

- malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- any non-melanoma skin cancer, without lymph node or distant metastasis;
- prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;
- papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis;
- chronic lymphocytic leukemia classified less than Rai stage 1;
- malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than AJCC Stage 2; or
- Ductal Carcinoma in situ of the Breast

The Diagnosis of an Early Stage Cancer must be made by a Specialist.

Claims At Tugo

As an insured person under a Company critical illness insurance plan, you are eligible to access **Claims at** TuGo. **Claims at** TuGo is a service that provides assistance in obtaining specialized, private medical treatment at claim time. With access to treatment centres around the world, **Claims at** TuGo coordinates medical appointments and procedures with specialists and surgeons, and arranges travel and lodging, if required, at special pricing discounts.

For assistance in accessing this service, please contact **Claims at** TuGo toll-free at: 1.800.663.0399, via e-mail: claims@tugo.com, or visit tugo.com/claims. Note that utilization fees may apply.

General Provisions

Termination of Insurance in Respect of an Insured Person

The Basic Group Critical Illness Insurance in respect of an Insured Employee will terminate automatically on the earliest of the following dates:

a) the termination date of the Group Policy;
b) the date of death of the Insured Employee;
c) immediately upon the date the Insured Employee's employment terminates or changes so that he ceases to be eligible for insurance under the Group Policy;
d) the end of the Policy Month coincident with or next following the date the Company receives written notice from the Policyholder requesting cancellation of the Basic Group Critical Illness Insurance coverage;
e) the end of the Policy Month coincident with or next following the date on which a leave of absence has expired and the Insured Employee is not actively at work;
f) with respect to an Insured Employee who is not actively at work, as a result of a disability and who is under age 63 when such disability related absence from work commences, such Employee's Basic Group Critical Illness Insurance will terminate at the end of the month coincident with or next following the date the Employee attains age 65, unless such Employee returns to fulltime active employment before age 65;

g) with respect to an Insured Employee who is not actively at work as a result of a disability and who is age 63 or older but less than age 80 when such disability related absence from work commences, such Employee's Basic Group Critical Illness Insurance will terminate at the end of the month coincident with or next following 24 consecutive months of disability related absence from work unless such Employee returns to full-time employment before 24 months of disability have expired;
h) with respect to an Insured Employee who is not actively at work as a result of a disability and who is age 80 or older when such disability related absence from work commences, such Employee's Basic Group Critical Illness Insurance will terminate at the end of the month coincident with or next following 12 consecutive months of disability related absence from work.

Conversion Privilege

If the Basic Group Critical Illness Insurance of an Insured Employee terminates as a result of such Insured Person ceasing to be eligible for insurance under the Group Policy and the Insured Person is not in receipt of a Covered Condition Benefit or AdvanceCare Benefit from the Company, the Insured Person may, on or before such Insured Person's 65th birthday and without evidence of insurability, convert such Employee's terminated Basic Group Critical Illness Insurance to a separate critical illness policy (the "**Converted Policy**"), issued by the Company subject to all of the following conditions:

a) the minimum amount of insurance in force with respect to the Insured Person on the date of termination must be $5,000;
b) the maximum amount of insurance under the Converted Policy will be limited to the lesser amount of $100,000 and the amount of coverage in force with respect to the Insured Person on the date of termination;
c) the Insured Person must reside in Canada at the time of application and submit a completed application and the first premium to the Company within 31 days of the date of termination of such Insured Person's insurance;
d) the Converted Policy will be of a type then issued by the Company providing term insurance to age 75;
e) the Converted Policy will be issued without waiver of premium benefit, return of premium benefit, paid-up benefit or guaranteed increase benefit;
f) the premium rates for the Converted Policy will be those then in effect for such policy;

g) the premium rates will be based on the Insured Person's gender, smoker status and age at the time of conversion;
h) if a special provision, exclusion and/or limitation had been imposed on the Basic Group Critical Illness Insurance, then a comparable special provision, exclusion and/or limitation will be imposed on the Converted Policy

Claims Procedures

Before paying a benefit under the Group Policy, we will require our claims forms to be duly completed and sent to the Company's address below. Please call us toll-free at: 1.800.266.5667 to obtain the appropriate forms and for details on claims procedures.
Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act. Insurance Act means the applicable insurance legislation in the applicable provincial jurisdiction.

Note: All claims will be adjudicated according to the definition of the Covered Condition or the AdvanceCare Benefit Condition applicable at the time of Diagnosis.

Questions? We're Here To Help.

Contact a Client Service Specialist at:

1.800.266.5667 (toll free)
604.737.3802 (Vancouver)
solutions@ia.ca
Monday to Friday 6:30 a.m. - 4:30 p.m. Pacific Time

Or write to:

Special Markets Solutions
Industrial Alliance Insurance and Financial Services Inc.
2165 Broadway W PO Box 5900
Vancouver, BC V6B 5H6

VOLUNTARY GROUP CRITICAL ILLNESS INSURANCE SUMMARY

(Underwritten by Industrial Alliance Pacific Insurance and Financial Services Inc. ("IAP")

Policy No. 100005769 issued to Catholic Independent Schools of Vancouver Archdiocese (CISVA)

This summary is designed to outline the Voluntary Group Critical Illness Insurance benefits which are available to employees of the Catholic Independent Schools of Vancouver Archdiocese ("CISVA") under the Group Policy issued by Industrial Alliance Pacific Insurance and Financial Services Inc. ("IAP"). In the event of any variation between the Group Insurance Certificate, this summary and the provisions of the Group Policy, the latter will prevail. All rights with respect to the benefits of an Insured Person will be governed solely by the Group Policy which may be amended from time to time.

This plan is designed to provide the financial resources that will allow you to adjust to the changes in lifestyle that will result after having suffered a critical illness or injury.

Critical Illness Benefit Amounts Available

Eligible employees and /or their eligible Spouse may apply for critical illness insurance benefits in units of $25,000 to a maximum of $300,000 each. Medical evidence must be provided by the applicant for all amounts unless application is made under a Special Offer time-limited enrollment.

Eligibility

Voluntary group critical illness insurance is available to all full-time employees working a minimum of 20 hours per week who are under age 70 and residents of Canada. A Spouse of an eligible employee is also eligible to apply for coverage under this plan if they are under age 70 and reside in Canada.

PLAN DESCRIPTION

Covered Condition Benefit

If an insured Employee and/or his insured Spouse is diagnosed by a Specialist with a Covered Condition while this Voluntary Group Critical Illness Insurance is in force and survives for thirty (30) days following the Date of Diagnosis or such longer period as described in certain Covered Conditions, IAP will pay to the Insured Person the Benefit Amount in force (the "Covered Condition Benefit"), subject to the limitations, exclusions and other terms and conditions of the Policy. The Date of Diagnosis must be later than the effective date of coverage. If the Insured Person dies prior to the approved Covered Condition Benefit being paid, IAP will pay the Covered Condition Benefit to the Insured Person's estate.

Payment of the Critical Condition Benefit is limited to only the first Covered Condition to occur.

This plan will pay you a lump sum benefit if you are diagnosed with one of the following Covered Conditions:

Alzheimer's Disease	Deafness	Major Organ Transplant
Aortic Surgery	Heart Attack	Motor Neuron Disease
Aplastic Anemia	Heart Valve Replacement	Multiple Sclerosis
Bacterial Meningitis	Kidney Failure	Occupational HIV Infection
Benign Brain Tumour	Loss of Independent Existence	Paralysis
Blindness	Loss of Limbs	Parkinson's Disease
Cancer (Life Threatening)	Loss of Speech	Severe Burns
Coma	Major Organ Failure on Waiting List	Stroke (Cerebrovascular Accident)
Coronary Artery Bypass Surgery		

AdvanceCare Benefit

If an Insured Person is diagnosed by a Specialist with an AdvanceCare Benefit Condition while his Voluntary Group Critical Illness Insurance is in force, IAP will pay to such Insured Person a benefit equivalent to 10% of the Benefit Amount in force with respect to such Insured Person (the "AdvanceCare Benefit"). The Date of Diagnosis of the AdvanceCare Benefit Condition must be later than the effective date of coverage If the Insured Person dies before the approved AdvanceCare Benefit is paid, the AdvanceCare Benefit will be paid to the estate of such Insured Person. The AdvanceCare Benefit Condition is a one-time benefit which IAP will pay for one AdvanceCare condition only.

Payment of the AdvanceCare Benefit in respect of an Insured Person will not affect the amount of benefit payment under a subsequent Covered Condition Benefit for such person.

Voluntary Group Critical Illness Insurance for an Insured Person will continue in force during the adjudication of an AdvanceCare Benefit and following the payment of an AdvanceCare Benefit providing premiums continue to be paid as required.

Limitations

a) Covered Condition Benefit

   An Insured Person will not be entitled to a Covered Condition Benefit for Benign Brain Tumour or Cancer(Life-Threatening) and coverage will be void I, within the first 90 days following the effective date of his Voluntary Group Critical Illness Insurance coverage, such Insured Person has any of the following:

   i) A Diagnosis of Benign Brain Tumour or any signs, symptoms or investigations that lead to a Diagnosis of Benign Brain Tumour, regardless of when the Diagnosis is actually made.

   ii) A Diagnosis of Cancer (Life-Threatening) or any signs, symptoms or investigations that lead to a Diagnosis of Cancer (Life-Threatening), regardless of when the Diagnosis is actually made.

b) AdvanceCare Benefit

An Insured Person's Voluntary Group Critical Illness Insurance will be void and IAP's liability will be limited to the return of any premiums paid if, within the first 90 days following the effective date of his Voluntary Group Critical Illness Insurance, such Insured Person has a Diagnosis of Early Stage Cancer or any signs, symptoms or investigations that's lead to a diagnosis of Early Stage Cancer, regardless of when the diagnosis is actually made.

However, in the event an Insured Person, who was insured under the Previous Plan, is diagnosed with Early Stage Cancer within 90 days following the introduction of the AdvanceCare Benefit to the group policyholder, the Voluntary Group Critical Illness will remain in force but Early Stage Cancer will no longer be considered as AdvanceCare Benefit Condition for such Insured Person.

Exclusions

In addition to the exclusions included within the definition of certain Covered Conditions, the following exclusions also apply.

a) No benefit will be paid if a Covered Condition or AdvanceCare Benefit Condition results directly or indirectly from any one or more of the following:

i) any Covered Condition or AdvanceCare Benefit Condition diagnosed prior to the effective date of an Insured Person's Voluntary Group Critical Illness Insurance;

ii) attempted suicide;

iii) taking poison or inhaling gas, whether voluntarily or involuntarily, not connected with the employment of the Insured Person;

iv) taking any drug other than as prescribed by a licensed physician;

v) war or full time active service in the armed forces of any country;

vi) flying as a student pilot or flying as a privately licensed pilot for less than 25 hours or more than 400 hours per year;

vii) participation in a criminal act or any attempt to commit a criminal offense, including but not limited to, operating a motor vehicle while the concentration of alcohol in 100 millilitres of the Insured Person's blood exceeds 80 milligrams; or

viii) intentionally self-inflicted injury, while sane or insane.

b) with respect to Voluntary Group Critical Illness Insurance issued to an Employee or Spouse as a result of a Special Offer or New Employee Offer, in addition to the exclusions described in a) above, no benefit will be paid if a Covered Condition or AdvanceCare Benefit Condition results directly or indirectly from any illness, disease, mental, nervous or psychiatric condition or disorder for which any one of medical advice, treatment, service, prescribed medication, diagnosis or consultation, including consultation to investigate and/or diagnose (where diagnosis has not yet been made) was received by the Insured Person or would have been received by a prudent individual within the 24 months immediately following the effective date of an Insured Person's Voluntary Group Critical Illness Insurance coverage under the Special Offer and New Employee Offer.

Note: Exclusion b) above applicable to the Special Offer and New Employee Offer coverages only, will be removed in the event that an Insured Person applies for additional Voluntary Group Critical Illness Insurance coverage which is subject to evidence of insurability and such coverage is approved by IAP.

c) In addition, the Critical Illness Benefit will not be paid if the Insured Person suffers Paraplegia/Quadriplegia/Hemiplegia, Blindness, Deafness, Major Burns, Stroke, Coma or Dismemberment as a result, directly or indirectly, from amateur or professional boxing, bungee jumping, B.A.S.E. jumping, cliff diving, mountain climbing, motor vehicle race or speed competition on land and/or water, parachuting or underwater activities, including scuba diving and snuba diving.

Termination of Insurance

An Insured Person's insurance will terminate automatically on the earliest of the following dates:

- the termination date of the Policy;
- the end of the policy month coincident with or following the date on which a maternity and/or parental leave of absence has expired and the Employee is not actively at work;

- the end of the policy month coincident with or following the date on which the Employee's employment terminates or the Employee ceases to be eligible for insurance under the Policy;
- the end of the policy month coincident with or following an Employee's 75th birthday;
- the due date of any unpaid premium;
- the date that IAP receives written notice from the Employee requesting cancellation of all or part of the insurance;
- the date of death of the Employee;
- the date that the Critical Illness Benefit is paid; and
- with respect to a Spouse's insurance, the earlier of the above, or the end of the policy month coincident with or next following the Insured Spouse's 75th birthday, or the date on which he/she no longer qualifies as a "Spouse".

Conversion Privilege

(For insured Employees Only)

If your employment terminates or changes so that you are no longer eligible under the plan, you may convert your critical illness insurance to an individual policy for the lesser of the amount of coverage in force and $100,000, provided you have been insured continuously for at least the past 24 months and you are under age 65 at the date of termination. You will be provided with an individual term insurance policy to age 75 providing critical illness coverage of a type then issued by IAP. This may be done without further evidence of health at rates applicable to your age at the time of conversion.

You must apply to IAP in writing, within 31 days of the date your insurance terminates.

For more information concerning conversion, please contact IAP for details.

POLICY DEFINITIONS

"AdvanceCare Benefit Conditions" are medical conditions for which an AdvanceCare Benefit is paid under the Group Policy with respect to an Insured Person. These are Coronary Angioplasty or Early Stage Cancer as defined in this document.

"Age" means the attained age of an Insured Person on each and every first day of September in any policy year.

"Benefit Amount" means the amount of Voluntary Group Critical Illness Insurance for which the Insured Person has been approved by IAP.

"Covered Conditions" for which a Benefit Amount is paid under the policy with respect to an Insured Person are Alzheimer's Disease, Aortic Surgery, Aplastic Anemia, Bacterial Meningitis, Benign Brain Tumour, Blindness, Cancer (Life-Threatening), Coma, Coronary Artery Bypass Surgery, Deafness, Heart Attack, Heart Valve Replacement, Kidney Failure, Loss of Independent Existence, Loss of Limbs, Loss of Speech, Major Organ Failure on Waiting List, Major Organ Transplant, Motor Neuron Disease, Multiple Sclerosis, Occupational HIV Infection, Paralysis, Parkinson's Disease, Severe Burns and Stroke, as defined in the section titled "Definitions of Covered Conditions".

"Date of Diagnosis" means the date on which a Specialist diagnoses the Insured Person with one of the Covered Conditions or one of the AdvanceCare Benefit Conditions.

"Diagnosis" means the certified diagnosis of the Insured Person with a Covered Condition or one of the AdvanceCare Benefit Conditions by a Specialist.

"Employee" means an employee as defined in the Policy.

"Insured Person" means a person who is eligible and insured for Voluntary Group Critical Illness Insurance under the Policy.

"New Employee Offer" means the Voluntary Group Critical Illness Insurance available to a new Employee on a guaranteed issue basis during the first 60 days following date of hire.

"Special Offer" means Voluntary Group Critical Illness Insurance available to eligible Employees and Spouses on a guaranteed issue basis during a specified open enrollment period.

"Specialist" means a licensed medical practitioner who has been trained in the specific area of medicine relevant to the Covered Condition or AdvanceCare Benefit Condition for which a benefit is being claimed, and who has been certified by a specialty examining board. Specialist includes but is not limited to: cardiologist, neurologist, nephrologist, oncologist, ophthalmologist, burn specialist and internist. The Specialist must not be the Insured Person, a relative or business associate of the Insured Person.

"Spouse" means a person who is under the age of 70 and a) to whom the Employee is legally married; and b) to whom the Employee is married by a marriage that is voidable and has not been declared null and void. Only one individual will qualify as a Spouse.

"You" or "your" refers to the Insured Person.

DEFINITIONS OF COVERED CONDITIONS

Alzheimer's Disease means a definite Diagnosis of a progressive degenerative disease of the brain. The Insured Person must exhibit the loss of intellectual capacity involving impairment of memory and judgement, which results in a significant reduction in mental and social functioning, and requires a minimum of 8 hours of daily supervision. The Diagnosis of Alzheimer's Disease must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for all other dementing organic brain disorders and psychiatric illnesses.

Aortic Surgery means the undergoing of surgery for disease of the aorta requiring excision and surgical replacement of the diseased aorta with a graft. Aorta refers to the thoracic and abdominal aorta but not its branches. The surgery must be determined to be medically necessary by a Specialist.

Aplastic Anemia means a definite Diagnosis of a chronic persistent bone marrow failure, confirmed by biopsy, which results in anemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following: marrow stimulating agents; immunosuppressive agents; bone marrow transplantation. The Diagnosis of Aplastic Anemia must be made by a Specialist.

Bacterial Meningitis means a definite Diagnosis of meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least 90 days from the date of Diagnosis. 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 means a definite Diagnosis of a non malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nevers or pituitary gland. The tumour must require surgical or radiation treatment or cause irreversible objective neurological deficit(s). The Diagnosis of Benign Brain Tumour must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for pituitary adenomas less than 10 mm.

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

- the corrected visual acuity being 20/200 or less in both eyes; or,
- the field of vision being less than 20 degrees in both eyes.

The Diagnosis of Blindness must be made by a Specialist.

Cancer (Life-Threatening) means a definite Diagnosis of a tumour characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue. The Diagnosis of Cancer must be made by a Specialist.

Exclusion: No benefit will be payable under this condition for the following non-life-threatening cancers:

- carcinoma in situ, or
- Stage 1A malignant melanoma (melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or level V invasion), or
- any non-melanoma skin cancer that has not metastasized, or
- Stage A (T1a or T1b) prostate cancer.

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

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

- a medically induced coma; or,
- a coma which results directly from alcohol or drug use; or,
- a diagnosis of brain death.

Coronary Artery Bypass Surgery means the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s), excluding any non-surgical or trans-catheter techniques such as balloon angioplasty or laser relief of an obstruction. The surgery must be determined to be medically necessary by a Specialist.

Deafness means a definite Diagnosis of the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3,000 hertz. The Diagnosis of Deafness must be made by a Specialist.

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

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

The Diagnosis of Heart attack must be made by a Specialist.

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

- elevated biochemical cardiac markers as a result of an intra-arterial cardiac procedure including, but not limited to, coronary angioplasty, in the absence of new Q waves, or
- ECG changes suggesting a prior myocardial infarction, which do not meet the Heart Attack definition as described above.

Heart Valve Replacement means the undergoing of surgery to replace any heart valve with either a natural or mechanical valve. The surgery must be determined to be medically necessary by a Specialist.

Exclusion: No benefit will be payable under this condition for heart valve repair.

Kidney Failure means a definite Diagnosis of chronic irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation is initiated. The Diagnosis of Kidney Failure must be made by a Specialist.

Loss of Independent Existence means a definite Diagnosis of:

- a total inability to perform, by oneself, at least 2 of the following 6 Activities of Daily Living, or
- 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 Independent Existence must be made by a Specialist.

Activities of Daily Living are:

- Bathing – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of equipment.
- Dressing – the ability to put on and remove necessary clothing including braces, artificial limbs or other surgical appliances.
- Toileting – the ability to get on and off the toilet and maintain personal hygiene
- 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.
- Transferring – the ability to move in and out of a bed, chair or wheelchair, with or without the use of equipment.
- 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 means mental deterioration and loss of intellectual ability, evidenced by deterioration in memory, orientation and reasoning, which are measureable 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 demonstrable organic cause.

Loss of Limbs means a definite Diagnosis of the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation. The Diagnosis of Loss of Limbs must be made by a Specialist.

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

Exclusion: No benefit will be payable under this condition for all psychiatric related causes.

Major Organ Failure on Waiting List means a definite Diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow, and transplantation must be medically necessary. To qualify under Major Organ Failure on Waiting List, the Insured Person must become enrolled as the recipient in a recognized transplant center in Canada or the United States of America that performs the required form of transplant surgery. The date that the Insured Person is enrolled in the transplant centre will be deemed the Date of Diagnosis for this Covered Condition. The Diagnosis of major organ failure must be made by a Specialist.

Major Organ Transplant means a definite Diagnosis of the irreversible failure of the heart, both lungs, liver, both kidneys or bone marrow transplantation must be medically necessary. To qualify under Major Organ Transplant, the Insured Person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities. The Diagnosis of the major organ failure must be made by the Specialist.

Motor Neuron Disease means a definite Diagnosis of one of the following: amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy, and limited to these conditions. The Diagnosis of Motor Neuron Disease must be made by a Specialist.

Multiple Sclerosis means a definite Diagnosis of at least one of the following:

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

The Diagnosis of Multiple Sclerosis must be made by a Specialist.

Occupational HIV Infection means a definite Diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Insured Person's normal occupation, which exposed the person to HIV contaminated body fluids. The accidental injury leading to the infection must have occurred after the effective date of such Insured Person's insurance coverage.

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

- The accidental injury must be reported to IAP within 14 days of the accidental injury;
- A serum HIV test must be taken within 14 days of the accidental injury and the result must be negative;
- A serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;
- All HIV tests must be perfomed by a duly licensed laboratory in Canada or the United States of America;
- The accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States of America workplace guidelines.

The Diagnosis of Occupational HIV Infection must be made by a Specialist.

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

- the Insured Person has elected not to take any available licensed vaccine offering protection against HIV; or,
- a licensed cure for HIV infection has become available prior to the accidental injury; or,
- HIV infection has occurred as a result of a non-accidental injury including, but not limited to, sexual transmission and intravenous (IV) drug use.

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

Parkinson's Disease means a definite Diagnosis 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 Person must require substantial physical assistance from another adult to perform at least 2 of the following 6 Activities of Daily Living. The Diagnosis of Parkinson's Disease must be made by a Specialist.

Activities of Daily Living are:

- Bathing – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of equipment.
- Dressing – the ability to put on and remove necessary clothing including braces, artificial limbs or other surgical appliances.
- Toileting – the ability to get on and off the toilet and maintain personal hygiene
- 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.
- Transferring – the ability to move in and out of a bed, chair or wheelchair, with or without the use of equipment.
- Feeding – the ability to consume food or drink that already has been prepared and made available, with or without the use of adaptive utensils.

Exclusion: No benefit will be payable under this condition for all other types of Parkinsonism.

Severe Burns means a definite Diagnosis of third-degree burns over at least 20% of the body surface. The Diagnosis of Severe Burns must be made by a Specialist.

Stroke (Cerebrovascular Accident) means a definite Diagnosis of an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism from an extra-cranial source with:

- acute onset of new neurological symptoms, and
- new objective neurological deficits on clinical examination,

persisting for more than 30 days following the Date of Diagnosis. These new symptoms and deficits must be corroborated by diagnostic imaging testing. The Diagnosis of Stroke must be made by a Specialist.

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

- Transient Ishaemic Attacks; or
- Intracerebral vascular events due to trauma; or
- Lacunar infarcts which do not meet the definition of stroke as described above.

Definition of AdvanceCare Benefit Conditions

Coronary Angioplasty means the undergoing of an interventional procedure to unblock or widen a coronary artery that supplies blood to heart to allow an uninterrupted flow of blood. The procedure must be determined to be medically necessary by a Specialist.

Early Stage Cancer refers to one of the following conditions:

- Malignant Melanoma means an invasive malignant melanoma into the dermis equal to or lower than a depth of 1.0mm;
- Stage A Prostate Cancer (T1a or T1b)
- Ductal Carcinoma in situ of the Breast

The Diagnosis of an Early Stage Cancer must be made by a Specialist.

CLAIMS PROCEDURES

Before paying the Critical Illness Benefit, we will require our claims forms to be duly completed and sent to IAP's Head Office. Please call us toll-free at: 1-800-266-5667 to obtain the appropriate forms and for details on claims procedures.

Note: All claims will be adjudicated according to the definition of the Covered Condition or the AdvanceCare Benefit Condition applicable at the time of Diagnosis.

OneWorld Medicare

As an Insured Person under an IAP Voluntary Group Critical Illness plan, you are also eligible to access OneWorld Medicare's Treatment Management service. This service provides assistance in obtaining specialized, private medical treatment at claim time. With access to treatment centres around the world, OneWorld Medicare coordinates medical appointments and procedures with specialists and surgeons, and arranges travel and lodging, if required, at special pricing discounts.

For assistance in accessing this service, please contact OneWorld Medicare
toll-free at: 1-800-533-8718,
via e-email: info@oneworldmedicare.com,
or visit OneWorld Medicare at: www.oneworldmedicare.com.

CATHOLIC INDEPENDENT SCHOOLS OF VANCOUVER ARCHDIOCESE

SUMMARY OF INSURANCE COVERAGE

Policy No. 100005769 issued by Industrial Alliance Pacific Insurance and Financial Services Inc.

BASIC ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

You are covered for any injury sustained as the result of an accident anywhere in the world 24 hours per day on or off the job.

ACCIDENTAL DEATH, DISMEMBERMENT AND SPECIFIC LOSS INDEMNITY

The "loss" or "loss of use" must occur within 365 days of the date of the accident. These benefits are payable on a lump sum basis and in addition to any other benefits you may receive.

	% of Principal Sum
Life	100%
Both Hands or Both Feet or Entire Sight of Both Eyes	100%
One Hand and One Foot or One Hand and Entire Sight of One Eye	100%
One Foot and Entire Sight of One Eye or Speech and Hearing in both Ears	100%
One Arm or One Leg	75%
One Hand or One Foot or Entire Sight of One Eye or Speech or Hearing in both Ears	66 2/3%
Thumb and Index Finger of Either Hand or Four Fingers of Either Hand	33 1/3%
Hearing in One Ear	33 1/3%

All Toes of One Foot	25%
Quadriplegia (total paralysis of all four limbs) or Paraplegia (total paralysis of the lower limbs)	200%
Hemiplegia (total paralysis of one side of the body)	200%

BEREAVEMENT BENEFIT

If an Injury sustained by an Insured Person results in loss of life and indemnity becomes payable in accordance with the terms of this policy, the Company will pay the reasonable and necessary expenses actually incurred by the Spouse and Dependent Children of the Insured Person for up to six sessions of grief counselling, by a Professional Counsellor, subject to a maximum of $1,000.00.

CONTINUATION OF COVERAGE

Coverage can be continued while the insured is on an approved leave of absence, maternity/parental leave, lay-off or disability. This continuation is subject to continued payment of premiums and is granted for a maximum of 12 months (or to age 65 if on disability leave) or on the date the insured returns to work, whichever is earlier.

CONVERSION OPTION

Upon termination of active employment with the Policyholder, an insured may convert his/her insurance to an individual accident insurance plan, with no evidence of insurability, for an amount of principal sum equal to or lower than the amount of principal sum in force at the time of termination. Application for conversion must be made within 31 days. Premiums become payable annually in advance.

CRITICAL DISEASE BENEFIT

If an Insured Person, prior to age 65, is diagnosed by a Specialist with a Covered Disease while this policy is in force and is Totally Disabled from the Covered Disease for at least nine months following the Date of Diagnosis, the Company will pay 10% of the Principal Sum up to a maximum of $50,000.00. This benefit is payable only if investigations leading to the diagnosis of a Covered Disease is initiated more than 90 days following the effective date of insurance with respect to an Insured Person. Payment of the Critical Disease Benefit is limited to only the first Covered Disease to occur.

"Covered Disease" whenever used in this policy means Acute Poliomyelitis, Acute Rheumatic Fever, Amyotrophic Lateral Sclerosis (ALS), Encephalitis, Huntington's Disease, Meningitis, Necrotizing Fasciitis, Parkinson's Disease, Tuberculosis, Typhoid Fever and Yersinia Pesitis.

DAY CARE BENEFIT ($5,000)

If injury results in the loss of life, the Company will pay 5% of the principal sum for each year the dependent child is enrolled in a legally licensed day care (not to exceed four years) for each dependent child who is under 13 years of age and enrolled in a legally licensed day care centre on the date of the accident, or within the 12 months following.

EDUCATION BENEFIT ($5,000)

If injury results in loss of life, the Company will pay 5% of the principal sum to any dependent child who, on the date of the accident, was enrolled as a full-time student in any institution of higher learning beyond the secondary school level (not to exceed four years). If, at the time of loss, there is no dependent children eligible for the Education Benefit, the Company shall pay an additional amount of $2,500.00 to the designated beneficiary.

EYEGLASSES, CONTACT LENSES AND HEARING AIDS BENEFIT ($1,000)

When, as the result of injury, which requires and receives treatment by a physician, which results in the purchase of eyeglasses, contact lenses or hearing aids within 365 days of the date of the accident, when none of which were previously required or worn, the Company will pay the reasonable and necessary expense.

FAMILY TRANSPORTATION BENEFIT ($15,000)

If injury results in confinement as an inpatient in a hospital, and such injury results in a loss being payable under the Accidental Death, Dismemberment and Specific Loss Indemnity, and the hospital is located at least 150 km from the insured's residence, the Company will pay the expenses actually incurred by a member of the immediate family for hotel accommodation and transportation by the most direct route to the confined insured.

FUNERAL EXPENSE BENEFIT ($10,000)

If an Insured Person sustains an injury which results in loss of life payable under Accidental Death and Dismemberment Benefits of the policy, the Company will pay the actual expense incurred of a funeral for the Insured Person.

HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT ($15,000)

If injury requires the use of a wheelchair to be ambulatory, the Company will pay the cost of alterations to the insured's principal residence and/or the cost of modification to one motor vehicle utilized by the insured, provided such injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity.

HOME CARE BENEFIT

If Injury sustained, within 30 days of the date of the accident, by an Insured Person, who is the primary home care provider, wholly and continuously disables and prevents the Insured Person from performing the duties necessary to provide the basic needs of the Insured Person's Dependent Children and the Insured Person's principal occupation is their home care, the Company will pay a $50.00 daily benefit for such period of continuous disability not to exceed 60 days as the result of any one injury. Benefits under this part are payable only while the Insured Person is under the regular care and attendance of a Physician or surgeon.

IDENTIFICATION BENEFIT ($5,000)

In the event accidental loss of life is sustained by an Insured Person not less than one hundred and fifty kilometres (150 kms) from the Insured Person's normal place of residence and identification of the body by a member of the immediate family has been requested by the police or a similar governmental authority, the Company will reimburse the reasonable and customary expenses actually incurred by such member for transportation and hotel accommodation.

REHABILITATION BENEFIT ($15,000)

If injury requires that the insured undergo special training in order to be qualified to engage in a special occupation in which the insured would not have engaged except for such injury, the Company will pay the reasonable and necessary expense incurred for such training, provided such injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity.

REPATRIATION BENEFIT ($15,000)

If injury results in loss of life, the Company will pay the expense incurred for shipment of the body to the city of residence of the deceased.

SEAT BELT BENEFIT

If injury results in a loss payable under the Accidental Death, Dismemberment and Specific Loss Indemnity, the principal sum will be increased by 10% if, at the time of the accident, the insured was driving or riding in a vehicle and wearing a properly fastened seat belt.

SPOUSAL RETRAINING BENEFIT ($15,000)

If injury results in the loss of life, the Company will reimburse the spouse for the actual expenses incurred for a formal occupational training program in order to become qualified for active employment in an occupation in which the spouse would not otherwise have sufficient qualifications.

WAIVER OF PREMIUM

In the event of total disability and waiver of premium has been approved and accepted by the group life carrier, then premium under this plan will be waived until the earlier of: death, recovery, attainment of age 65 or the date the policy is cancelled.

TERMINATION OF INSURANCE OF AN INSURED

Coverage will terminate immediately on the earliest of: (a) the policy termination date; (b) the premium due date if the Policyholder fails to pay the insured's premium, except as a result of an inadvertent error; (c) the premium due date coinciding with or immediately following the date an insured attains age 70; (d) the premium due date next following the date an insured is ineligible for coverage.

LIMITED AIR TRAVEL COVERAGE

Coverage includes injury sustained in consequence of riding as a passenger and not as a pilot or member of the crew; in boarding or alighting from or being struck by; or making a forced landing with or from:

(a) any aircraft having a current and valid airworthiness certificate and which is operated by a person holding a current and valid pilot's license of a rating authorizing him to pilot such aircraft, or

(b) any transport-type aircraft operated by the Canadian Armed Forces or by the similar air transport service of any duly constituted governmental authority of the recognized government of any nation anywhere in the world, provided the aircraft is not being used for test or experimental purposes.

Notwithstanding (a) and (b) above, coverage excludes injury sustained while and in consequence of riding as a passenger, pilot, operator or member of the crew, in or on, boarding or alighting from or being struck by or making a forced landing with or from any aircraft owned, operated or leased by the policyholder.

WHEN DOES THIS INSURANCE NOT APPLY?

- declared or undeclared war or any act thereof;
- active full-time service in the armed forces of any country;
- suicide or any attempt thereat or intentionally self-inflicted Injury, while sane or insane;
- injury sustained in consequence of riding as a passenger or otherwise in any vehicle or device for aerial navigation, except as provided in the part titled "Limited Air Travel Coverage".

This summary is for information purposes only. For further details, refer to the Master Policy which is on file with the Policyholder. This group Master Policy sets forth in detail the terms and conditions of the Plan and all rights and obligations are determined in accordance with the Master Policy, not this summary.

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