NLTA
GROUP INSURANCE PROGRAM

Revised August 2018
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>4</td>
</tr>
<tr>
<td>Directory</td>
<td>5</td>
</tr>
<tr>
<td>General Information</td>
<td>6</td>
</tr>
<tr>
<td>Current Underwriters</td>
<td>7</td>
</tr>
<tr>
<td>Eligibility Guidelines</td>
<td>9</td>
</tr>
<tr>
<td>Termination of Eligibility for Coverage</td>
<td>11</td>
</tr>
<tr>
<td>Enrolment</td>
<td>11</td>
</tr>
<tr>
<td>Effective Date of Coverage</td>
<td>12</td>
</tr>
<tr>
<td>Payment of Premiums</td>
<td>12</td>
</tr>
<tr>
<td>Summary of Plan Benefit Coverage – Overview</td>
<td>12</td>
</tr>
<tr>
<td>Basic Life – Option A1</td>
<td>17</td>
</tr>
<tr>
<td>Voluntary Life – Option A2/A5</td>
<td>20</td>
</tr>
<tr>
<td>Basic &amp; Voluntary Accidental Death and Dismemberment (AD&amp;D)</td>
<td>22</td>
</tr>
<tr>
<td>- Option A3/A4</td>
<td></td>
</tr>
<tr>
<td>Health – Option B</td>
<td>44</td>
</tr>
<tr>
<td>Dental – Option B2</td>
<td>52</td>
</tr>
<tr>
<td>Long Term Disability (LTD) – Option C</td>
<td>58</td>
</tr>
<tr>
<td>Basic Critical Illness – Option CI</td>
<td>65</td>
</tr>
<tr>
<td>Voluntary Critical Illness – Option CV/CS/CC</td>
<td>69</td>
</tr>
<tr>
<td>MEDOC Travel Insurance Plan – Option T</td>
<td>74</td>
</tr>
<tr>
<td>Voluntary Automobile &amp; Home Insurance</td>
<td>78</td>
</tr>
<tr>
<td>Automobile Insurance – Option D</td>
<td>84</td>
</tr>
<tr>
<td>Home Insurance – Option E</td>
<td>82</td>
</tr>
<tr>
<td>Definitions</td>
<td>85</td>
</tr>
</tbody>
</table>

Throughout this booklet, the male pronoun will be construed as the feminine when the person is a female.
INTRODUCTION

The Newfoundland and Labrador Teachers’ Association (NLTA) Group Insurance Trustees have responsibility for, and reserve the right to change, alter, or delete benefits and set premiums for all insured members covered by the NLTA Group Insurance Plan, including retirees.

This booklet contains important information concerning Group Insurance coverage and, therefore, should be kept in a safe place. It supersedes and replaces all previous communication material.

The purpose of this booklet is to outline the benefits for which you are eligible as a member/employee of the NLTA. A member of the NLTA includes both active and retired teachers. The information in this booklet is a summary of the provisions of the Group Policy. The booklet, in either its paper or electronic form, provides members with important information about their benefits under the group insurance policies; members should refer to the full Group Policy for complete information with respect to member’s rights under a specific Group Policy. However, if there is any question as to interpretation, all rights with respect to an Insured Person will be governed solely by the Group Policy issued by the underwriting companies to the Group Insurance Trustees of the Newfoundland and Labrador Teachers’ Association. In the event of a discrepancy between this booklet (paper or electronic version) and the Group Policy, the terms of the Group Policy will apply.

A copy of the master policies may be obtained upon written request to the Newfoundland and Labrador Teachers’ Association office.

All information contained in this booklet is available on the NLTA website www.nlta.nl.ca. The Plan Administrator, Johnson Inc., maintains a members-only website at www.johnson.ca which contains your individual coverage and claims experience. A confidential password is required for access to your personal information at the Johnson website and may be obtained by contacting the Plan Administrator, Johnson Inc.
DIRECTORY

Important Addresses and Telephone Numbers:

Newfoundland and Labrador Teachers’ Association
3 Kenmount Road
St. John’s, NL A1B 1W1
Tel: 726-3223 (Local); 1-800-563-3599 (Toll Free)
Fax: 726-4302 (Local); 1-877-711-NLTA (6582) (Toll Free)
Website: www.nlta.nl.ca
E-mail: mail@nlta.nl.ca

Johnson Inc. – Group Plan Benefits
P.O. Box 12049
10 Factory Lane
St. John’s, NL A1B 1R7
Group Plan Benefit Enquiries: 737-1528 (Local);
1-800-563-1528 (Toll Free)
Claims Enquiries: 737-1640 (Local);
1-800-563-1727 (Toll Free)
Fax: 737-1021
Website: www.johnson.ca

Johnson Inc. Home and Auto (Quote): 1-800-563-0677 (Toll Free)
GENERAL INFORMATION

Ownership and Control
The NLTA Group Insurance Plan is owned by the Newfoundland and Labrador Teachers’ Association and operated through a seven person Board of Teacher Trustees, appointed by and answerable to the Provincial Executive of the Association. Under the terms of the Deed of Trust, the Trustees are given the mandate and responsibility for overseeing the operation of all aspects of the Group Insurance Plan. The Trust document stipulates that the Trustees shall consist of seven members of the Association, appointed by the Executive, and that the Provincial Executive shall designate one of those members as the Chairperson. The Trustees are essentially a Board of Directors appointed by Executive to manage the Group Insurance Plan.

Administration and Consultation
In 1964 Johnson Inc. was hired as Plan Administrator and Consultant when the plan was initiated and the company continues in that role to present day. Johnson Inc. possesses the insurance expertise and technical systems that provides services to NLTA in areas of consultation, administration, payment of claims and collection/disbursement of premiums. The Trustees authorize Johnson Inc. to accept bids from insurance underwriters and enter into approved contracts with underwriters after the options in the Plan are placed on the market. All final contractual decisions are made by your NLTA Group Insurance Trustees.
CURRENT UNDERWRITERS

A1 - Basic Life
Underwritten by Desjardins Financial Security
Policy 140834

A2 - Member Voluntary Life
Underwritten by Manulife Financial
Policy 70671

A3 - Basic Accidental Death & Dismemberment
Underwritten by SSQ Insurance Company Inc.
Policy 1FX45

A4 - Voluntary Accidental Death & Dismemberment
Underwritten by SSQ Insurance Company Inc.
Policy 1FX50

A5 - Spousal Voluntary Life Insurance
Underwritten by Manulife Financial
Policy 70671

B - Health
Underwritten by Desjardins Financial Security
Policy 140834

B2 - Dental
Underwritten by Desjardins Financial Security
Policy 140834

C - Long Term Disability
Underwritten by Manulife Financial
Policy GH36349

CI - Basic Critical Illness
Underwritten by Desjardins Financial Security
Policy 140834

CV - Voluntary Critical Illness Member
Underwritten by Desjardins Financial Security
Policy 140834

CS - Voluntary Critical Illness Spouse
Underwritten by Desjardins Financial Security
Policy 140834

CC - Voluntary Critical Illness Child
Underwritten by Desjardins Financial Security
Policy 140834
T - MEDOC Travel Insurance
Underwritten by Royal & Sun Alliance
MEDOC

D - Automobile
Underwritten by Unifund Assurance
As per individual policy

E - Home
Underwritten by Unifund Assurance
As per individual policy
ELIGIBILITY GUIDELINES TO BE A MEMBER OF NLTA GROUP INSURANCE PROGRAM

Unrestricted Eligibility
The following NLTA members and employees are eligible for participation in all options of the Group Insurance Plan, subject to the guidelines of the master policies, with automatic enrolment in the Basic Life, Basic Accidental Death and Dismemberment, Health, Dental and Basic Critical Illness plans; and automatic enrolment in Long Term Disability for those eligible, if less than age 40. If over age 40, application for LTD is required and proof of medical insurability is necessary.

- Permanent teachers on regular government or school board payroll.
- President of the NLTA (compulsory enrolment in LTD).
- Permanent employees of the NLTA (compulsory enrolment in LTD for administrative officers).
- Retired teachers and NLTA employees on pension (no LTD).
- Retired NLTA employees, not in receipt of a pension.

Note: Members of the Group Insurance Program must maintain their membership in the NLTA while working as a teacher on approved leave of absence, or working as an NLTA employee.

Restricted Eligibility

Substitute Teacher Plan

<table>
<thead>
<tr>
<th>Option</th>
<th>Maximum Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic Life (Member only)</td>
<td>$15,000</td>
</tr>
<tr>
<td>Basic AD&amp;D (Member only)</td>
<td>$15,000</td>
</tr>
<tr>
<td>LTD</td>
<td>Not Eligible</td>
</tr>
<tr>
<td>Basic Critical Illness</td>
<td>Not Eligible</td>
</tr>
<tr>
<td>All other options</td>
<td>Same as Permanent Teacher</td>
</tr>
</tbody>
</table>

The following NLTA members and employees are eligible for participation in the NLTA Group Insurance Plan as described below:

Substitute Teachers
- Eligible for the Substitute Teacher Plan only, subject to the following criteria:
  (i) After one day substituting, a substitute teacher is eligible for substitute coverage. No evidence of insurability is required if application is made within 31 days of the first day of substitution. If application is made more than 31 days after the first teaching day, the application will be subject to Evidence of Insurability.
  (ii) For continuation of coverage for the following school year, a substitute teacher must have taught ten (10) days the previous school year and must teach at least once before November 30th of that following year. Otherwise, there will be a lapse of coverage and a new application will be required after the substitute teacher has taught ten (10) days during a
school year, requiring Evidence of Insurability.

**Replacement and Term Contract Teachers**
- Eligible for participation in all options of the Group Insurance Plan for the period of their teaching contract.
- Beyond the period of their teaching contract, these teachers are eligible for the Substitute Teacher Plan for the balance of the school year in which they taught, and the following school year based on the eligibility guidelines for continuation of coverage for substitute teachers.

**NLTA Members Teaching in Private Schools**
- Eligible for the Substitute Teacher Plan coverage for the period of their teaching contract only.
- Application is required and is subject to Evidence of Insurability, confirmation of salary and NLTA membership in good standing.

**Members on Approved Leave**

a) Unpaid Leave
Teachers must arrange with Johnson Inc. to pay by bank deduction for all their group insurance benefits, as well as the government's share (Life, Accidental Death and Dismemberment, and Health plans only) of the group insurance premiums. Failure to do so will result in termination of insurance. If insurance is terminated, the teacher will be required to apply for coverage, and provide proof of medical insurability subject to policy limitations, should the teacher wish to resume coverage at a later date.

b) Paid Sick Leave
Payment of group insurance premiums continue to be paid via normal payroll deduction and government's contribution of their share continues.

c) Unpaid Sick Leave
Teachers must arrange with Johnson Inc. to pay by bank deduction for all their group insurance benefits, as well as the government's share (Life, Accidental Death and Dismemberment, and Health plans only) of the group insurance premiums. Failure to do so will result in termination of insurance. If insurance is terminated, the teacher will be required to apply for coverage, and provide proof of medical insurability subject to policy limitations, should the teacher wish to resume coverage at a later date.

d) Paid Educational Leave
Payment of group insurance premiums continue to be paid via normal payroll deduction and government's contribution of their share continues.

e) Unpaid Educational Leave
Teachers must arrange with Johnson Inc. to pay by bank deduction for all their group insurance benefits, as well as the government's share (Life, Accidental Death and Dismemberment, and Health plans only) of the group insurance
premiums. Failure to do so will result in termination of insurance. If insurance is terminated, the teacher will be required to apply for coverage, and provide proof of medical insurability subject to policy limitations, should the teacher wish to resume coverage at a later date.

f) Deferred Salary Leave
Payment of group insurance premiums continue to be paid via normal payroll deduction and government's contribution of their share continues.

g) Maternity Leave
Teachers must arrange with Johnson Inc. to pay by bank deduction their share of all their group insurance benefits. Government will continue to pay their share of premiums for the Basic/Dependent Life, Basic Accidental Death and Dismemberment, and Health plans only of the group insurance program. Failure to do so will result in termination of insurance. If insurance is terminated, the teacher will be required to apply for coverage, and provide proof of medical insurability subject to policy limitations, should the teacher wish to resume coverage. Should a teacher take more than 39 weeks, they must arrange with Johnson Inc. to pay back by bank deduction both their share and government's share of the group insurance premiums for the additional leave period. Otherwise, if insurance is allowed to lapse during a period of parenthood leave, medical proof of insurability will be required in order to be reinstated in the plan.

**Teachers on Layoff (Subject to Article 9)**
Eligible to continue coverage (except LTD) while on recall under Article 9, if actively seeking employment as a teacher. No increase in Voluntary Life and Voluntary AD&D.

**Suspension/Termination**
Subject to approval of Trustees, eligible to continue coverage until the grievance process has been completed.

**Retired Substitute Teachers**
Eligible, in the month following their 55th birthday, to continue receiving the substitute coverage that they had in place at the time of retirement provided the substitute teacher has:

(i) been paying premiums for the last five (5) years for the specified coverage;
(ii) at least five (5) years substitute teaching;
(iii) at least 100 substitute days in the last five (5) years of their career;
(iv) ten (10) years attachment to the teaching profession;
(v) and proof to the Plan Administrator in receipt of benefits under the Government Money Purchase Plan (GMPP).

**Member on Deferred Pension**
Deferred pensioners refers to those persons with:
(a) 30 or more years of service;  
(b) between 20 and 30 years of pensionable service and within 10 years of  
receiving a regular pension;  
(c) less than 20 years of pensionable service and within 5 years of receiving a  
regular pension.

This category of members is not eligible to continue coverage during the  
period of time from the date of resignation to the date upon which the  
individual qualifies to receive a pension benefit. Furthermore, in order to be  
automatically enrolled in the Group Insurance Program upon receipt of a  
pension benefit, the member is required to complete and submit a Group  
Insurance Continuation Form to Johnson Inc., the Plan Administrator, within 31  
days of resignation or termination of coverage. Failure to complete and submit  
the applicable form at the time of resignation will result in the member having  
to apply for coverage and be subject to medical evidence of insurability when  
they are in receipt of their teacher’s pension.

Retired Teacher/Retired NLTA Employee  
A retired teacher/retired NLTA employee is defined as:  
a) A teacher/employee who is eligible to receive a pension benefit from the  
Teachers' Pension Plan or the NLTA Support Staff Pension Plan immediately  
upon resigning from his/her position shall be eligible to continue coverage  
under the NLTA Group Insurance Program.  
b) A teacher/employee who, due to a diagnosed terminal illness as verified by  
a Physician's Statement, resigns and receives the commuted value payout of  
his/her pension benefit from the Teacher's Pension Plan or the NLTA Support  
Staff Pension Plan shall be eligible to continue Health and/or Dental cover-  
age under the NLTA Group Insurance Program. Teachers must arrange with  
Johnson Inc. to pay 100% of the premiums for these benefits through bank  
deduction.

Retired Insured Members Residing Outside Canada  
Retired insured members residing outside Canada may continue the same  
Group Insurance coverage held while residing in Canada. Benefits will be  
paid as though the retirees were still residing in Newfoundland and Labrador  
and still covered under the provincial health plan. No benefit that would have  
been covered under the provincial health plan will be paid to these members.  
Benefits will be paid in Canadian funds.

Survivor of a Teacher/NLTA Employee  
A survivor of a member/employee is defined as:  
a) A spouse or partner, as defined by the Teachers' Pension Plan or the NLTA  
Support Staff Pension Plan, who is eligible to receive the Survivor pension  
benefit from a deceased spouse or partner shall be eligible to maintain  
coverage for Health and/or Dental under the NLTA Group Insurance Program.  
b) A spouse or partner, as defined by the Teachers' Pension Plan or the NLTA  
Support Staff Pension Plan, who receives the commuted value payout of the
survivor benefit from the Teacher's Pension Plan or the NLTA Support Staff Pension Plan shall be eligible to maintain Health and/or Dental coverage under the NLTA Group Insurance Program.

**Eligible Dependents of Deceased NLTA Members/Employees**
Eligible to continue Health and Dental coverage only, provided the deceased insured had dependent insurance under the NLTA plan up to the date of death. Spouse or partner must arrange with Johnson Inc. to pay 100% of the premiums for these benefits through bank deduction.

Note: It is the member’s responsibility to notify Johnson Inc. within 31 days of any change to their employment status (e.g., accepted position at the District Office or the Department of Education or is seconded to Memorial University of Newfoundland or the Department of Education).

Note: Teachers who choose to "opt out" of any or all of the benefits must:
- a) Complete the appropriate "Opting-Out Form" available through Johnson Inc., Plan Administrator.
- b) If, at a later date, the member wishes to enrol in benefits, the member will be required to provide medical evidence of insurability and be approved by the underwriters.

Note: Teachers who fail to pay the appropriate premiums while on leave will:
- a) Receive notification from Johnson Inc. re no premium received.
- b) Be provided the option to pay the premium through automatic bank deductions.
- c) Result in automatic termination of policy/policies.
- d) If, at a later date, the member wishes to enrol in benefits, the member will be required to provide satisfactory medical evidence of insurability and be approved by the underwriters.

**TERMINATION OF ELIGIBILITY FOR COVERAGE**
- For those teachers who resign during the school year and cease to be NLTA members, coverage will cease on the effective date of resignation.
- For those teachers who resign at the end of the school year and cease to be NLTA members, coverage (except LTD) will cease as at August 31 of that year. LTD coverage ceases the date of resignation.
- For those insured members on replacement/term contract, coverage will cease at the end of the contract period.
- At normal termination as stated in the master policies.

**ENROLMENT**
All new teachers and NLTA employees on continuing or term/replacement contracts are automatically enrolled in the Basic Life, Basic Accidental Death and Dismemberment, Health, Dental and Basic Critical Illness plans. New members under age 40 are automatically enrolled in the Long Term Disability
plan as of the first day of active employment. No application is necessary. Insured members are entitled to decline coverage under any or all of the benefits by completing an “Opting Out Form”. Insured members opting out and who later wish to enrol will be required to provide satisfactory evidence of insurability and be approved by the underwriters.

Members may apply for coverage under any of the plan options at any time by contacting the Plan Administrator, Johnson Inc., for the appropriate applications.

**EFFECTIVE DATE OF COVERAGE**
Upon enrolment, the effective date of coverage is the first day of active employment or the date the application is approved by the underwriters, whichever date is later.

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

**PAYMENT OF PREMIUMS**
Premiums are automatically deducted from 24 of the 26 pay cheques for insured members on regular payroll. For insured members on pension, premiums are automatically deducted from the 24 regular pension cheques.

All other insured members must make arrangements with the Plan Administrator, Johnson Inc., to have the premiums deducted from a bank account.

**SUMMARY OF PLAN BENEFIT COVERAGE - OVERVIEW**

**A1 – BASIC LIFE INSURANCE**

**Prior to Age 65 Benefit Coverage**
- Two (2) times annual salary or annual pension rounded to the next highest multiple of $1,000 to a maximum of $400,000.
- Dependent coverage: $10,000 on spouse; $5,000 on each eligible dependent child.
- Coverage ceases at age 65, and is replaced by Post-65 Benefit*.
- Conversion option available within 31 days of termination or reduction in coverage.

*Post-65 Benefit (Member Only)*
- $15,000 for those reaching age 65 on or after September 1, 1985, and who have continued coverage under the Basic Life plan until their 65th birthday.
An insured member who continues to teach beyond age 65 will continue coverage at two times salary until the date of retirement.

A2 – MEMBER/A5 – SPOUSE VOLUNTARY LIFE INSURANCE
- Maximum coverage of $500,000 in units of $10,000.
- Member and/or spouse by application only.
- Rates are step rated based on member or spouse’s age.
- Effective May 1, 2011, maximum coverage of $50,000 from age 65 to 84.
- Coverage ceases when member/spouse reaches age 85.
- Conversion option available within 31 days following your 65th birthday.

A3 – ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE
- Maximum coverage of two (2) times annual salary or annual pension (minimum of $40,000) rounded to the next highest multiple of $1,000 to a maximum of $400,000.
- Coverage on teacher and NLTA employee only.
- Coverage ceases at age 65*.
*An insured member who continues to teach beyond age 65 will continue coverage at two times salary until the date of retirement.

A4 – VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE
- Maximum member coverage of $500,000 in units of $10,000 for those under age 70. Maximum member coverage of $100,000 for those age 70-74.
- Spousal coverage is 50% of member coverage with eligible dependent children; 60% of member coverage with no dependent children.
- Eligible dependent child coverage is 15% of member coverage; 20% of member coverage if no spouse.
- Member coverage ceases at age 75.

B – HEALTH INSURANCE PLAN
- Drug Plan:
  Coverage is 100% of generic ingredient drug cost for eligible drugs.
  Member pays dispensing fee and pharmacy markup.
- Hospital Care:
  Coverage is 100% of the semi-private room rate.
- Vision Care:
  Coverage is 80% to a maximum payment of $125 in any three consecutive calendar years for adults, and once every calendar year for eligible dependent children under age 18 with a prescription change.
- Other Benefits:
  Paid at 80%, subject to maximums as outlined in the Health section of this booklet.
B2 – DENTAL INSURANCE PLAN
- 80% of eligible benefits as per the Fee Guide approved by Trustees.
- Recall examinations, cleanings, fluoride treatments and bitewing x-rays once every 12 months.
- No coverage for orthodontics, dentures and bridges.

C – LONG TERM DISABILITY (LTD)

a) Long Term Disability Insurance

  • Elimination Period:
    30 days or expiry of sick leave, whichever is greater.
  
  • Monthly Benefit:
    66 2⁄3 % of gross monthly earnings in effect on the date benefit payments commence, subject to the integration offset which allows an all-source maximum of 85% of net salary (gross minus income tax). Maximum benefit $8,000.
  
  • Benefit Age Limit:
    To age 60.
  
  • Own Occupation Disability Period:
    24 months of benefit payable.
  
  • Any Occupation Disability Period:
    Up to age 60.
  
  • Integration/offset:
    Retirement and employer sponsored disability pension plans including TPP and CPP, and others as per master contract.

  • Tax Status:
    LTD benefit is tax free.

b) LTD – Workers’ Compensation Top-up

  • Eligibility:
    In receipt of Workers’ Compensation lost time benefits.
  
  • Benefit Level:
    Difference between bi-weekly Workers’ Compensation benefit and 85% of Net Income (gross minus income tax minus CPP and EI premium).
  
  • Benefit Duration:
    Lifetime maximum period of the lesser of one year (195 work days for teachers), or number of work days an insured member is in receipt of Workers’ Compensation benefits.

C1 – BASIC CRITICAL ILLNESS INSURANCE (Member Only)
This option is automatic for all NLTA members and NLTA employees, only if the member is currently enrolled in the Group Insurance Program.

  • $10,000 benefit that covers up to 31 illnesses/conditions.
  
  • A 24 month Pre-Existing Condition Limitations Clause applies.
  
  • No benefit paid for cancer or benign brain tumour if symptoms or problems that give rise to the diagnosis of these conditions appear within the first 90 days of coverage or reinstatement of coverage.
• Member must survive at least thirty (30) days after the date the diagnosis was made by a licensed physician.
• Coverage ceases upon retirement or attainment of age 65 or the date on which the underwriter pays a benefit for a covered critical illness/condition.
• Conversion Option is available within 31 days of termination or at attainment of age 65.

**CV – Member/CS – Spouse Voluntary Critical Illness Insurance**
This option is by application only.
• All NLTA members and NLTA employees and/or spouses of NLTA members and NLTA employees, can only avail of this option if the member is enrolled in the Basic Critical Illness Insurance.
• Retired NLTA members, spouses of retired NLTA members, retired NLTA employees, spouses of retired NLTA employees, substitute teachers, and spouses of substitute teachers can only avail of coverage if the retired teacher or substitute teacher is a member of the Group Insurance Program.
• Available in units of $10,000, to a maximum of $300,000.
• Up to $50,000 available to the member and/or spouse without a medical application.
• A 24 month Pre-Existing Condition Limitations Clause applies.
• No benefit paid for cancer or benign brain tumour if symptoms or problems that give rise to the diagnosis of these conditions appear within the first 90 days of coverage or reinstatement of coverage.
• Coverage ceases at attainment of age 65 or the date on which the underwriter pays a benefit.
• Conversion Option is available within 31 days of termination or at attainment of age 65.

**CC – Voluntary Dependent Child Critical Illness Insurance**
This option is by application only.
• Only members who are enrolled in the Voluntary Critical Illness Insurance are eligible to avail of this additional benefit.
• $5,000 benefit for each eligible dependent child under age 21 or under age 25 if in full-time attendance at an accredited educational institution.
• Covers up to 20 illnesses/conditions.

**LC – LONG TERM CARE**
• Personal individual policies available to NLTA members, NLTA employees and their family members (spouse, adult children, parents) between the ages of 18 and 89 who apply by completing the application with health questions.
• 10% reduction in monthly premium rates of more than one insured member.

<table>
<thead>
<tr>
<th>Three plan options</th>
<th>Daily Maximum Benefit</th>
<th>Maximum Lifetime Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan A</td>
<td>$50</td>
<td>$50,000</td>
</tr>
<tr>
<td>Plan B</td>
<td>$75</td>
<td>$100,000</td>
</tr>
<tr>
<td>Plan C</td>
<td>$100</td>
<td>$200,000</td>
</tr>
</tbody>
</table>
• Benefit level is the less of daily maximum or 80% of actual covered expenses which include: Home Care, Nursing Facility, Adult Day Care, Respite Care, etc.
• Additional features include inflation protection, caregiver training benefit, durable medical equipment and emergency response system.
• 30 day elimination period.

T – MEDOC Travel Insurance
• Out of Province/Canada emergency medical insurance plan.
• Trip cancellation included.

D/E – HOME AND AUTOMOBILE INSURANCE
• Personal individual policies.
• Available through Johnson Inc. with premium paid by payroll deduction without interest or service charge.

BASIC LIFE – OPTION A1
Current Underwriter (2014) - Desjardins Financial Security
Policy Number 140834

ELIGIBILITY
Subject to eligibility guidelines, all NLTA members and employees residing in Canada are eligible to participate in this plan. Spouses and eligible dependent children may also be insured.

If a member is initially insured for single coverage only, and later acquires a dependent, or has a change in marital status, their dependent will be enrolled in the Plan without medical evidence, providing the Plan Administrator, Johnson Inc., is notified within 31 days of the date you have such a change, in order to be eligible for family coverage.

Any NLTA member/employee may choose to remove him/herself from this plan by contacting the Plan Administrator, Johnson Inc., to complete an Opting Out form. If at a later date a member wishes to rejoin this plan, an application for coverage will be required providing evidence of medical insurability for the member and their dependents. This application will be subject to the approval of the insurance company.

SCHEDULE OF BENEFITS
Basic Life Benefit
1. Active Member/NLTA Employee (Permanent/Term Contract)
   Two times annual earnings, rounded to the next higher multiple of $1,000, if not already a multiple. The maximum benefit is $400,000.
2. Reduction
   Retired Members/NLTA Employees under age 65
   Upon retirement, the amount of coverage will change to two times annual pension, rounded to the next higher multiple of $1,000, if not already a multiple. The maximum benefit is $400,000.
The amount of insurance for teachers retired on disability pension is two times the salary last worked, until attaining age 60. At age 60, the benefit will change to two times annual pension.

Teachers who became disabled prior to September 1, 1993 were eligible for waiver of premium under this policy. The amount of insurance for teachers on waiver of premium prior to September 1, 1993 is two times the salary last worked prior to going on waiver until attaining age 60. At age 60, the benefit changes to two times annual pension. The waiver of premium benefit is not available for teachers who became disabled after September 1, 1993.

Retired Members/NLTA Employees who attain age 65 on or after September 1, 1985
The insurance benefit will change to $15,000 (member only). (Teachers on waiver of premium prior to September 1, 1993 maintain the Post-65 Life coverage in effect at the date of their disability.)

3. Dependents
The Dependent Life Insurance Benefit (not available under the substitute teachers’ plan):
Spouse $10,000
Each Eligible Child $5,000

4. Substitute Teachers’ Plan
$15,000 member only

5. Replacement and Term Contract Teachers
The amount of insurance for term contract/replacement teachers is two times annual salary rounded to the next higher multiple of $1,000, if not already a multiple, for the term of their contract period to a maximum benefit of $400,000. After the end of the contract period, these teachers are eligible for $15,000 coverage as a substitute teacher until November 30 of the following year.

NOTE: Coverage is available for the benefits indicated above, provided eligibility requirements have been met.

CLAIM PROCEDURES
If an insured member or one of their dependents should die, the Plan Administrator, Johnson Inc., will provide the necessary claim form(s) to the beneficiary of the insurance benefit. Proof of death should be submitted as soon as reasonably possible.

The insurance benefit will be paid to the appointed beneficiary(ies). Payment of benefit and changes in beneficiary designation are subject to applicable government legislation. If the appointed beneficiary dies before the insured member or if there is no beneficiary designated, the benefit will be payable to the estate.
For the Dependent Life Benefit the member/employee is the beneficiary.

CONVERSION OPTION – BASIC LIFE
If individual coverage terminates or reduces, the insured member may convert their Group Life Insurance and that of their spouse to an individual life insurance policy, subject to a maximum amount of the lesser of:
1) $400,000 for each benefit; and
2) the amount of insurance that terminated, less the amount of insurance under any replacing group policy within 31 days following the date of termination.

The individual life insurance policy will be issued without proof of satisfactory health provided the completed application form is mailed to the underwriter within 31 days following the date of termination.

The conversion policy will not include disability, double indemnity, or accidental death and dismemberment provisions.

If the insured member or their spouse dies during the 31 day period in which they are eligible to make application for conversion, the amount of Group Life Insurance available for this purpose will be payable, upon application, whether or not the member applied for conversion.

Certain conversion rights are also available on policy termination. Details on conversions may be obtained from the Plan Administrator, Johnson Inc., or by contacting the underwriter.

TERMINATION OF INSURANCE
Insurance for the insured member and their dependents will cease on the earliest of the following events:
1. Termination of employment, other than retirement under the provisions of the eligibility guidelines.
2. On the date of death.
3. On the day the insured member enters the armed forces of any country on a full-time basis.
4. Termination of the policy or eligibility of coverage.
5. On the date the insured member no longer pays the required premium towards the cost of insurance, where applicable.
6. Dependent Life Insurance terminates when the retired member reaches age 65, or when dependent is no longer eligible as per the policy.
7. For substitute teachers, on November 30th of the following school year if, during the preceding three months, the substitute teacher has not taught at least one day, and has not taught at least 10 days in the previous school year.
8. For private school teachers, coverage terminates upon termination of the teaching contract.
VOLUNTARY LIFE – OPTION A2/A5
Current Underwriter (2014) - Manulife Financial
Policy Number 70671

ELIGIBILITY
Subject to eligibility guidelines, effective May 1, 2011 all NLTA members and employees under the age of 85 are eligible to participate in Option A2. Spouses under age 85 are eligible for insurance under Option A5.

COVERAGE
A member may apply for coverage for themselves and/or their spouse in units of $10,000 up to a maximum of $500,000 each.

Maximum coverage from age 65 to 84 is $50,000 each. No application accepted beyond age 65.

Coverage ceases at age 85.

If a member is not presently insured or wishes to increase the benefit level, application is required, with proof of good health. The application can be obtained by contacting the Plan Administrator, Johnson Inc.

CLAIMS PROCEDURES
If an insured member or an insured spouse should die, the Plan Administrator, Johnson Inc., will provide the necessary claim form(s) to the beneficiary of the insurance benefit. Proof of death should be submitted as soon as reasonably possible.

The insurance benefit will be paid to the appointed beneficiary(ies). Payment of benefit and changes in beneficiary designation are subject to applicable government legislation. If the appointed beneficiary dies before the insured or if there is no beneficiary designated, the benefit is payable to the estate of the insured.

Suicide Limitations
No benefit is payable for any amount of Optional Life Insurance that has been in force for less than one (1) year if death is due to suicide while sane or insane. The one (1) year period includes any time that coverage has been in force with the previous carrier(s) and which has been grandfathered.

CONVERSION TO INDIVIDUAL INSURANCE
The insured member and/or insured spouse may convert their insurance to an individual life insurance policy within 31 days following termination of their insurance subject to a maximum of $200,000 without evidence of insurability. Waiver of premium, disability benefits or riders are not available. Conversion not available after age 65.
Extension of Coverage
If the insured dies during the 31 day period in which they are eligible to apply for conversion to individual insurance, the amount of group insurance which the insured was eligible to convert shall be payable as a claim under the Group Policy. Any individual insurance policy issued or for which application has been made under the conversion privilege shall be of no effect.

BASIC & VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) – OPTION A3/A4
Current Underwriter (2014) - SSQ Insurance Company Inc.
Policy Number 1FX45 (Basic AD&D) & 1FX50 (Voluntary AD&D)

ELIGIBILITY – BASIC ACCIDENTAL DEATH & DISMEMBERMENT
Subject to eligibility guidelines, NLTA members and employees residing in Canada are eligible to participate in this plan.

Any NLTA member/employee may choose to remove him/herself from this plan by contacting the Plan Administrator, Johnson Inc., to complete an Opting Out form. Subsequent to opting out or allowing coverage to lapse or terminate, should a teacher wish to rejoin this plan, an application will be required.

ELIGIBILITY – VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT
Subject to eligibility guidelines, NLTA members and employees residing in Canada are eligible to participate in this plan. Spouses and eligible dependent children are also eligible to be insured under this plan option.

COVERAGE – BASIC ACCIDENTAL DEATH AND DISMEMBERMENT
The amount of insurance with respect to each eligible member/employee is:
1. Member/Employee: Two times annual salary/pension rounded to the next higher multiple of $1,000 if not already a multiple of $1,000, subject to a minimum of $40,000 and a maximum of $400,000.

2. Replacement and Term Contract Teacher: The amount of insurance for term contract/replacement teachers for the term of their contract period is two times annual salary rounded to the next higher multiple of $1,000, if not already a multiple of $1,000, subject to a minimum of $40,000 and a maximum of $400,000. After the end of the contract period, these teachers are eligible for $15,000 coverage as a substitute teacher until November 30 of the following year.

3. Substitute Teachers’ Plan: $15,000 members only.

4. NLTA Members Teaching in Private Schools: $15,000 members only.

COVERAGE – VOLUNTARY ACCIDENTAL DEATH AND DISMEMBERMENT
Enrollment forms for this benefit are available by contacting the Plan Administrator, Johnson Inc. Coverage is effective on the date the completed enrollment form is received by the Plan Administrator, Johnson Inc. If a member
is not presently insured or wishes to increase the benefit level, application
is required. The application can be obtained by contacting the Plan
Administrator, Johnson Inc.

1. **Member/Employee Only Plan**
The member or employee, under age 75, may apply for coverage from
a minimum of $10,000 to a maximum of $500,000 in units of $10,000.
Maximum coverage from age 70-74 is $100,000.

2. **Family Plan**
The member or employee, under age 70, may apply for coverage from
a minimum of $10,000 to a maximum of $500,000 in units of $10,000.
Coverage terminates at age 75. Maximum coverage from age 70-74 is
$100,000.

The member or employee’s family is insured for the following:
(a) Spousal Coverage: The spouse is insured for 50% of the member
coverage if there are dependent children, or 60% of the member
coverage if there are no dependent children.

(b) Each Dependent Child: Each dependent child is insured for 15% of
member coverage if there is an insured spouse, or 20% of member
coverage if there is no spouse.

**SCHEDULE OF BENEFITS**
The insurance includes benefits for Accidental Death, Dismemberment, Loss of
Speech and/or Hearing, Paralysis and Loss of Use, any of which are caused
by accident.

**Specific Loss Accident Indemnity**
If within one year from the date of the accident, injury results in any of the
following specific losses, the underwriter pays the percentage set opposite
such loss for injury resulting from an accident. Each sum is calculated based on
the amount of insurance.

<table>
<thead>
<tr>
<th>For Loss of:</th>
<th>Percentage of Amount of Insurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>100%</td>
</tr>
<tr>
<td>Entire Sight of Both Eyes</td>
<td>100%</td>
</tr>
<tr>
<td>One Hand and Entire Sight of One Eye</td>
<td>100%</td>
</tr>
<tr>
<td>One Foot and Entire Sight of One Eye</td>
<td>100%</td>
</tr>
<tr>
<td>Speech and Hearing in Both Ears</td>
<td>100%</td>
</tr>
<tr>
<td>Entire Sight of One Eye</td>
<td>100%</td>
</tr>
<tr>
<td>Speech or Hearing in Both Ears</td>
<td>100%</td>
</tr>
<tr>
<td>Hearing in One Ear</td>
<td>66%</td>
</tr>
<tr>
<td>All Toes of One Foot</td>
<td>33%</td>
</tr>
<tr>
<td>For Loss of or Loss of Use of:</td>
<td></td>
</tr>
<tr>
<td>Both Arms, Both Hands, or Both Feet</td>
<td>100%</td>
</tr>
<tr>
<td>One Hand and One Foot</td>
<td>100%</td>
</tr>
</tbody>
</table>
One Arm or One Leg ........................................... 100%
One Hand or One Foot .......................................... 100%
Thumb and Index Finger of the Same Hand
or Four Fingers of One Hand .................................... 66 2⁄3 %

For Paralysis of:
All Four Limbs (quadriplegia) .................................... 200%
Both Lower Limbs (paraplegia) ................................. 200%
One Arm and One Leg on the Same Side of the Body (hemiplegia) ..... 200%

“Loss” means, with regard to:
Life ....................... Death of the insured member;
Arm or Leg ................. Complete severance through or above the elbow or knee joint;
Eyes ...................... Complete and irrecoverable loss of entire sight;
Hands and Feet .......... Complete severance through or above the wrist or ankle joint, but below the elbow or knee joint;
Loss of Use ............... Total and irrecoverable Loss of Use, provided the Loss of Use is continuous for 12 consecutive months and such loss is determined to be permanent at the end of such period;
Paralysis ................... The loss of ability to move all or part of the body;
Speech .................... Complete and irrecoverable loss of the ability to utter intelligible sounds;
Hearing ................... Complete and irrecoverable loss of hearing;
Thumbs .................... Complete severance of one (1) entire phalanx of the thumb;
Fingers .................... Complete severance of two (2) entire phalanges of the finger;
Toes ...................... Complete severance of one (1) entire phalanx of the big toe and all phalanges of the other toes;
Quadriplegia ............... The permanent paralysis and functional loss of use of both upper and lower limbs;
Paraplegia ................ The permanent paralysis and functional loss of use of both lower limbs;
Hemiplegia ................ The permanent paralysis and functional loss of use of upper and lower limbs on the same side of the body.

The benefit provided under this section for all losses the insured sustains as a result of any one accident does not exceed the following:
1. With the exception of quadriplegia, paraplegia and hemiplegia, the amount of insurance;
2. With respect to quadriplegia, paraplegia and hemiplegia, two times the amount of insurance; or the amount of insurance if loss of life occurs within ninety (90) days after the date of the accident. In no event will indemnity payable for all losses under this section exceed, in the aggregate, two times the Principal Sum as the result of the same accident.

**The following benefits are included:**

**Basic AD&D (Policy 1FX45), Voluntary AD&D (Policy 1FX50)**

<table>
<thead>
<tr>
<th>Schedule of Benefits</th>
<th>Maximum Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assault</td>
<td>10% of amount insured (max. $25,000)</td>
</tr>
<tr>
<td>Bereavement**</td>
<td>6 grief sessions to a max. $2,500</td>
</tr>
<tr>
<td>Brain Damage</td>
<td>Amount of Insurance (less other AD&amp;D benefits paid)</td>
</tr>
<tr>
<td>Carjacking</td>
<td>10% of amount insured (max. $10,000)</td>
</tr>
<tr>
<td>Comatose</td>
<td>Amount of Insurance (less other AD&amp;D benefits paid)</td>
</tr>
<tr>
<td>Cosmetic Disfigurement</td>
<td>Amount of Insurance</td>
</tr>
<tr>
<td>Critical Illness Benefit</td>
<td>Maximum $2,000 (Basic AD&amp;D only)</td>
</tr>
<tr>
<td>Day Care**</td>
<td>5% of amount insured (max. $5,000)</td>
</tr>
<tr>
<td>Education**</td>
<td>5% of amount insured (max. 5,000)</td>
</tr>
<tr>
<td>Exposure and Disappearance</td>
<td>Specific Loss Accident Indemnity or Principle Sum</td>
</tr>
<tr>
<td>Family Transportation</td>
<td>Maximum $15,000</td>
</tr>
<tr>
<td>Funeral Expenses**</td>
<td>Maximum $5,000</td>
</tr>
<tr>
<td>Home Alteration and/or Vehicle Modification</td>
<td>Maximum $20,000</td>
</tr>
<tr>
<td>Identification**</td>
<td>Maximum $25,000</td>
</tr>
<tr>
<td>Hospital Indemnity</td>
<td>Maximum $2,500 per month</td>
</tr>
<tr>
<td>Occupational Training</td>
<td>Maximum $20,000</td>
</tr>
<tr>
<td>Permanent and Total Disability</td>
<td>Amount of Insurance (less other AD&amp;D benefits paid)</td>
</tr>
<tr>
<td>Psychological Therapy**</td>
<td>12 sessions to a max. $5,000</td>
</tr>
<tr>
<td>Public Transportation</td>
<td>Maximum 100% of Amount of Insurance</td>
</tr>
<tr>
<td>Rehabilitation</td>
<td>Maximum $20,000</td>
</tr>
<tr>
<td>Repatriation</td>
<td>Maximum $25,000</td>
</tr>
<tr>
<td>Seat Belt</td>
<td>25% of the Specific Loss Accident Indemnity</td>
</tr>
<tr>
<td>Workplace Modification and Accommodation</td>
<td>Maximum $10,000</td>
</tr>
</tbody>
</table>

**Benefits are coordinated between both policies. All other benefits are payable under both.**
Aircraft Coverage
Insurance provided under the Policy includes coverage for loss when such loss results from Injury sustained while and as a result of the Insured Person:
(a) riding as a passenger, and not as a pilot, operator or member of the crew, in or on any aircraft having a current and valid certificate of airworthiness and being piloted by a person who then holds a current and valid pilot’s license of a rating authorizing him to pilot such aircraft.
(b) riding as a passenger, and not as a pilot, operator or member of the crew, in or on any aircraft operated by the Canadian Armed Forces or by a similar military service of any duly constituted governmental authority of any other recognized country.
(c) boarding or alighting from or being struck by any aircraft.
The Policy excludes Injury sustained while and as a result of riding in or on any aircraft owned, operated, leased or chartered by or on behalf of the Policyholder.

Assault Benefit
In the event an Insured Person suffers a Specific Loss resulting from an Injury and indemnity for such loss becomes payable under the section of this booklet entitled “Specific Loss Accident Indemnity”, the Insurer will pay an additional indemnity equal to ten percent (10%) of the applicable indemnity payable under that section, subject to a maximum of twenty-five thousand dollars ($25,000), if the Injury is caused by an Assault on premises owned or rented by the Policyholder or if the Assault occurred while the Insured Person was travelling on company business. However, no benefit will be payable under this section if the Assault was the act of another employee of the Policyholder or an Immediate Family Member of the Insured Person or a member of the Insured Person’s household.

Bereavement Benefit
In the event an Insured Person suffers a Loss of Life resulting from Injury and indemnity for such loss becomes payable under the section of this booklet entitled “Specific Loss Accident Indemnity”, the Insurer will pay the reasonable and necessary expenses associated with grief counselling actually incurred within three hundred and sixty-five (365) days after the date of the Accident resulting in such loss, and provided by a Professional Counsellor for:
(a) your insured Spouse and/or your insured Dependent Children, in the event that you are the Insured Person who suffers a Loss of Life; or
(b) you and/or your insured Dependent Children, in the event that your insured Spouse is the Insured Person who suffers a Loss of Life; or
(c) you and/or your insured Spouse, in the event that your insured Dependent Child is the Insured Person who suffers a Loss of Life. The Insurer will pay such expenses for up to a maximum of six (6) grief counselling sessions subject to an overall maximum of two thousand five hundred dollars
($2,500) in relation to the death of the Insured Person. This benefit will not pay for any grief counselling provided by a person who would not ordinarily charge a fee for his services. The indemnity will be payable to the person who actually incurred the expenses. Indemnity under this section will be paid in excess of any other insurance or indemnity plans only for the amount which has not been covered after all other insurance or indemnity plans or other form of reimbursement have been exhausted, provided the amount is equal to or less than the reasonable and necessary charge.

Brain Damage Benefit
In the event an Insured Person suffers Brain Damage as a result of an Injury, the Insurer will pay the Principal Sum, less any other amount paid or payable under the section of this booklet entitled “Specific Loss Accident Indemnity” as the result of the same Accident, provided:
1. The Insured Person incurs Brain Damage within one hundred and twenty (120) days from the date of the Accident; and
2. The Insured Person is hospitalized as a result of Brain Damage at least seven (7) of the first one hundred and twenty (120) days of the Injury; and
3. A Physician determines and the Insurer is satisfied that the Insured Person has evidence of Brain Damage for at least six (6) consecutive months.

Business Venture Benefit (Applicable to Voluntary AD&D only)
When an insured member sustains an injury which results in a Loss payable under the “Specific Loss Accident Indemnity”, the insured member will qualify for a Business Venture benefit which covers the Initial Costs applicable to the development of a new independent business enterprise in Canada.

To qualify for benefits the insured member must be totally disabled from his/her own occupation beginning within 365 days following the date of injury; remain totally disabled for a continuous period of one year providing proof of disability to the underwriter within said one-year period; and submit to the insurer a Business Plan as defined by the Master Policy at the end of said one-year period.

The Initial Cost must be incurred by the insured member within the second year following the date total disability begins and are subject to the lesser of a maximum of 20% of the insured member’s principal sum or $50,000.

Initial Costs include land, buildings, fixtures, machinery, supplies, vehicles, pre-opening expenses but exclude daily operating costs as defined in the Master Policy. The Initial Costs will not include more than the insured member’s equitable share, if in a partnership or facility sharing agreement with one or more persons.

Carjacking Benefit
In the event an Insured Person suffers a Specific Loss resulting from an Injury and indemnity for such loss becomes payable under the section of this booklet entitled “Specific Loss Accident Indemnity”, the Insurer will pay an additional
indemnity equal to ten percent (10%) of the applicable indemnity payable under the section of this booklet entitled “Specific Loss Accident Indemnity”, if the Injury occurs during a carjacking of an automobile that the Insured Person was operating, getting into or out of, or riding as a passenger, subject to a maximum of ten thousand dollars ($10,000). Verification of the carjacking must be made part of an official police report within twenty-four (24) hours of the carjacking, or as soon as reasonably possible, or be certified in writing by the investigating officer(s) within twenty-four (24) hours of the carjacking, or as soon as reasonably possible, and the Insurer must receive a copy of the relevant police report or certification in order for any indemnity to become payable under this section.

Comatose Benefit
In the event a Physician determines that an Insured Person has become Comatose as a result of an Injury, the Insurer will pay an indemnity equal to the amount of the Principal Sum less any other amount paid or payable under the section of this booklet entitled “Specific Loss Accident Indemnity” as the result of the same Accident, provided:
(1) The Insured Person becomes Comatose within three hundred and sixty-five (365) days after the date of the Accident; and
(2) The Insured Person has been Comatose for at least sixty (60) consecutive days.

Common Disaster Benefit (Applicable to Voluntary AD&D Only)
In the event you and your insured Spouse both suffer a Loss of Life resulting from an Injury and indemnity for such losses becomes payable under the section of this booklet entitled “Specific Loss Accident Indemnity” as a result of a Common Accident, the indemnity for such Loss of Life applicable to your insured Spouse will be increased up to your Principal Sum amount, but in no event will the amount payable under the Policy exceed, in the aggregate, one million two hundred thousand dollars ($1,200,000).

Cosmetic Disfigurement Benefit
In the event an Insured Person suffers a Burn resulting from an Injury, the Insurer will pay an indemnity determined by multiplying the applicable Area Classification Factor, as shown in the following Cosmetic Burn Indemnity Schedule, by the percentage of body surface actually burned subject to the Maximum Allowable Percentage for Body Surface Burned as stipulated in the Cosmetic Burn Indemnity Schedule. The Maximum Allowable Percentage for Body Surface Burned, as shown in the following Cosmetic Burn Indemnity Schedule, is based on one hundred percent (100%) of the specific body part that was burned. The attending Physician will determine the actual percentage applicable to each burn.

If an Insured Person suffers a Burn or Burns to more than one (1) body part as a result of any one (1) Accident, indemnities payable for all such Burn or Burns
will not exceed one hundred percent (100%) of the Insured Person’s Principal Sum.

**Cosmetic Burn Indemnity Schedule**

<table>
<thead>
<tr>
<th>Body Part</th>
<th>Area Classification Factor</th>
<th>Maximum Allowable Percentage for Body Surface Burned</th>
</tr>
</thead>
<tbody>
<tr>
<td>Face, Neck, Head</td>
<td>11</td>
<td>9.0%</td>
</tr>
<tr>
<td>Hand &amp; Forearm (Right)</td>
<td>5</td>
<td>4.5%</td>
</tr>
<tr>
<td>Hand &amp; Forearm (Left)</td>
<td>5</td>
<td>4.5%</td>
</tr>
<tr>
<td>Upper Arm (Right)</td>
<td>3</td>
<td>4.5%</td>
</tr>
<tr>
<td>Upper Arm (Left)</td>
<td>3</td>
<td>4.5%</td>
</tr>
<tr>
<td>Torso (Front)</td>
<td>2</td>
<td>18.0%</td>
</tr>
<tr>
<td>Torso (Back)</td>
<td>2</td>
<td>18.0%</td>
</tr>
<tr>
<td>Thigh (Right)</td>
<td>1</td>
<td>9.0%</td>
</tr>
<tr>
<td>Thigh (Left)</td>
<td>1</td>
<td>9.0%</td>
</tr>
<tr>
<td>Lower Leg - below knee (Right)</td>
<td>3</td>
<td>9.0%</td>
</tr>
<tr>
<td>Lower Leg - below knee (Left)</td>
<td>3</td>
<td>9.0%</td>
</tr>
</tbody>
</table>

In the event indemnities are payable under this section and any of the sections entitled “Specific Loss Accident Indemnity”, “Permanent Total Disability Indemnity”, “Comatose Benefit” or “Brain Damage Benefit”, the total amount payable under all such sections will not exceed one hundred percent (100%) of the Insured Person’s Principal Sum or, in the case such indemnities include an indemnity for Paralysis, two hundred percent (200%) of the Insured Person’s Principal Sum.

**Critical Illness Benefit (Only Applicable to Basic AD&D)**

In the event you (to be referred to within this section as the “Insured Person”) is Diagnosed with a Critical Illness after your respective individual coverages under the policy have been in effect for a minimum period of ninety (90) consecutive days, the Insurer will pay an indemnity of two thousand dollars ($2,000) provided that such Insured Person is still living at the end of the Survival Period and subject to the exclusions listed in the present section of this booklet.

The above indemnity will be paid to the Insured Person who is Diagnosed with the Critical Illness.

Should an Insured Person claim for a Critical Illness which occurred or was diagnosed outside of Canada, such Insured Person may be eligible to receive indemnity under this section upon that person’s return to Canada. Prior to
determining eligibility, however, the Insurer will have the right to require that the Insured Person obtain, on his return to Canada, a Diagnosis by a Physician in Canada.

Wherever used in the present section of this booklet, “Critical Illness” means one of the following illnesses, conditions or surgical operations:
(a) Cancer (life-threatening);
(b) Coronary artery bypass surgery;
(c) Heart Attack;
(d) Stroke (cerebrovascular accident).

Any illness or health problem which is not included in the definition of Critical Illness in the present section of this booklet is not covered and therefore no indemnity is payable in respect of such illness.

a) “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 V invasion); or
• any non-melanoma skin cancer that has not metastasized; or
• Stage A (T1a or T1b) prostate cancer.

Moratorium Period Exclusion
No benefit will be payable under this condition if, within the first ninety (90) days following the later of:
• the effective date of the Insured Person’s insurance or
• the effective date of last reinstatement of the Insured Person’s insurance, the Insured Person 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).

This medical information as described above must be reported to the Insurer within six (6) months of the date of the Diagnosis. If this information is not provided, the Insurer has the right to deny any claim for Cancer or, any Critical Illness caused by any cancer or its treatment.

b) “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 coronary artery bypass surgery must be determined to be medically necessary by a
c) “Heart Attack” means a definite Diagnosis of the death of heart muscle due to obstruction of blood flow, that results in rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one (1) of the following:
• heart attack symptoms;
• new electrocardiogram (ECG) changes consistent with a heart attack; or
• 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.

Exclusion
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.

d) “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 thirty (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.

“Diagnosis” or “Diagnosed” refers to the determination by a Specialist, using tests or other diagnostic methods, that the Insured Person has a specific illness covered under the Policy. The Diagnosis of any covered illness must be made in Canada by a Specialist licensed to practice in Canada. Furthermore, his area of practice must include the area of medicine directly related to the illness in question.

“Irreversible” means a condition of the Insured Person where the prognosis cannot be improved by medical or surgical treatment at the time of Diagnosis.
However, when the prognosis could be improved by medical or surgical treatment but would impose, in the opinion of the Insured Person’s Physician, a risk to the Insured Person’s health that would outweigh the expected benefit(s) of such treatment, the condition is then also considered as Irreversible for the purpose of this definition.

“Survival Period” means the thirty (30) days following the date of Diagnosis. The Survival Period does not include days on Life Support as defined in the present section of this booklet.

“Life Support” means the Insured Person is under the regular care of a Physician and is kept alive due to nutritional, respiratory and/or cardiovascular support, even if Irreversible cessation of all brain functions has occurred.

“Specialist” means a licensed Physician who has been trained in the specific area of medicine relevant to the covered Critical Illness condition for which benefit is being claimed, and who has been certified by a specialty examining board. In the absence or unavailability of a Specialist, and as approved by the Insurer, a condition may be diagnosed by a qualified Physician practising in Canada. 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 of or business associate of the Insured Person.

Critical Illness Benefit Exclusions

No indemnity will be paid if a Critical Illness results directly or indirectly from any one or more of the following causes or situations:

1. Within ninety (90) days following the Insured Person’s effective date of individual coverage:
   (a) diagnosis of cancer is made; or
   (b) any sign(s) or symptom(s) of, or investigation(s) leading to, a diagnosis of cancer, regardless of when the diagnosis is made.

2. The Insured Person does not survive the Survival Period.

3. The Insured Person experiences Irreversible cessation of all brain functions before the end of the Survival Period;

4. The Insured Person suffers a self-inflicted Injury, Sickness or Disease, whether the Insured Person was sane or insane at the time of such infliction.

5. The Insured Person has used illicit drugs, or any drug other than as prescribed, recommended or administered by or in accordance with the instruction of a Physician, whether or not such drugs are available only by prescription.

6. The Insured Person has any cancer that manifests itself prior to the Insured effective date of individual coverage when the same cancer either recurs or metastasizes after such effective date.

The Insurer will only pay one (1) indemnity under this section for any Insured Person.
**Day-Care Benefit**

In the event you or your insured spouse suffer a Loss of Life resulting from an Injury and indemnity for such loss becomes payable under the section of this booklet entitled “Specific Loss Accident Indemnity”, the Insurer will pay the reasonable and necessary expenses actually incurred for Day-Care Centre attendance for any Dependent Child under thirteen (13) years of age at the date of the Insured Person’s death and who on the date of or within the following three hundred and sixty-five (365) days after such Insured Person’s death, is enrolled or enrolls in a Day-Care Centre, to the lesser of the following amounts:

(a) five percent (5%) of such deceased Insured Person’s Principal Sum; or

(b) five thousand dollars ($5,000), for each year (up to five (5) consecutive years) per Dependent Child during which such Dependent Child remains enrolled in a Day-Care Centre. The total maximum payable under this section will not exceed five thousand dollars ($5,000) per year per Dependent Child. The indemnity will be paid each year upon receipt of satisfactory proof that the Dependent Child is enrolled in a Day-Care Centre, but payment will not be made for expenses incurred prior to the Loss of Life of such Insured Person, nor for room, board or other ordinary living, travelling or clothing expenses.

The indemnity payable under this section will be payable to the person who actually incurred the expenses.

The amount payable under this section will be coordinated with any amount which is paid or payable for a same or similar benefit provided under any other policies issued to the Policyholder by the Insurer.

If none of the Insured Person’s Dependent Children satisfy the above requirements or the requirements as shown under the section entitled “Education Benefit”, the Insurer will pay to your beneficiary the lesser of the following amounts:

(a) five percent (5%) of the deceased Insured Person’s Principal Sum; or

(b) two thousand and five hundred dollars ($2,500), under only one (1) of the policies issued by the Insurer.

**Education Benefit**

In the event you or your insured spouse suffer a Loss of Life resulting from an Injury and indemnity for such loss becomes payable under the section of this booklet entitled “Specific Loss Accident Indemnity”, the Insurer will pay the reasonable and necessary tuition fees for any Dependent Child who, on the date of or within the following three hundred and sixty-five (365) days of the Insured Person’s death, is enrolled or enrolls as a full-time student in any Institution for Higher Learning, up to the lesser of the following amounts:

(a) five percent (5%) of such deceased Insured Person’s Principal Sum; or
(b) five thousand dollars ($5,000), for each year (up to five (5) consecutive years) per Dependent Child during which such Dependent Child remains enrolled as a full-time student in an Institution for Higher Learning.

The total maximum payable under this section will not exceed five thousand dollars ($5,000) per year per Dependent Child.

The indemnity will be paid each year upon receipt of proof satisfactory to the Insurer that the Dependent Child is enrolled as a full-time student in an Institution for Higher Learning. Payment will not be made for expenses incurred prior to the Loss of Life of such Insured Person, nor for room, board, books or other living, travelling or clothing expenses.

The indemnity payable under this section will be payable to the person who actually incurred the expenses.

The amount payable under this section will be coordinated with any amount which is paid or payable for a same or similar benefit provided under any other policies issued to the Policyholder by the Insurer.

**Enhanced Child Benefit (Applicable to Voluntary AD&D Only)**

In the event an insured Dependent Child suffers a Specific Loss resulting from an Injury and indemnity for such loss becomes payable under the section of this booklet entitled “Specific Loss Accident Indemnity”, the Insurer will pay double the applicable indemnity with exception of Loss of Life.

This provision is not applicable if the insured Dependent Child dies as a result of the Injury or from any cause within ninety (90) days after the date of the Accident.

**Escalation Benefit (Only Applicable to Voluntary AD&D)**

In the event an Insured Person suffers a Specific Loss resulting from an Injury and indemnity for such loss becomes payable under any of the sections of this booklet entitled “Specific Loss Accident Indemnity”, “Permanent Total Disability Indemnity”, “Comatose Benefit” or “Brain Damage Benefit” of the Policy, the Insurer will pay three percent (3%) of such indemnity, for each year your individual coverage has remained continuously in force under the Policy without interruption, subject to a total maximum of fifteen percent (15%) of such indemnity, based on the Principal Sum approved by the Insurer for this Insured Person at the time of the Accident or, if such approval was not required, the Principal Sum, as to this Insured Person, stated on your most recently signed enrollment card on file with the Policyholder at the time of the Accident.

The number of years your individual coverage remained in force will be counted as follows:

1. if you become insured on or before the effective date of this benefit, one (1) year will be counted on the first anniversary date of this benefit and one (1) year will be added on each subsequent anniversary date thereafter; or
(2) If you become insured after the effective date of this benefit, one (1) year will be counted on the first anniversary date of your insurance under the Policy and one (1) year will be added on each such subsequent anniversary date thereafter.

An Insured Person who discontinues his coverage and subsequently re-applies for coverage will be considered as a person becoming insured for the first time in the year he re-applies for coverage.

**Exposure and Disappearance Coverage**

In the event an Insured Person undergoes unavoidable exposure to natural elements and, as a direct result, suffers a Specific Loss for which indemnity would have been payable under the section of this booklet entitled “Specific Loss Accident Indemnity” if it had been caused by an Accident, the Insurer will pay the amount specified for the same loss as in the section of this booklet entitled “Specific Loss Accident Indemnity”.

In the event an Insured Person is not found within one (1) year following the date of the disappearance or sinking or wrecking of the conveyance in which he was riding at the time of such disappearance or sinking or wrecking and under such circumstances as would otherwise be covered under the section of this booklet entitled “Specific Loss Accident Indemnity”, it will be presumed the Insured Person suffered a Loss of Life resulting from an Injury at the time of such disappearance, sinking or wrecking.

**Family Transportation Benefit**

In the event an Insured Person suffers a Specific Loss resulting from an Injury and indemnity for such loss becomes payable under the section of this booklet entitled “Specific Loss Accident Indemnity” and such Insured Person is under the Regular Care and Attendance of a Physician, the Insurer will pay the reasonable and necessary expenses actually incurred by one (1) Immediate Family Member or family representative for Transportation to the bedside of such Insured Person by the most direct route from the normal place of residence of the Immediate Family Member or family representative, Accommodation in the vicinity, and return to the normal place of residence of such Immediate Family Member or family representative by the most direct route if the Insured Person had been travelling unaccompanied by an Immediate Family Member. Payment will not be made for other ordinary living, travelling or clothing expenses.

The Insurer will not pay any indemnity under this section unless such Insured Person is confined as an inpatient in a Hospital located more than fifty (50) kilometres from his normal place of residence.

Reimbursement of Transportation expenses under this section is limited to the cost of a single return trip to the bedside of the Insured Person while in Hospital. More than one form of conveyance may be used for the Transportation if necessary, but the indemnity paid will be limited to the Fare
or Fares reasonably required for a single return trip. If Transportation occurs in a Motorized Vehicle other than one operated under a license for the conveyance of passengers, then reimbursement of Transportation expenses will be limited to a maximum of thirty-five cents ($0.35) per kilometre travelled for such return trip.

The total maximum amount payable under this section by the Insurer will not exceed fifteen thousand dollars ($15,000) as a result of any one (1) Accident.

The indemnity payable under this section will be payable to the person who actually incurred the expenses.

**Funeral Expense Benefit**

In the event an Insured Person suffers a Loss of Life resulting from Injury and indemnity for such loss becomes payable under the section of this booklet entitled “Specific Loss Accident Indemnity”, the Insurer will pay the reasonable and necessary expenses actually incurred at the time of the Insured Person’s death for the services and/or materials provided by a mortician, undertaker, crematorium or funeral home that are related to the burial or cremation of a deceased Insured Person, as well as charges for the purchase of a burial plot, gravesite or mausoleum for the interment of the remains of the Insured Person, including any markers or monuments. The aggregate amount payable under this section shall not exceed the amount of five thousand dollars ($5,000), and the Insurer shall deduct from the amount payable under this section any expenses incurred for preparation of the remains for travel paid or payable under the section of this booklet entitled “Repatriation Benefit”.

The indemnity payable under this section will be payable to the person who actually incurred the expenses.

The amount payable under this section will be coordinated with any amount which is paid or payable for a same or similar benefit provided under any other policies issued to the Policyholder by the Insurer.

**Home Alteration and/or Vehicle Modification Benefit**

In the event an Insured Person suffers a Specific Loss listed below resulting from an Injury:

1. Loss of both feet or legs; or
2. Loss of Use of both feet or legs; or
3. Quadriplegia, Paraplegia or Hemiplegia,

and indemnity for such loss becomes payable under the section of this booklet entitled “Specific Loss Accident Indemnity” and such Insured Person requires the use of a wheelchair, as result of such loss, in order to be ambulatory, the Insurer will pay the reasonable and necessary expenses actually incurred by the Insured Person within three (3) years following the date of Loss for home alteration and/or vehicle modification as provided under this section.
To be covered under this section, the alteration or modification must enable the Insured Person to access his residence and/or his vehicle in a wheelchair and must be approved, where required by law, by licensing authorities.

The total maximum amount payable under this section by the Insurer will not exceed twenty thousand dollars ($20,000) as a result of any one (1) Accident.

**Home-maker Weekly Indemnity (Only Applicable to Voluntary AD&D)**
When an Insured Spouse who is neither gainfully employed nor receiving employment insurance benefits sustains an Injury and, as a result of such Injury and commencing within thirty (30) days from the date of the Accident, becomes totally and continuously disabled and is prevented from performing any and all of his regular household and/or child-caring duties, the insurer will pay one hundred and fifty dollars ($150), provided that the disability has continued for a period of seven (7) consecutive days, for the period the Insured Person is so disabled, including the seven (7) day period, while under the Regular Care and Attendance of a Physician, subject to a maximum period payable of twenty-six (26) weeks or to age seventy (70), whichever first occurs.

**Hospital Indemnity Benefit**
In the event an Insured Person suffers a Specific Loss resulting from an Injury and indemnity for such loss becomes payable under the section of this booklet entitled “Specific Loss Accident Indemnity” and such Injury requires the Insured Person to stay in a Hospital and under the Regular Care and Attendance of a Physician for at least four (4) consecutive days, the Insurer will pay a Daily Indemnity provided such Period of Hospitalization is necessary for the treatment of such Injury. Such Daily Indemnity will be paid from the first Day of Hospitalization, but in no event for more than three hundred and sixty-five (365) days per Accident.

Notwithstanding anything contained to the contrary in the Policy, a Period of Hospitalization which becomes necessary for the treatment of an Injury other than for a Specific Loss will be covered in accordance with the terms of this section, provided such Period of Hospitalization commences:
- within three hundred and sixty-five (365) days after the date of the Accident causing such Injury; and
- while this Insured Person’s individual coverage under the Policy is in force.

Such Daily Indemnity will be calculated as payable from the first Day of Hospitalization, provided the Insured Person is hospitalized for at least four (4) consecutive days.

Only one (1) Period of Hospitalization will be payable for all Injuries sustained by the Insured Person as the result of one (1) Accident.
Identification Benefit
In the event an Insured Person suffers a Loss of Life resulting from an Injury and indemnity for such loss becomes payable under the section of this booklet entitled “Specific Loss Accident Indemnity” and the police or similar governmental authority requires identification of the Insured Person’s body, the Insurer will pay the reasonable and necessary expenses actually incurred by one (1) Immediate Family Member or family representative for Transportation to the location of the Insured Person’s body by the most direct route from the normal place of residence of the Immediate Family Member or family representative, Accommodation in the vicinity, and return to the normal place of residence of such Immediate Family Member or family representative by the most direct route, if, at the time of death, the Insured Person had been travelling unaccompanied by an Immediate Family Member. Payment will not be made for other ordinary living, travelling or clothing expenses.

The Insurer will not pay any indemnity under this section unless the Insured Person’s body is located more than fifty (50) kilometres from the Insured Person’s normal place of residence.

Reimbursement of Transportation expenses under this section is limited to the cost of a single return trip to identify the deceased Insured Person. More than one form of conveyance may be used for the Transportation if necessary, but the indemnity paid will be limited to the Fare or Fares reasonably required for a single return trip. If Transportation occurs in a Motorized Vehicle other than one operated under a license for the conveyance of passengers, then reimbursement of Transportation expenses will be limited to a maximum of thirty-five cents ($0.35) per kilometre travelled for such return trip.

The total maximum amount payable under this section by the Insurer will not exceed twenty-five thousand dollars ($25,000) as a result of any one (1) Accident.

The indemnity payable under this section will be payable to the person who actually incurred the expenses.

The amount payable under this section will be coordinated with any amount which is paid or payable for a same or similar benefit provided under any other policies issued to the Policyholder by the Insurer.

Occupational Training Benefit
In the event you suffer a Loss of Life resulting from an Injury and indemnity for such loss becomes payable under the section of this booklet entitled “Specific Loss Accident Indemnity”, the Insurer will pay the reasonable and necessary expenses actually incurred within the following three (3) years after the date of such loss by your Spouse who engages in a formal occupational training program in order to become specifically qualified for active employment in an occupation for which he would not otherwise have sufficient qualifications. Payment will not be made for room, board or other ordinary living, travelling or clothing expenses.
Payment by the Insurer for the total of all expenses incurred by your Spouse under this section will not exceed twenty thousand dollars ($20,000).

The indemnity payable under this section will be payable to the person who actually incurred the expenses.

**Permanent Total Disability Indemnity**
In the event you suffer an Injury resulting in Total Disability within three hundred and sixty-five (365) days after the date of the Accident causing such Injury, provided such Total Disability was continued over a period of twelve (12) consecutive months following Commencement of Total Disability and is permanent at the end of this period, the Insurer will pay the Principal Sum, less any amount paid or payable as the result of the same Accident under the section of this booklet entitled “Specific Loss Accident Indemnity”.

**Psychological Therapy Benefit**
In the event an Insured Person suffers a Specific Loss resulting from an Injury and indemnity for such loss becomes payable under the section of this booklet entitled “Specific Loss Accident Indemnity” and such Injury requires such Insured Person to undergo psychological therapy, the Insurer will pay an indemnity equivalent to the reasonable and necessary expenses actually incurred within three hundred and sixty-five (365) days after the date of the Accident resulting in such loss for psychological therapy provided by a Professional Counsellor. The Insurer will pay up to a maximum of twelve (12) counselling sessions to an overall maximum of five thousand dollars ($5,000) per any one (1) Accident. This benefit will not pay for any counselling provided by persons who would not ordinarily charge a fee for their services. The above indemnity will be paid to the person who actually incurred the expenses.

Indemnity under this section will be paid in excess over any other insurance or indemnity plans only for the amount which has not been covered after all other insurance or indemnity plans or other form of reimbursement have been exhausted, provided the amount is equal to or less than the reasonable and necessary charge.

**Public Transportation**
In the event an Insured Person suffers a Loss of Life resulting from an Injury and indemnity for such loss becomes payable under the section of this booklet entitled “Specific Loss Accident Indemnity”, the Insurer will pay an additional indemnity equal to one hundred percent (100%) of the payable indemnity if, at the time of the Accident, the Insured Person was riding as a passenger in a regularly scheduled public land, air or water conveyance licensed to carry fare-paying passengers, including a train, bus, taxi, subway, tramway, boat or commercial airplane.
Rehabilitation
In the event an Insured Person sustains an injury which results in a Loss payable in accordance with the terms of this policy, the insurer will pay, within three (3) years from the date of the accident, the reasonable and necessary expenses actually incurred for special training in order to become specifically qualified in an occupation for which he/she would not otherwise have sufficient qualifications.

Payment by the insurer for all such expenses will not exceed twenty thousand dollars ($20,000) as the result of any one accident. Payment will not be made for room, board or other ordinary living, travelling or clothing expenses.

Repatriation Benefit
In the event an Insured Person suffers a Loss of Life resulting from Injury more than fifty (50) kilometres from that Insured Person’s normal place of residence and indemnity for such loss becomes payable under the section of this booklet entitled “Specific Loss Accident Indemnity”, the Insurer will pay the reasonable and necessary expenses actually incurred for the transportation of the body of the deceased Insured Person to a resting place (including but not limited to a funeral home or the place of interment) in proximity to the normal place of residence of the deceased Insured Person, including charges for the preparation of the body for such transportation, not to exceed, in the aggregate, the amount of twenty-five thousand dollars ($25,000) for all such expenses paid under this section as a result of one (1) Accident. The indemnity payable under this section will be payable to the person who actually incurred the expenses.

Seat Belt
In the event an Insured Person suffers a Specific Loss resulting from an Injury and indemnity for such loss becomes payable under the section of this booklet entitled “Specific Loss Accident Indemnity”, the Insurer will pay an additional indemnity equal to twenty-five percent (25%) of the applicable indemnity payable under the section of this booklet entitled “Specific Loss Accident Indemnity”, if at the time of the Accident causing such Injury, the Insured Person was driving or riding in a Motorized Vehicle and wearing a properly fastened Seat Belt. At the time of the Accident, the driver of the Motorized Vehicle must hold a current and valid driver’s license of a rating authorizing him to operate such Motorized Vehicle and neither be Intoxicated nor Under the Influence of Drugs.

Proof of Seat Belt use to the satisfaction of the Insurer must be provided as part of the written proof of loss.

Surgical Reattachment Benefit
If an Injury sustained by an Insured Person results in the complete severance of the Insured Person’s limb or appendage or part of either a limb or appendage, and if such severed limb, appendage or part is then surgically reattached
to that Insured Person within three hundred and sixty-five (365) days after the date of the Accident resulting in such Injury, then the Insurer will pay an indemnity to such Insured Person as follows:

(1) Whether or not the Insured Person regains use of the severed limb, appendage or part, the Insurer will pay an indemnity equal to 50% of the indemnity that would have been payable under the section of this booklet entitled “Specific Loss Accident Indemnity” for the Loss of such limb, appendage or part, if the surgical reattachment had not been performed.

(2) If, after the reattachment of the severed limb, appendage or part and within three hundred and sixty-five (365) days after the date of the Accident resulting in such Injury, the Insured Person suffers a total, irrecoverable and permanent Loss of Use of such reattached limb, appendage or part, the Insurer will pay an indemnity as provided under the section of this booklet entitled “Specific Loss Accident Indemnity” for Loss of Use of such limb, appendage or part, less any amount(s) paid or payable under the Surgical Reattachment Benefit provision shown under item (1) above.

(3) If, after the reattachment of the severed limb, appendage or part and within three hundred and sixty-five (365) days after the date of the Accident resulting in such Injury, such reattachment fails and the limb, appendage or part must be amputated, the Insurer will pay an indemnity as provided under the section of this booklet entitled “Specific Loss Accident Indemnity” for the Loss of such limb, appendage or part, less any amount(s) paid or payable under this Surgical Reattachment Benefit section, under items (1) and (2).

Indemnity payable under this section and the section of this booklet entitled “Specific Loss Accident Indemnity” for any one (1) Insured Person as the result of any one (1) Accident will not exceed the Principal Sum.

**Workplace Modification and Accommodation**

In the event you suffer a Specific Loss resulting from an Injury and indemnity for such loss becomes payable under the section of this booklet entitled “Specific Loss Accident Indemnity” and you require special adaptive equipment and/or workplace modification in order to reasonably accommodate your return to active work with the Policyholder, the Insurer will pay the reasonable and necessary expenses actually incurred by the Policyholder for such equipment and/or modification provided:

(1) The Policyholder agrees in writing to provide the special adaptive equipment and/or make modifications to the workplace for the purpose of making it accessible and adaptable to your needs; and

(2) The Policyholder acknowledges in writing that the performance of the essential duties of your job would be compromised in the absence of such modification or accommodation; and
(3) The proposed special adaptive equipment and/or workplace modification have prior written approval by the Insurer.

The Insurer has the right to have you examined by a professional of its choice to evaluate the appropriateness of the proposed modifications and/or equipment.

The indemnity under this section will be paid to the Policyholder once you have returned to active work with the Policyholder and the Insurer has been provided with written proof of the expenses incurred. The benefit is not payable if the Policyholder does not incur any cost in providing the special adaptive equipment and/or the workplace modification.

Payment by the Insurer for the total of all expenses incurred by the Policyholder under this section will not exceed ten thousand dollars ($10,000) as a result of any one (1) Accident.

EXCLUSIONS
No benefit will be paid for any loss, fatal or non-fatal, caused or contributed to by:

a) self-inflicted injuries, suicide or attempted suicide, whether the Insured Person was sane or insane;
b) war whether declared or undeclared, and whether or not the Insured Person was actually participating therein;
c) civil commotion, riot, insurrection, armed conflict if the Insured Person was participating therein;
d) the Insured Person’s service, whether as a combatant or noncombatant, in the armed forces of any country;
e) the Insured Person riding as a passenger or otherwise in any vehicle or device for aerial navigation, other than as provided in the section of this booklet entitled “Aircraft Coverage”;
f) medical treatment or surgery on the Insured Person, except if the medical treatment or surgery was needed because of an Accident.

CLAIMS PROCEDURE
To make a claim, the insured or insured’s beneficiary should notify the Plan Administrator, Johnson Inc., immediately after an accident. The Plan Administrator, Johnson Inc., must provide written notice of claim to the underwriter within thirty (30) days from the date of the accident and written proof of loss must be submitted to the underwriter within ninety (90) days after the date of such loss. Failure to submit such proof within the time required shall not invalidate nor reduce any claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible; but in no event later than one (1) year after the date of accident.

In the event of accidental death, the Accidental Death benefit shall be payable to the beneficiary or beneficiaries designated by the insured on the most recent
enrollment form under this policy. If there is no such beneficiary designation, the benefit shall be payable to the beneficiary or beneficiaries designated under the Basic Group Life Insurance. In the event that there is no beneficiary designation under this policy and the NLTA Group Insurance Program Basic Group Life policy, the Accidental Death benefit shall be payable to the estate. All other benefits payable other than “Education Benefit” and “Day-Care Benefit” are payable to the insured.

Conversion to an Individual Insurance Contract
In the event your coverage is terminated because:
(a) you cease to be an active person of the Policyholder on account of resignation, dismissal, retirement or failure to return to work for the Policyholder following a period of total disability; or
(b) you cease to be an eligible person under the Policy.

The benefits provided will be set out in a Specific Loss Accident Indemnity schedule available from the Insurer at the time of conversion, and the amount of insurance that may be converted will not exceed the lesser of:
(a) the amount of insurance then in effect on the date of termination; or
(b) a total aggregate amount of five hundred thousand dollars ($500,000) for all such conversions by any insured person. Premiums for such an individual accident policy being issued in compliance with the aforementioned condition will be calculated at the Insurer’s rates then in force for your attained age at the date of conversion.

Premiums will be payable annually in advance and the accident policy will be issued on an annually renewable basis.

Termination of Voluntary Death and Dismemberment Insurance
Insurance for the Insured Person will cease on the earliest of the following events:
1. Termination of employment, other than retirement under the provisions of the eligibility guidelines.
2. On the date of death.
3. On the day the Insured Person enters the armed forces of any country on a full-time basis.
4. Termination of the Policy or eligibility of coverage.
5. On the date the Insured Person no longer pays the required premium towards the cost of insurance, where applicable.
6. On the date the Insured Person reaches age 75.
7. For substitute teachers, on November 30th of the following school year if, during the preceding three months, the substitute teacher has not taught at least one day, and has not taught at least 10 days in the previous school year.
8. For private school teachers, coverage terminates upon termination of the teaching contract.
HEALTH – OPTION B
Current Underwriter (2014) - Desjardins Financial Security
Policy Number 140834

ELIGIBILITY
Subject to eligibility guidelines, all NLTA members and employees residing in Canada are eligible to participate in this plan. Spouses and eligible dependent children residing in Canada are also eligible to be insured under this plan option.

If a member is initially insured for single coverage only, and later acquires a dependent, their dependent will be enrolled in the plan without medical evidence, providing the Plan Administrator, Johnson Inc., is notified within 31 days of the date of eligibility for family coverage.

Coverage may continue for the surviving spouse and eligible dependent children after the death of the insured member, provided the spouse and children were insured at the time of the member’s death. Arrangement must be made to continue to pay the required premium, and dependents continue to satisfy the eligibility requirements.

If a member is covered under a spousal health care plan, the member is not required to maintain the Health Care coverage under this Plan. However, if coverage under a spouse’s plan should terminate, the member must notify the Plan Administrator, Johnson Inc., within 31 days to resume coverage without submitting application with evidence of insurability.

If the member notifies the Plan Administrator, Johnson Inc., after the 31 day period they will be required to submit evidence of medical insurability for themselves and their dependents. Coverage will become effective on the date the underwriter approves such evidence.

Any NLTA member/employee may choose to remove him/herself from this plan by contacting the Plan Administrator, Johnson Inc., to complete an Opting Out Form. Subsequent to opting out or allowing coverage to lapse or terminate, should a member wish to rejoin this plan, an application for coverage with evidence of medical insurability for the member and their dependents will be required.

SCHEDULE OF BENEFITS
Eligible Expenses
Eligible expenses must be reasonable and customary and recommended as medically necessary by a physician (except for paramedical expenses listed in the “Major Medical” section). Payment will be based on reasonable and customary charges in the area in which the treatment is rendered.

The following is a summary of the items currently eligible for payment under this Group Plan. However, should the Provincial Health Plan alter to include
any of these items, coverage under this Plan will automatically adjust in accordance with the approved legislation. Eligible expenses shall not include expenses incurred for any services, treatments and supplies which are not specifically listed in the Eligible Expenses Clause of the Master Policy.

In order to avoid unnecessary out-of-pocket expenses, members should consult the Plan Administrator, Johnson Inc., prior to incurring any expense.

**Prescription Drugs**

The member pays the pharmacy dispensing fee plus the pharmacy markup for eligible drugs. The plan pays for 100% of the ingredient cost of eligible drugs, subject to policy maximums as follows:

- Coverage is limited to drugs which legally require a written prescription in order to be dispensed including seras, injectables and oral contraceptives. Prescription by law smoking cessation drugs are subject to a maximum lifetime payment of $500 per insured member.
- Drugs used in the treatment of sexual dysfunction are subject to a maximum of $500 per person per calendar year. Fertility drugs are subject to a lifetime maximum of $15,000 per insured member.
- Whenever an interchangeable generic product is available, but not dispensed, eligible expenses shall be limited to the cost of the lowest priced generic substitute.
- Life sustaining drugs of a non-prescription nature when prescribed by a physician or dentist, and dispensed by a pharmacist, physician or dentist may be eligible for coverage.
- Drugs and medically required supplies of a non-prescription nature required as a result of a colostomy and/or for the treatment of cystic fibrosis, diabetes and parkinsonism may be eligible for coverage.

**Hospital Benefit**

If a member or eligible dependent is confined to a licensed hospital and requests semi-private or private accommodation, coverage is limited to payment of 100% of the hospital’s charge for a semi-private room. Charges for any portion of the cost of ward accommodation, utilization or co-payment fees, or similar charges are not eligible.

**Major Medical**

The plan pays 80% of eligible expenses subject to certain restrictions and limitations.

1. Transportation when recommended by a medical doctor to and from the nearest medical or surgical specialist, or to and from the nearest hospital for special hospital services is subject to a ground transportation deductible of 500 kilometers per calendar year for each insured member. If transportation is in a private automobile, the eligible expense will be $0.15 per kilometre. Payment is based on the lowest cost transportation available. The maximum transportation benefit is $600 per Insured Person
per calendar year. The cost for transportation outside Newfoundland and Labrador will only be considered if the treatment is not available in Newfoundland and Labrador. The patient must be referred by a specialist in Newfoundland and Labrador, who would have to give reason for such referral. Transportation must originate in the Province of Newfoundland and Labrador.

2. Diagnostic procedures, radiology, radium, administration of anaesthetics, blood transfusions including supply of plasma and blood and oxygen (including the equipment necessary for its administration).

3. With a written prescription, the purchase of trusses, braces, crutches, canes, walkers and artificial limbs or eyes. Compression stockings less than 20 mg are payable at 80% to a maximum of $50 per calendar year. If compression is greater than 20 mg, a maximum of four pairs of stockings will be paid per calendar year. This benefit includes orthopaedic shoes that are part of a brace provided they are on a written prescription. If the orthopaedic shoes do not form part of a brace, the benefit percentage is limited to 80% to a maximum payment of $200 per calendar year. With a written prescription, this benefit also includes custom made orthotic inserts to a maximum of two pairs every three calendar years.

4. Rental, or, at the underwriter's option, purchase of a wheelchair, hospital bed or respirator/ventilator.

5. Dental treatment for the repair of damage resulting directly from an accidental injury to natural teeth. The treatment must be rendered within twelve (12) months following the accident, and coverage, as well as the policy, must still be in force. Payment will be made based on the amount for the least expensive procedure which will provide a professionally adequate result.

6. Charges for physician services for medically necessary services outside the province, on the referral of a specialist, provided such treatment is not available in the province. For referral outside Canada, the service must not be available in Canada. The maximum payment per person per calendar year for referral treatment outside Canada is $5,000.

7. Private duty nursing services which are deemed to be within the practice of nursing and which are provided in the patient’s home by a registered nurse. Eligible expenses are subject to a maximum payment of $10,000 per person per calendar year. Charges for the following services are not eligible:
   a) service provided for custodial care, homemaking, duties or supervision;
   b) service performed by a nursing practitioner who is an immediate family member or lives with the patient;
   c) services performed while the patient is confined in a hospital, nursing home or similar institutions;
   d) service which can be performed by a person of lesser qualification, a relative, friend, or a member of the patient’s household. The Plan Administrator, Johnson Inc., requires that an “Authorization Form for Registered Nurse at Home” be completed.
8. Purchase of two hearing aids per insured (one per ear) to a maximum payment of $600 per hearing aid in any two (2) consecutive calendar years.

9. Fees of an oral surgeon other than for dental services for visits and consultations, up to a maximum payment of $50 per visit and limited to a maximum of two (2) visits per calendar year.

10. Purchase of Transcutaneous Nerve Stimulators to a lifetime maximum of $700.

11. Bandages, gauzes, incontinent pads and mattress pads, on the written prescription of a physician.

12. Wigs or hairpieces required as a result of medical treatment or alopecia up to a maximum payment of $1,500 per person in any five (5) consecutive calendar years.

13. Water purification system and valve used in connection with a dialysis machine.

14. Ambulance services when medically required.

15. Professional services of the following licensed, certified or registered paramedical practitioners (when operating within their recognized fields) up to the levels specified in the following chart:

<table>
<thead>
<tr>
<th>Practitioner</th>
<th>Total yearly maximum payable per person</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychologist/Registered Social Worker</td>
<td>$800</td>
</tr>
<tr>
<td>Speech Therapist</td>
<td>$800</td>
</tr>
<tr>
<td>Acupuncturist</td>
<td>$800</td>
</tr>
<tr>
<td>Podiatrist*</td>
<td>$800</td>
</tr>
<tr>
<td>Osteopath**</td>
<td>$800</td>
</tr>
<tr>
<td>Naturopath</td>
<td>$800</td>
</tr>
<tr>
<td>Masseur</td>
<td>$800</td>
</tr>
<tr>
<td>Chiropractor**</td>
<td>$800</td>
</tr>
<tr>
<td>Physiotherapist</td>
<td>$800</td>
</tr>
</tbody>
</table>

*Also eligible is a payment of up to $100 for the surgical removal of toe nails or the excision of plantar warts.

**Also eligible is up to $15 for one x-ray annually.

*** Under some circumstances, benefits may not be payable until the government plan concerned has paid its yearly maximum.
Vision Care
16. Purchasing and fitting of prescription glasses, as well as repairs, or elective laser vision correction procedure, including contact lenses and prescription sunglasses, reimbursed at 80% to a maximum payment of $125 in any three (3) consecutive calendar years for adults, and once in any calendar year for eligible dependents under age 18, only with a prescription change, which has been recommended by an optometrist or ophthalmologist. However, if special eye glasses are required due to eye surgery performed while insured, up to $150 during a lifetime will be paid for frames, lenses and the fitting of prescription glasses.

17. Contact lenses prescribed for severe corneal astigmatism, severe corneal scarring, keratoconus or aphasia, provided vision can be improved to at least the 20/40 level by contact lenses (but cannot be improved to that level by regular glasses). Payment will be made up to $250 per Insured Person in any two (2) consecutive calendar years.

18. Treatment of eye for accidental injury or disease.

19. Diagnostic services for suspected disease.

20. Services for visual training or remedial exercises at 50% co-insurance.

21. Eye examinations (including refraction) – one (1) per calendar year for dependent children and one (1) in any two (2) consecutive calendar years for other persons.

22. Laser eye surgery, with a lifetime maximum of $500 per insured member.

Expenses Not Covered
No payment will be made for expenses resulting from:

1. Any charges or services, treatment or supplies:
   • for which there would be no charge except for the existence of insurance;
   • which are performed or provided by an immediate family member or a person who lives with the patient;
   • which are provided while confined in a hospital on an in-patient basis;
   • which are not specified as an Eligible Expense under this plan.

2. Services, treatments or supplies eligible under this Plan and payable under any government plan, whether or not the claimant is covered under such a plan. The underwriter will only consider that amount of an eligible expense which is over and above the amount that would be payable by the government plan.

3. Intentional self-inflicted injuries or illness while sane or insane.

4. Injury resulting directly or indirectly from insurrection, war, service in the armed forces of any country or participation in a riot.

5. Any injury or illness for which the person is entitled to benefits under any Workers’ Compensation Act.

6. Travel for health reasons or periodic health examination or examinations required for a third party.
7. Cosmetic surgery or treatment (when so classified by the underwriter) unless such surgery or treatment is for accidental injuries and commenced within 90 days of an accident.

8. Charges levied by a physician or dentist for completion of medical reports and forms, time spent travelling, broken appointments, transportation costs, room rental charges or for advice given by telephone or other means of telecommunication.

9. Drugs, sera, injectables and supplies which are not approved by Health Canada (Food and Drugs) or are experimental or limited in use whether or not so approved.

10. Experimental medical procedures or treatment methods not approved by the Canadian Medical Association and the Newfoundland and Labrador Medical Association or the appropriate medical specialty society.

11. Charges for intrauterine devices and diaphragms.

CLAIMS PROCEDURES

Health Claims
The member may submit claims to the Plan Administrator, Johnson Inc. at any time up to the end of the calendar year following the year in which the expense was incurred. All claims are paid based on the date the expense was incurred.

For all Health claim benefits, when the member’s insurance terminates for any reason, written proof of claim must be submitted to the Plan Administrator, Johnson Inc., within 90 days of the date of termination of insurance.

Direct Pay Drugs
A drug card is issued by the Plan Administrator, Johnson Inc., to all new members, and to any member, upon request. For drug claims incurred in Newfoundland and Labrador, an eligible member may upon presentation of the drug card, obtain drugs from a pharmacy by paying only the pharmacy dispensing fee and markup. The pharmacist will bill the Plan Administrator, Johnson Inc., for 100% of the ingredient cost of the eligible prescribed drug.

If a drug claim is not payable in the above manner, an eligible member must pay the entire purchase cost to the pharmacy and submit proof of claim to the Plan Administrator, Johnson Inc., for reimbursement of eligible expenses.

Hospital
An expense will be incurred if the member requests semi-private or private accommodation while in hospital. Upon presentation of the drug card to the hospital, the hospital will bill the Plan Administrator, Johnson Inc., for the eligible expenses covered under the Hospital Benefit. The member will be required to pay the hospital the remaining expenses not covered by the Plan.
Other Expenses
For all other expenses not payable in the above manner, you are initially required to pay the full cost. A claim form should be completed and returned to the Plan Administrator, Johnson Inc., along with the original paid in full receipt, for reimbursement of eligible expenses.

Eligible expenses shall not include expenses incurred for any services, treatments and supplies which are not specifically listed in the Eligible Expenses Clause of the Master Policy.

CO-ORDINATION OF BENEFITS
(Payment from more than one Plan)
This plan includes a Co-ordination of Benefits Provision. This provision operates in the event that the member or their dependents are covered under more than one group health plan, and ensures that while claim may be made under all plans, total reimbursement received does not exceed the actual expense incurred. If a plan does not have such a provision, that plan must be the first payer for eligible expenses covered under that plan.

When both plans include the provision, expenses should be first submitted to the plan which covers the insured as a member/employee.

For dependent children, expenses should first be submitted to the plan of the spouse whose birthday falls first in the year. Any amount not paid may then be submitted to the other spouse’s plan.

When submitting claims under the second plan, any information and payment details provided by the first plan should be included.

NOTE: The co-ordination of benefits may apply to two members (spouses) who are both paying into the NLTA Plan.

TERMINATION OF INSURANCE
Insurance for the insured member and their dependents will cease on the earliest of the following events:
1. Termination of employment, other than retirement under the provisions of the eligibility guidelines.
2. On the date of death.
3. On the day the insured member enters the armed forces of any country on a full-time basis.
4. Termination of the Policy or eligibility of coverage.
5. On the date the insured member no longer pays the required premium towards the cost of insurance, where applicable.
6. For substitute teachers, on November 30th of the following school year if, during the preceding three months, the substitute teacher has not taught at least one day, and has not taught at least 10 days in the previous school year.
7. For private school teachers, coverage terminates upon termination of the teaching contract.
Benefits After Termination
If an insured is totally disabled when Hospital and Major Medical Benefits terminate, benefits for such disability will be payable, as long as the insured remains disabled, up to a maximum period of:
1. For Hospital Benefits – 90 days after termination.
2. For Major Medical Benefits – 365 days after termination. However, coverage will terminate if the insured becomes eligible for insurance under another group plan.

Extension of the Hospital and Major Medical Benefits will cease if the Policy should terminate.

Dependent coverage may be continued after the death of a member provided the dependents were insured at the time of the member’s death, and provided the dependents continue to pay the required premium and continue to satisfy the definition of dependent.
DENTAL – OPTION B2  
Current Underwriter (2014) - Desjardins Financial Security  
Policy Number 140834  

ELIGIBILITY  
Subject to eligibility guidelines, all NLTA members and employees residing in Canada are eligible to participate in this plan. Spouses and eligible dependent children residing in Canada may also be insured.  

If a member is initially insured for single coverage only, and later acquires a dependent, their dependent will be enrolled in the Plan without penalty, providing the Plan Administrator, Johnson Inc., is notified within 31 days of the date of eligibility for family coverage.  

Coverage may continue for the surviving spouse and eligible dependent children after the death of the insured member, provided the spouse and children were insured at the time of the member’s death. Arrangement must be made to continue to pay the required premium, and dependents continue to satisfy the eligibility requirements.  

If a member is covered under a spousal dental plan, the member may choose to opt out of the NLTA Dental plan. Subsequent to opting out, should a member wish to rejoin the plan, application will be required. However, if coverage under the spouse’s plan should terminate, the member must notify the Plan Administrator, Johnson Inc., within 31 days to resume coverage without penalty.  

If the member notifies the Plan Administrator, Johnson Inc., after the 31 day period, application is required and coverage will commence on the date the application is received by the Plan Administrator, Johnson Inc., and the amount payable will be limited to $125 for each Insured Person during the first 12 months the insurance is in force.  

Any NLTA member/employee may choose to remove him/herself from this plan by contacting the Plan Administrator, Johnson Inc., to complete an Opting Out Form. Subsequent to opting out or allowing coverage to lapse or terminate, should a member wish to rejoin the plan, application will be required. Coverage will commence on the date the application is received by the Administrators, and the amount payable will be limited to $125 for each Insured Person during the first 12 months the coverage is in force.  

SCHEDULE OF BENEFITS  
Eligible Expenses  
Eligible expenses are those which are recommended as necessary by a physician or dentist and are based on the Newfoundland and Labrador Dental Association Suggested Fee Guide approved by Trustees in a particular policy year. (For example, effective May 2014, dental claims are based on the 2013 Fee Guide.)
Dental treatments are considered eligible if performed by dentists or denturists who practice within the scope of their license.

There are several dental procedures which are covered by Provincial Health Plans up to certain maximums. If the dentist or dental surgeon chooses to charge more than the amount payable by the Provincial Plan, a portion of the excess charges may be eligible under this Plan. For children under age thirteen (13), who are residents of Newfoundland and Labrador, services covered under their MCP Dental Health Plan will not be covered under this policy.

Situations may arise where alternate methods of treatment may be available. The insured and their dentist may decide which method will be used. However, the underwriter reserves the right to use the least expensive method of treatment that will provide a professionally adequate result as the basis for determining the eligible expense. It is recommended that insured members obtain a pre-determination of eligible expenses from the Plan Administrator, Johnson Inc.

**Treatment Plan**  
*(Pre-determination of eligible expenses recommended)*

A treatment plan is a plan of dental treatment (including x-rays if required) showing the patient’s dental needs, a written description of the proposed treatment necessary in the professional judgement of the dentist and the cost of the proposed treatment. The insured member should submit a copy of the treatment plan to the Plan Administrator, Johnson Inc., who will provide a pre-determination of eligible expenses covered under the plan, and the amount payable by the member in excess of the plan’s coverage. This treatment plan identifies coverage and limitations for specific services. It also clarifies insurance percentages, specific limits and the Dental Fee Guide allowance, before dental treatment commences. The treatment plan is not intended to limit a member in their choice of dentist or to tell the member or the dentist what treatment should be performed. The intent is to avoid any misunderstanding as to the extent of coverage.

**Basic Services**  
**Percentage Payable – 80% of Applicable Fee Guide**

Expenses incurred for the following items are considered eligible expenses:

1. **Diagnostic Services**
   - oral examinations, once every 12 months
   - occlusal, posterior bitewing or extra-oral films, limited to 4 of each type every 12 months
   - full mouth films once every 12 months
   - single films, limited to 10 every 12 months
   - consultation required by the attending dentist
2. Preventative Services
   • one unit of scaling and one unit of polishing, once every 12 months
   • topical fluoride treatment, once every 12 months
   • provision of space maintainers for missing primary teeth
   • provision of habit breaking appliances

3. Restorative Services
   • amalgam, silicate, acrylic and composite restorations

4. Endodontic Services
   • treatment of the diseases of the dental pulp (including root canal therapy)

5. Periodontal Services
   • treatment of diseases of the gums and other supporting tissue of the teeth including:
     1. scaling not covered under preventative services and root planing up to a combined maximum of 16 units per calendar year;
     2. provisional splinting; and
     3. occlusal equilibration, up to a maximum of 8 units per calendar year.

   However, procedures for guided tissue regeneration are considered eligible only if performed in conjunction with the following periodontal surgical procedures: Flap approach or Osseous grafts - autographs or allografts, provided natural teeth are involved.

6. Prosthodontic Services
   • relining, rebasing, and repairing an existing denture
   • repairing an existing bridge

7. Surgical Services
   • the following items required in relation to dental surgery:
     1. diagnostic radiographs
     2. laboratory procedures
     3. general anaesthetic
        • extractions (including extractions of impacted teeth)
        • simple alveolecctomy at the time of tooth extraction
        • removal of tumours, cysts, neoplasms, plus the incision and drainage of an abscess

8. Protective athletic appliances for the teeth, limited to 1 in every 12 months.

**MAJOR RESTORATIVE SERVICES**

*Percentage Payable – 80% of Applicable Fee Guide - Annual Calendar
Maximum Payment of $2,500*

1. Crowns, including gold and porcelain veneer restorations when other material is not suitable.
2. Onlays, when the major portion of the clinical crown is decayed, heavily filled or the cusps are fractured and cannot be restored using basic restorative services.

3. Inlays, when 3 or more surfaces are involved and the tooth cannot be restored using basic restorative materials. If only 1 or 2 tooth surfaces are involved, the inlay will be considered for reimbursement as a restorative service under Basic Services and payment will be determined based on the cost of a comparable amalgam or composite restoration.

EXPENSES NOT COVERED
No payment will be made for expenses resulting from:
1. Self-inflicted injuries or illness while sane or insane.
2. Injury resulting directly or indirectly from insurrection, war, service in the armed forces of any country or participation in a riot.
3. Any injury or illness for which the person is entitled to benefits under any Workers’ Compensation Act.
4. Examinations required for the use of a third party.
5. Charges levied by a physician or dentist for time spent travelling, broken appointments, transportation costs, room rental charges, advice given by telephone or other means of telecommunication, or the completion of dental reports and forms.
6. Cosmetic surgery or treatment (when so classified by the underwriter) unless such surgery or treatment is for accidental injuries and commenced within 90 days of an accident.
7. Services, treatments or supplies eligible under this Plan and payable under any government plan, whether or not the claimant is covered under such a plan. The underwriter will only consider that amount of an eligible expense which is over and above the amount that would be payable by the government plan.
8. The replacement of an existing dental appliance which has been lost, mislaid or stolen.
9. Dental services and supplies rendered for full-mouth reconstruction, for a vertical dimension correction, or for a correction to temporomandibular joint dysfunction.
11. Transportation to and from the dentist or dental specialist (e.g. endodontist, periodontist, etc.)
12. Dental treatment received from a dental or medical department maintained by an employer, an association, or a labour union.
13. Restorative treatment (dentures and fixed bridges).

14. Treatment which is not generally recognized by the dental profession as an effective, appropriate, and essential form of treatment for the dental condition.

15. Implants, or any services rendered in conjunction with implants.

CLAIMS PROCEDURE

Dental Care
The member may submit claims to the Plan Administrator, Johnson Inc., at any time up to the end of the calendar year following the year in which the expense was incurred. All claims are paid based on the date the expense was incurred.

For all dental care benefits, when the member’s insurance terminates for any reason, written proof of claim must be submitted to the Plan Administrator, Johnson Inc., within 90 days of the date of termination of insurance.

Claim forms are available at the dentist’s office. When dental expenses are incurred, dentists must complete their portion of the form. The insured completes their portion and returns it to the Plan Administrator, Johnson Inc., for payment of eligible expenses. A direct pay option may be available at your dental office.

CO-ORDINATION OF BENEFITS
(Payment from more than one Plan)

This Plan includes a Co-ordination of Benefits Provision. This provision operates in the event that the member or their dependents are covered under more than one group dental plan, and ensures that while claim may be made under all plans, total reimbursement received does not exceed the actual expense incurred. If a plan does not have such a provision, that plan must be the first payer for eligible expenses covered under that plan.

When both plans include the provision, expenses should be first submitted to the plan which covers the insured as a member/employee.

For dependent children, expenses should first be submitted to the Plan of the spouse whose birthday falls first in the year. Any amount not paid may then be submitted to the other spouse’s plan.

When submitting claims under the second plan, information and payment details provided by the first plan should be included.

NOTE: The co-ordination of benefits may apply to two members (spouses) who are both paying into the NLTA plan.
Benefits after Termination
In most cases no dental benefits are payable for expenses incurred after the date insurance terminates, even if a treatment plan has been filed and benefits have been approved by the underwriter prior to the date insurance terminates.

However, benefits are payable:

1. Where an impression for a crown, inlay or onlay had been taken prior to the date insurance terminated and the appliance is installed after the insurance terminates. Dental expenses in connection with this procedure and incurred within 30 days after the termination of insurance are eligible.

2. Dependent coverage ceased due to a member’s death and, within 90 days following the death, a dependent of the deceased employee has dental work done which is part of a series of planned essential treatment which had begun, or for which definite dental appointments had been made prior to the member’s death.

Dependent coverage may be continued after the death of a member provided the dependents were insured at the time of the member’s death, and provided the dependents continue to pay the required premium and continue to satisfy the definition of dependent.
LONG TERM DISABILITY (LTD) – OPTION C

ELIGIBILITY
Subject to eligibility guidelines, all NLTA members and employees under age 60 who have permanent or term contract positions are eligible to participate in this plan.

Substitute teachers, private school teachers and retirees are not eligible for LTD coverage. Teachers under age 40 on continuing or term/replacement contracts are automatically enrolled when they commence teaching. No application is necessary at that time.

Any NLTA member/employee may choose to remove him/herself from this plan by contacting the Plan Administrator, Johnson Inc., to complete an Opting Out Form. Subsequent to opting out or allowing coverage to lapse or terminate, should a teacher wish to rejoin this plan, an application for coverage with evidence of medical insurability will be required.

EFFECTIVE DATE OF COVERAGE
Upon enrolment, the effective date of coverage is the first day of active employment or date the application is approved by the underwriter, whichever date is later.

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

TERMINATION OF COVERAGE
Your coverage will cease on the earliest of the following events:
1. Termination of employment.
2. On the day the insured dies.
3. On the day entry is made in the armed forces on a full-time basis.
4. Termination of the Policy or eligibility of coverage.
5. On the date of retirement.
6. On the date age 60 is reached, less the qualifying period where applicable.
7. On the date premiums are no longer paid.

EXTENSION OF BENEFITS
(Continuation of benefits after insurance coverage has terminated.)

If coverage terminates while an insured member is receiving benefits, the benefits will continue as long as the member qualifies under the terms and provisions of the policy, regardless of the subsequent termination of the Group Policy.

The underwriter reserves the right to require that while in receipt of LTD income, a member furnishes proof of the continuance of total disability, and submits to an examination by the underwriter’s medical advisors when requested.
NOTE: Please note that benefits for Term Contract/Replacement teachers will terminate at the end of the contract period.

A. LONG TERM DISABILITY INSURANCE
Current Underwriter (2014) – Manulife Financial
Policy Number GH36349

Long Term Disability Insurance (formerly called Salary Continuance) is intended to protect the income of an insured member in the event that a medical disability prevents an insured member from performing the duties of their occupation beyond the expiry of paid sick leave. LTD insurance does not automatically “kick in” when an insured member’s sick leave runs out. **Application must be made and detailed medical documentation provided.** To avail of the LTD benefit, a member must be totally disabled from performing their duties, and must have medical documentation, satisfying the underwriter, confirming a continual disability from the onset of sick leave. The underwriter will perform a medical adjudication as to whether benefits are, or are not, payable.

The period of benefit payment can be short term or long term depending on the medical circumstances. This plan option provides the member with the ability to insure their income, thereby protecting themselves and their family against financial disaster should the insured member become unable to earn a living due to medical disability.

DISABILITY INCOME BENEFIT
Application for benefit is necessary. The application requires completion of forms by the insured member, the school principal (immediate supervisor), and the attending physician (usually a medical specialist). Medical proof of continuous total disability, satisfactory to the underwriter, must be submitted. The underwriter will determine eligibility for benefit based on a medical adjudication of the medical evidence.

If approved, benefit will commence after the expiration of paid sick leave, or a qualifying period of 30 calendar days, whichever is later, provided application and proof of disability is submitted within six (6) months of this qualifying period.

**Waiver of Premium**
Premiums must be paid during the qualifying period. However, a member does not pay premiums while receiving LTD benefits.

**Benefit Level**
The amount of monthly benefit is $8,000 per month.

The amount of benefit will be reduced so that the Long Term Disability payment...
plus the total income from all sources as outlined under integration of benefits does not exceed 85% of net earnings on the date of expiration of sick leave.

This benefit is not taxable since the employer does not pay any portion of the premium.

Duration of Benefit (‘own occupation’ versus ‘any occupation’)
The maximum benefit level payable for an insured member who has been deemed totally disabled from performing the duties of their normal occupation is 24 months. Thereafter, benefit can be maintained until age 60 if a medical adjudication by the underwriter confirms a total disability from any occupation for which the insured is, or may become, fitted by education, training, and/or experience.

Benefit may be continued beyond 24 months if disabled from any occupation which will pay no less than 75% of the current monthly earnings for the insured’s normal occupation. The availability of such occupations, jobs, or work will not be considered in assessing the existence of an ‘any occupation’ disability.

Continuous medical treatment and documentation is required regularly throughout the time a member accesses Disability Insurance benefits. The member must be under the regular care of a physician and receiving treatment deemed appropriate by the underwriter. The member must also be prepared to attempt rehabilitative employment, or participate in a rehabilitation program considered appropriate by the underwriter. If the member’s job requires a government permit or license, he/she will not be considered totally disabled solely because such permit or license has been withdrawn or not renewed.

Integration of Benefits
The LTD plan is designed to ensure a reasonable level of income, but is not designed as a “Stand Alone Plan”. The premium structure is based on the premise that the benefit paid will be reduced by other sources of income which a member may be eligible to access. Therefore, the plan is said to be integrated with other sources of income to which the teacher may be eligible:
1. Disability benefits payable under the Canada/Quebec Pension Plan, not including CPP/QPP dependent benefits.
3. Disability or retirement benefits payable under the Teachers’ Pension Act or the Pension Plan for the Support Staff of the Newfoundland and Labrador Teachers’ Association.
4. Disability or retirement benefits under an employer sponsored retirement plan.
5. Earnings recovered through a legally enforceable course of action against some other person or corporation.
The LTD benefit can be used to top up the other sources of income to 85% of net income.

In applying for the LTD benefit, the insured member will also be asked to sign an agreement to apply for TPP/CPP benefits or other employer sponsored disability benefits, if required by the insurance underwriter. If an insured member is approved for TPP/CPP or other employer sponsored disability benefits, the LTD monthly benefit will be adjusted accordingly. If the Pension benefits are received retroactively, then the LTD benefits will be recalculated retroactively, and the insured will be required by the underwriter to remit in full any overpayment that may occur due to this retroactive adjustment. Members should be aware that the LTD benefits are nontaxable, while the TPP/CPP employer sponsored benefits are taxable.

In the event that the insured member fails to apply for CPP or TPP or other employer sponsored disability benefits; or a disability decision from these plans has not been rendered within six (6) months from the application date, the underwriter reserves the right to commence deducting an estimate of CPP/TPP or other employer sponsored benefits from the LTD benefits.

REHABILITATION
Long Term Disability benefits are designed to be paid during periods when a member is disabled and cannot work. Often however, there will be a time when, although not yet fully recovered, a member can work at some type of job and possibly earn an income. Therefore, the insured will be encouraged to participate in a rehabilitation program developed by the underwriter’s rehabilitation counsellors in consultation with the physician, employer and rehabilitation specialists. In order to participate in a rehabilitation program not developed by the underwriter, the program must be approved by the underwriter. In the case of rehabilitation, only half of these earnings will be used to reduce the monthly benefits. Rehabilitation benefits will be paid for a maximum of 24 months. If at any time the income received from rehabilitative employment equals 75% or more of the current monthly earnings for the normal occupation, benefit payments will cease.

RECURRENT DISABILITIES
If a member recovers during the qualifying period and becomes disabled again within two weeks due to the same cause, the qualifying period will be extended by the number of days during which the member ceased to be disabled. Once the member has been disabled and received benefits under this Plan, and has returned to work, a later disability will be defined as recurrent when it occurs within six (6) months after returning to active employment. A disability will be considered to be recurrent if it results from an injury or sickness which is directly related to the causes of the immediately preceding disability. Once receiving Long Term Disability benefits, any period of disability which is classified as “recurrent” will be treated as a continuation of the previous disability. An insured member will not have to re-satisfy the
qualifying period, and benefits will begin again immediately based upon the same earnings level as at the original date of disability.

EXCEPTIONS AND LIMITATIONS
Disability income is not payable for the following:
1. A disability caused by self-inflicted injuries or illness.
2. A disability resulting from insurrection, war, service in the armed forces of any country, or participation in a riot.
3. When an insured member is not under continuing medical supervision and treatment considered satisfactory to the underwriter.
4. Pregnancy, childbirth, or miscarriage, either as a cause or effect, except complications thereof. Complications due to pregnancy are covered. However, a member will not be able to receive benefits for any cause during the time on maternity/parental leave, or placed on such leave by the employer in accordance with relevant government legislation, or the leave agreed upon by the teacher and the employer.

CESSATION OF BENEFIT PAYMENTS
Monthly payments will cease on the earliest of the following events:
1. The date a member is no longer totally disabled, as defined in the policy.
2. The date a member reaches age 60. However, should the qualifying period be completed after the 59th birthday but prior to the 60th birthday, the monthly payments will continue beyond age 60 until a total of twelve (12) monthly payments have been made.
3. The date a member fails to undergo, when requested by the underwriter, medical, psychiatric, psychological, educational and/or vocational examinations by examiners selected by the underwriter.
4. The date a member fails to undergo medical, psychiatric or psychological treatment or participate in a rehabilitation program for alcoholism, drug addiction or substance abuse treatment program when recommended by the underwriter.
5. The date a member is incarcerated in a prison or mental institution by authority of a criminal court.
6. The date a member refuses to complete and return a Reimbursement Agreement form or comply with the terms of a signed Reimbursement Agreement form, when requested, with respect to disability benefits payable under a public pension plan or the Teachers’ Pension Act or the Pension Plan for the Support Staff of the Newfoundland and Labrador Teachers’ Association, or other employer sponsored disability pension plan.
7. The date a member dies.
8. For insured members in term contract/replacement positions, the date the contract terminates.

CLAIM PROCEDURES
Claim forms are available from the Plan Administrator, Johnson Inc. The insured member will be required to complete the member portion. The immediate supervisor (i.e., principal or assistant director) must also complete a portion. The doctor must complete the Attending Physician’s statement. The family physician or medical specialist must understand the necessity of providing all and complete medical documentation, even if it means adding details for which there is no room on the form. Copies of medical history, consultation reports, chart notes and test results should also be sent. Should the medical documentation be incomplete, unnecessary delays will occur. Expenses incurred in compiling this information are the insured member’s responsibility. It is the member’s responsibility to ensure that all reports are completed and sent to the Plan Administrator, Johnson Inc. Claims must be submitted no later than six (6) months following the qualifying period (i.e. the expiration of sick leave or thirty (30) calendar days, whichever is later).

It is recommended that application for benefits be made at least twelve (12) weeks prior to the end of the qualifying period (i.e., before sick leave expires).

B. LONG TERM DISABILITY WORKERS’ COMPENSATION TOP-UP
Current Underwriter (2014) – Manulife Financial
Policy Number AOS71386

WORKERS’ COMPENSATION TOP-UP BENEFIT
Application for benefit is necessary. The application requires completion of forms provided by NLTA, and submitted to NLTA. The applicant must be in receipt of workers’ compensation lost time benefits to qualify for the LTD - Workers’ Compensation Top-Up Benefit. The NLTA Group Insurance Trustees, as policy holder, in conjunction with the insurance underwriter will determine eligibility for benefit.

If approved, the benefit will commence beginning the first day of reduced regular net income due to a lost time accident injury at work, and the benefit will be paid for a lifetime maximum period of one (1) year (195 worked days in the case of teachers).

PREMIUM
There is no waiver of premium and insured members will continue to pay LTD premium while in receipt of the LTD - Workers’ Compensation Top-Up Benefit.

BENEFIT LEVEL
The amount of benefit payable is equal to the difference between the bi-weekly workers’ compensation benefit as paid in accordance with the WHSCC Act and 85% of the bi-weekly Net Income, where Net Income is defined as gross
bi-weekly income less income tax less CPP premium less EI premium. Such income will be pro-rated to the daily rate by dividing the respective bi-weekly net incomes by 10. This benefit is not taxable since the employer does not pay any portion of the premium.

**DURATION OF BENEFIT**
The maximum lifetime benefit period is one (1) year (195 days in the case of teachers) commencing the first day of a lost time accident injury at work, or the number of work days in receipt of workers’ compensation benefits, whichever is lesser.

**CLAIMS PROCEDURES**
Claim forms are available from the NLTA. The insured member will be required to complete the application form. It is the member’s responsibility to ensure that all reports are completed and sent to the NLTA. Application must be submitted no later than six (6) months following the first day of a lost time accident injury at work where reasonably practicable.
Eligibility

• In order for a member to be eligible for Basic Critical Illness coverage they must be currently participating in the NLTA Group Insurance Program.
• Subject to eligibility guidelines, NLTA members and employees residing in Canada are eligible to participate in this option.
• Spousal/Dependent coverage is not available under this Option but is available under option CS/CC – Voluntary Critical Illness.
• Any NLTA member/employee may choose to remove him/herself from this option by contacting the Plan Administrator, Johnson Inc., to complete an Opting Out form. Subsequent to opting out or allowing coverage to lapse or terminate, should a teacher wish to rejoin this plan, an application will be required providing medical evidence of insurability to the insurance carrier.

Pre-existing Conditions Limitations Clause

It is important to note that this Critical Illness benefit has a 24-month Pre-existing Conditions Limitations clause. This limitation states that “no benefit is payable for an illness or pre-existing condition for which the participant has received care, treatment or services, consulted a physician or taken medication that was prescribed to him/her, in the 24 months prior to the effective date of coverage, unless the illness in question was diagnosed at least 24 months after the effective date of the insurance of the participant, subject to other applicable provisions of this policy”.

Illnesses or conditions covered under this benefit

<table>
<thead>
<tr>
<th>Conditions covered under the extended coverage</th>
<th>% payable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alzheimer’s disease</td>
<td>100%</td>
</tr>
<tr>
<td>Aortic surgery</td>
<td>100%</td>
</tr>
<tr>
<td>Aplastic anemia</td>
<td>100%</td>
</tr>
<tr>
<td>Bacterial meningitis</td>
<td>100%</td>
</tr>
<tr>
<td>Benign brain tumour</td>
<td>100%</td>
</tr>
<tr>
<td>Blindness (loss of sight of both eyes)</td>
<td>100%</td>
</tr>
<tr>
<td>Coma</td>
<td>100%</td>
</tr>
<tr>
<td>Coronary bypass</td>
<td>100%</td>
</tr>
<tr>
<td>Deafness (loss of hearing in both ears)</td>
<td>100%</td>
</tr>
<tr>
<td>Dilated cardiomyopathy</td>
<td>100%</td>
</tr>
<tr>
<td>Fulminant viral hepatitis</td>
<td>100%</td>
</tr>
<tr>
<td>Heart attack (myocardial infarction)</td>
<td>100%</td>
</tr>
<tr>
<td>Heart valve replacement</td>
<td>100%</td>
</tr>
<tr>
<td>HIV infection (occupationally-acquired infection)</td>
<td>100%</td>
</tr>
<tr>
<td>Kidney failure</td>
<td>100%</td>
</tr>
</tbody>
</table>
Life-threatening cancer ........................................... 100%
Liver failure .................................................... 100%
Loss of independent existence ..................................... 100%
Loss of limbs ................................................... 100%
Loss of speech ................................................. 100%
Major burns (severe) ............................................ 100%
Major organ failure (on waiting list) ................................ 100%
Major organ transplant .......................................... 100%
Motor neuron disease ........................................... 100%
Multiple sclerosis ............................................. 100%
Muscular dystrophy ............................................. 100%
Paralysis ...................................................... 100%
Parkinson’s disease ............................................. 100%
Primary pulmonary hypertension .................................. 100%
Progressive Systemic Sclerosis .................................... 100%
Stroke (cerebrovascular accident) .................................. 100%

Restrictions, Exclusions and Limitations
1. No benefit is payable for any Critical Illness resulting directly or indirectly from any of the following:
   a) intentionally self-inflicted injury, voluntary exposure to an Illness or attempted suicide while sane or insane;
   b) war, whether declared or not, active service in the armed forces of any country or participation in a riot, insurrection or civil commotion;
   c) committing or attempting to commit a criminal offence;
   d) alcohol abuse;
   e) the use of any medication, narcotic, intoxicant or any other harmful substance, except when prescribed or recommended by a Physician.

2. No benefit is payable for the following:
   a) an Illness or pre-existing condition for which the Participant has received care, treatment or services, consulted a Physician or taken medication that was prescribed to him, in the 24 months prior to the effective date of coverage, unless the Illness in question was diagnosed at least 24 months after the effective date of the insurance of the Participant, subject to other applicable provisions of this policy;
   b) paralysis, paraplegia, hemiplegia or quadriplegia resulting directly or indirectly from the practice of one or more of the following activities: amateur or professional boxing, bungee jumping, cliff diving, mountain climbing, car racing or speed races on land or water, parachuting or underwater activities;
   c) transient cerebral ischemia;
   d) all types of parkinsonism other than idiopathic and degenerative Parkinson’s disease;
   e) non-surgical techniques such as balloon angioplasty or the correction of an occlusion using laser treatment or any other non-bypass technique;
f) organic brain syndromes and psychiatric disorders other than Alzheimer’s disease;
g) lesser acute coronary syndromes including unstable angina and acute coronary insufficiency.

3. Restrictions, exclusions and limitations related to cancer diagnosis. This Benefit does not apply when cancer is diagnosed within 90 days of the effective date of coverage or last reinstatement of coverage or when the medical symptoms or problems giving rise to the diagnosis of cancer appeared during this initial 90-day period.

In addition, no benefit is payable for the following forms of cancer:

a) early prostate cancer, diagnosed as T1A N0 M0 and T1B N0M0 or equivalent staging;
b) non-invasive cancer in situ;
c) precancerous lesions, benign tumours or polyps;
d) any tumour that develops in a person who is HIV seropositive;
e) any skin cancer other than invasive malignant melanoma greater than 0.75 mm.

4. Restrictions, exclusions and limitations related to diagnosis of HIV infection. Benefits are payable provided that the following conditions are met:

a) the Insured Person (or the Policyholder) must inform the Insurer of any Accident or injury that could result in HIV infection within 14 days of the event;
b) within 14 days of the Accident or injury, the Insured Person must undergo blood tests confirming that he is HIV seronegative;
c) an HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;
d) the accidental injury must have been reported, investigated and documented in accordance with workplace legislation and regulations;
e) the Insurer may require that all blood samples taken be provided so they can be analyzed by an independent lab and may request any other blood test that it deems appropriate;
f) if an HIV vaccine becomes available, no benefits will be paid to an Insured Person who has an Accident or is injured on the job and who previously refused to be vaccinated. In addition, no benefits will be payable if a cure for HIV became available prior to the Accident or injury giving rise to the claim. HIV infections resulting from any cause not related to the Insured Person’s work, such as sexual activity or drug use, are not covered under this Benefit.

Schedule of Benefits
The Basic Critical Illness coverage provides a benefit of $10,000 to NLTA Members and staff who are under age 65, actively at work, and currently participating in the NLTA Group Insurance Program.
Termination of Benefits

- Basic Critical Illness insurance has no waiver of premium clause. Member must continue paying the applicable premium when on an approved leave of absence.
- After a lump-sum benefit has been paid, the Basic Critical Illness coverage terminates and no additional premiums are payable.
- The plan member’s coverage will terminate for the Basic $10,000 benefit on the earliest of:
  - Retirement or the plan member’s 65th birthday
  - Termination of Policy or eligibility of coverage
  - The date on which the insurance company pays a benefit for a covered critical illness under your group contract

Notice and Proof of Claim

Before settling any claim under this Benefit, the Insurer will require satisfactory written proof of the existence of the relevant Illness and of the Participant’s eligibility for benefits at the time the diagnosis was made.

A written initial notice of claim must be submitted to the Insurer within 30 days of the event.

The Insurer reserves the right to verify the diagnosis with the attending Physician(s) and to require any Participant who has submitted a claim to be examined at the Insurer’s expense.

Proof of claim related to an accident or injury that may result in HIV infection.

A written notice of claim must be submitted to the Insurer within 14 days of the Accident or injury.

The Insured Person (or the Policyholder) must notify the Insurer of the Accident or injury, which will then be investigated and a report produced in accordance with the established procedures for the occupation in question.

Conversion Option

Your group contract includes a conversion privilege clause that allows you and your spouse to convert your group Critical Illness insurance to an individual contract when your group coverage ends (age 65) or if you decide to terminate your group benefits. This individual Critical Illness insurance will terminate when you turn 70. **To avail of the Conversion Privilege, you must contact the insurance company within 31 days of the termination of your Critical Illness benefit.**
Voluntary Critical Illness – CV/CS/CC
Current Underwriter (2014) - Desjardins Financial Security
Policy Number 140834

Eligibility
Subject to the eligibility guidelines, NLTA members and employees residing in Canada are eligible to participate in this option providing they are a member of the NLTA Group Insurance Program. Note: In order for active teachers to be eligible to apply for Voluntary Critical Illness insurance benefits they must be enrolled in the $10,000 Basic Critical Illness Insurance Benefit.

Pre-existing Conditions Limitations Clause
It is important to note that this Critical Illness benefit has a 24-month Pre-existing Conditions Limitations clause. This limitation states that “no benefit is payable for an illness or pre-existing condition for which the participant has received care, treatment or services, consulted a physician or taken medication that was prescribed to him/her, in the 24 months prior to the effective date of coverage, unless the illness in question was diagnosed at least 24 months after the effective date of the insurance of the participant, subject to other applicable provisions of this policy”.

Illnesses or conditions covered under option CV/CS
Conditions covered under the extended coverage ......................................................% payable
Alzheimer’s disease ..................................................................................................100%
Aortic surgery ........................................................................................................100%
Aplastic anemia ......................................................................................................100%
Bacterial meningitis ...............................................................................................100%
Benign brain tumour ..............................................................................................100%
Blindness (loss of sight of both eyes) ...................................................................100%
Coma ......................................................................................................................100%
Coronary bypass ...................................................................................................100%
Deafness (loss of hearing in both ears) .................................................................100%
Dilated cardiomyopathy .......................................................................................100%
Fulminant viral hepatitis ....................................................................................100%
Heart attack (myocardial infarction) .................................................................100%
Heart valve replacement ....................................................................................100%
HIV infection (occupationally-acquired infection) .........................................100%
Kidney failure .....................................................................................................100%
Life-threatening cancer ..................................................................................100%
Liver failure .........................................................................................................100%
Loss of independent existence ........................................................................100%
Loss of limbs .........................................................................................................100%
Loss of speech ......................................................................................................100%
Major burns (severe) ..........................................................................................100%
Major organ failure (on waiting list) ...............................................................100%
Major organ transplant .......................................... 100%
Motor neuron disease ........................................... 100%
Multiple sclerosis ................................................ 100%
Muscular dystrophy ............................................. 100%
Paralysis ........................................................ 100%
Parkinson’s disease ............................................. 100%
Primary pulmonary hypertension ................................ 100%
Progressive Systemic Sclerosis ................................. 100%
Stroke (cerebrovascular accident) ............................. 100%

Illnesses and conditions covered under Option CC – Dependent Child
To provide additional security for parents, dependent children are covered for 22 illnesses or conditions, some of which are often diagnosed early in life. The Dependent Child benefit is a flat $5,000 and covers all eligible dependent children.

Conditions covered under the extended coverage ................% payable
Aortic surgery .................................................... 100%
Benign brain tumour ............................................ 100%
Blindness (loss of sight of both eyes) .......................... 100%
Cancer ........................................................ 100%
Cerebral palsy .................................................. 100%
Coma ........................................................ 100%
Congenital heart disease requiring surgery ..................... 100%
Cystic fibrosis .................................................. 100%
Deafness (loss of hearing in both ears) .............................. 100%
Down’s syndrome ............................................. 100%
Heart valve surgery ............................................. 100%
Kidney failure .................................................. 100%
Liver failure .................................................... 100%
Loss of limbs ................................................... 100%
Loss of speech ................................................... 100%
Major burns (severe) ........................................... 100%
Major organ failure (on waiting list) ............................ 100%
Major organ transplant ........................................... 100%
Progressive Systemic Sclerosis .................................. 100%
Serious cerebral lesion ........................................ 100%
Serious mental deficiency ....................................... 100%
Spina bifida cystica ............................................. 100%

Schedule of Benefits:
The Voluntary Critical Illness for NLTA members and staff provides the following benefits:
• Plan members – Units of $10,000 to a maximum of $300,000
• Spouse – Units of $10,000 to a maximum of $300,000
• Dependent child(ren) – $5,000 maximum
• A $50,000 non-evidence maximum. However, the Pre-existing Conditions Limitations Clause applies

Termination of Benefits
• Voluntary Critical Illness insurance has no waiver of premium clause. Member must continue paying the applicable premium to maintain coverage when on an approved leave of absence.
• After a lump-sum benefit has been paid, the Voluntary coverage (Basic or Voluntary) terminates and no additional premiums are payable.
• Plan member’s coverage will terminate for the Voluntary Critical Illness benefit on the earlier of:
  - the plan member’s 65th birthday
  - Termination of Policy or eligibility of coverage
  - the date on which the insurance company pays a benefit for a covered critical illness under your group contract
• Spousal coverage will end on the earlier of:
  - the insured spouse’s 65th birthday
  - Termination of Policy or eligibility of coverage
  - the date on which the insurance company pays a benefit for a covered critical illness under your group contract
• The dependent child coverage will end on the earlier of:
  - The plan member’s 65th birthday
  - Termination of Policy or eligibility of coverage
  - The date on which the insurance company pays a benefit for a covered critical illness under your group contract

Conversion Option for Option CV/CS
Your group contract includes a conversion privilege clause that allows you and your spouse to convert your group Critical Illness insurance to an individual contract when your group coverage ends (age 65) or if you decide to terminate your group benefits. This individual Critical Illness insurance will terminate when you turn 70. To avail of the Conversion Privilege, you must contact the insurance company within 31 days of the termination of your Critical Illness benefit.

Restrictions, Exclusions and Limitations
1. No benefit is payable for any Critical Illness resulting directly or indirectly from any of the following:
   a) intentionally self-inflicted injury, voluntary exposure to an Illness or attempted suicide while sane or insane;
   b) war, whether declared or not, active service in the armed forces of any country or participation in a riot, insurrection or civil commotion;
   c) committing or attempting to commit a criminal offence;
   d) alcohol abuse;
   e) the use of any medication, narcotic, intoxicant or any other harmful substance, except when prescribed or recommended by a Physician.
2. No benefit is payable for the following:
   a) an Illness or pre-existing condition for which the Participant has received care, treatment or services, consulted a Physician or taken medication that was prescribed to him, in the 24 months prior to the effective date of coverage, unless the Illness in question was diagnosed at least 24 months after the effective date of the insurance of the Participant, subject to other applicable provisions of this policy;
   b) paralysis, paraplegia, hemiplegia or quadriplegia resulting directly or indirectly from the practice of one or more of the following activities: amateur or professional boxing, bungee jumping, cliff diving, mountain climbing, car racing or speed races on land or water, parachuting or underwater activities;
   c) transient cerebral ischemia;
   d) all types of parkinsonism other than idiopathic and degenerative Parkinson’s disease;
   e) non-surgical techniques such as balloon angioplasty or the correction of an occlusion using laser treatment or any other non-bypass technique;
   f) organic brain syndromes and psychiatric disorders other than Alzheimer’s disease;
   g) lesser acute coronary syndromes including unstable angina and acute coronary insufficiency;
   h) spina-bifida occulta.

3. Restrictions, exclusions and limitations related to cancer diagnosis. This Benefit does not apply when cancer is diagnosed within 90 days of the effective date of coverage or last reinstatement of coverage or when the medical symptoms or problems giving rise to the diagnosis of cancer appeared during this initial 90-day period.

In addition, no benefit is payable for the following forms of cancer:
   a) early prostate cancer, diagnosed as T1A N0 M0 and T1B N0M0 or equivalent staging;
   b) non-invasive cancer in situ;
   c) precancerous lesions, benign tumours or polyps;
   d) any tumour that develops in a person who is HIV seropositive;
   e) any skin cancer other than invasive malignant melanoma greater than 0.75 mm.

4. Restrictions, exclusions and limitations related to diagnosis of HIV infection. Benefits are payable provided that the following conditions are met:
   a) the Insured Person (or the Policyholder) must inform the Insurer of any Accident or injury that could result in HIV infection within 14 days of the event;
   b) within 14 days of the Accident or injury, the Insured Person must undergo blood tests confirming that he is HIV seronegative;
   c) an HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;
d) the accidental injury must have been reported, investigated and documented in accordance with workplace legislation and regulations;

e) the Insurer may require that all blood samples taken be provided so they can be analyzed by an independent lab and may request any other blood test that it deems appropriate;

f) if an HIV vaccine becomes available, no benefits will be paid to an Insured Person who has an Accident or is injured on the job and who previously refused to be vaccinated. In addition, no benefits will be payable if a cure for HIV became available prior to the Accident or injury giving rise to the claim. HIV infections resulting from any cause not related to the Insured Person’s work, such as sexual activity or drug use, are not covered under this Benefit.

Notice and Proof of Claim

Before settling any claim under this Benefit, the Insurer will require satisfactory written proof of the existence of the relevant Illness and of the Insured Person’s eligibility for benefits at the time the diagnosis was made.

A written initial notice of claim must be submitted to the Insurer within 30 days of the event.

The Insurer reserves the right to verify the diagnosis with the attending Physician(s) and to require any Insured Person who has submitted a claim to be examined at the Insurer’s expense.

Proof of claim related to an accident or injury that may result in HIV infection.

A written notice of claim must be submitted to the Insurer within 14 days of the Accident or injury.

The Insured Person (or the Policyholder) must notify the Insurer of the Accident or injury, which will then be investigated and a report produced in accordance with the established procedures for the occupation in question.
MEDOC TRAVEL INSURANCE PLAN – OPTION T
Current Underwriter (2014) – Royal & Sun Alliance Insurance Company of Canada

INTRODUCTION
The Provincial Health Insurance Plan provides basic coverage for hospital and physician services at Newfoundland and Labrador rates while a member travels outside their province of residence. However, hospital and physician charges in foreign countries typically are far in excess of the coverage under the provincial plan. NLTA Group Insurance Trustees advise that medical insurance for travel outside of Canada is essential.

The MEDOC Plan available through the NLTA program covers reasonable and customary expenses, in excess of any medical expenses payable by the Government Health Insurance Plan or any other insurance plan, for treatment medically required during a trip as a result of an emergency. Refer to your policy for eligible expenses.

Immediate contact with Global Excel Management is necessary to ensure any eligible expenses are covered. At the first onset of symptoms of a medical emergency and before medical attention is sought, the insured must contact the MEDOC Claims Assistance Centre. However, if the insured is unable to do so because he/she is medically incapacitated, someone else must contact Global Excel Management as soon as is reasonably possible. If Global Excel Management is not contacted for a referral, or the choice is made not to receive treatment from the referred physician/hospital, eligible expenses will be reimbursed at 70% based on reasonable and customary charges.

IMPORTANT: Benefits and services eligible for payment under this policy must be pre-approved and arranged in advance by Global Excel Management.

ELIGIBILITY
Subject to eligibility guidelines, NLTA members and employees residing in Canada and insured under the Provincial Health Insurance Plan in their province of residence are eligible to participate in this plan. Spouses and eligible dependent children are also eligible to be insured under this plan option.

Medical Stability Clause – Applies to all insureds under all health plans
This insurance will not pay for any expenses incurred directly or indirectly as a result of:
1. A medical condition or related condition (other than a minor ailment), if in the ninety (90) days before the day of departure for medical, non-medical or trip interruption, or day of booking for trip cancellation benefits, the insured’s medical condition or related condition has not been stable.

2. A heart condition, if in the ninety (90) days before the day of departure for medical, non-medical or trip interruption, or day of booking for trip
cancellation benefits:
a) any heart condition has not been stable; or
b) the insured has taken nitroglycerin more than once per week specifically for the relief of angina pain, for any heart condition.

3. A lung condition, if in the ninety (90) days before the day of departure for medical, non-medical, or trip interruption, or day of booking for trip cancellation for benefits:
a) any lung condition has not been stable; or
b) the insured has been treated with home oxygen or taken oral steroids (prednisone or prednisolone) for any lung condition.

**COVERAGE**

Application forms for this benefit are available by contacting the Plan Administrator, Johnson Inc. Coverage under the annual Base Plan is effective on the date the completed application form is received by the Plan Administrator, Johnson Inc. Coverage under the Supplemental Plan commences on the first day of travel.

In order for trip cancellation insurance to be in effect, the MEDOC Plan must be purchased within five (5) business days of booking your trip, or making a deposit or full payment for your trip, or prior to any cancellation penalties being charged for that trip.

Written confirmation of coverage, a certificate of insurance, and a Claims Card with the toll-free number of the MEDOC Claims Assistance Centre will be provided.

**PLAN DESIGN**

**Base Plan**
The Base Plan is a plan that provides emergency medical coverage for an unlimited number of trips per year, up to a maximum of 35 days duration for each trip. Proof of departure from the province or territory of residence is required if a claim occurs.

The insured can apply for the Optimum Health Option or the Preferred Health Option under the Base Plan, as outlined on the application form.

**Supplemental Plan**
The insured may elect coverage under the MEDOC Supplemental Plan for trips longer than 35 days, to a maximum of 212 days. The insured can apply for the Optimum Health Option or Preferred Health Option under the Supplemental Plan.

This plan provides coverage for a single trip occurring between the date of departure and the trip termination date as in the confirmation of coverage or as subsequently advised to, and confirmed by the Plan Administrator, Johnson Inc.

*The Supplemental Plan includes Base Plan coverage. Do not add the two together.*
Trip Cancellation, Interruption & Delay – up to maximum $8,000 per Insured Person, per trip available if the insured, the insured’s immediate or extended family member, close business associate or travelling companion suffers a medical emergency before or during the scheduled trip. This only applies to trips booked prior to your day of departure from your province or territory of residence.

Emergency Medical Expenses
Eligible expenses are in Canadian currency and include:
• Emergency medical expenses for hospital, physician, surgical and medical treatment, drugs and medication, x-rays, and nursing services up to the amounts specified and a maximum aggregate of $5,000,000 per insured, per sickness or injury.
• Air emergency transportation or evacuation.
• Transportation of a family member to the bedside.
• Return of vehicle up to a maximum of $3,000.
• Return of minor dependent child with escort.
• Additional expenses for meals and accommodation up to $150 per day, maximum $1,500.
• Repatriation or Burial at place of death up to a maximum of $5,000.
• Pet return up to a maximum of $500.
• Emergency dental up to a maximum of $5,000.
• Emergency relief of dental pain up to a maximum of $300.
• Incidental hospital expenses up to a maximum of $250.

All expenses must be approved and arranged in advance by contacting Global Excel Management at the MEDOC Claims Assistance Centre.

PREMIUM INFORMATION
• The premiums are annual – for a one year period – from September 1 to August 31 and are paid in monthly installments.
• Base Plan premiums are pro-rated in the first year only from the date coverage begins until the policy re-issue date, each year on September 1st. Base Plan premiums are non-refundable and non-cancellable until the policy renewal date.
• If the insured purchased the Supplemental Plan and returned home early he/she may request a refund for unused units of coverage. No downgrade in coverage or refund of premium is permitted under the Supplemental Plan if a claim has been incurred prior to your request. Proof of early return is required.
• If the insured cancels their Supplemental Plan prior to their date of departure, the insured must pay the Base Plan premium for the remainder of the policy year.
• For premium rates, contact the Plan Administrator, Johnson Inc.

The insured will receive written notification of the re-issue in advance of the September 1st re-issue date. Coverage will continue at re-issue for the next
policy year, unless written notice of termination is provided by the insured to the Plan Administrator, Johnson Inc. within sixty (60) days from the first premium deduction for that policy year.

**LIMITATIONS AND EXCLUSIONS**
The plan does not cover or pay for expenses resulting from:
- any medical condition if any of the answers provided in the Health Option Questionnaire are not complete and accurate.
- any treatment that is not emergency treatment.
- an emergency and/or event which requires the insured to submit a claim while the coverage is not in force.
- the continued treatment, recurrence, investigation or complications of a medical condition following emergency treatment for that medical condition during a trip if the medical advisors of the MEDOC Claims Assistance Centre determine the insured was medically able to return to their province or territory of residence and chose not to return. After receiving emergency treatment for a medical condition, this insurance will not cover that medical condition, or related condition, for any other trips within ninety (90) days following the emergency treatment, including trips within the Base Plan period.
- treatment of any heart or lung condition following emergency treatment for any related or unrelated heart or lung condition, during the trip, if the medical advisors of the MEDOC Claims Assistance Centre determine the insured was medically able to return to their province or territory of residence and chose not to return. After receiving emergency treatment for any heart or lung condition, this insurance will not cover any heart or lung condition for any trips within ninety (90) days following the emergency treatment, including trips within the Base Plan period.
- any medical condition for which, prior to your day of departure and prior to booking your trip:
  - the insured was awaiting the outcome of medical tests, the results of which show any irregularities or abnormalities;
  - future investigation, consultation with another physician, treatment or surgery (except routine monitoring) recommended by a physician or planned before the trip.
- the following:
  - routine pre-natal care;
  - any medical treatment, relating to pregnancy or childbirth, occurring within nine (9) weeks before or after the expected date of delivery; or
  - childbirth occurring within nine (9) weeks before or after the expected date of delivery; or
  - any child born during the trip.
- invasive testing or surgery (including cardiac catheterization, angioplasty, and MRI) unless pre-approved by the MEDOC Claims Assistance Centre.
- any emergency transplants including, but not limited to, organ transplants and bone marrow transplants.
• participation as a professional athlete in sports, participation as a professional in underwater activities, scuba diving as an amateur unless the insured holds a basic scuba designation from a certified school or other licensing body, participation in a motorized race or motorized speed contest, bungee jumping, parachuting, rock climbing, mountain climbing, hang-gliding or skydiving. 
• committing or attempting to commit a criminal offence. 
• intentional self-injury, suicide or attempted suicide (whether sane or insane). 
• substance abuse including medication, drug or alcohol, or deliberate non-compliance with prescribed medical therapy or treatment. 
• medication, drugs or toxic substance abuse or overdose (whether or not you are sane); or your deliberate non-compliance with prescribed medical therapy or treatment; alcohol abuse, alcoholism or an accident while being impaired by drugs or alcohol or having an alcohol concentration that exceeds 80 milligrams in 100 milligrams of blood. 
• mental or emotional disorders, other than acute psychoses, unless admitted to hospital. 
• trip cancellation or trip interruption/delay when the insured is aware, on the effective date of insurance and/or day of booking, of any reason that might reasonably prevent them from travelling. 
• war (declared or not), act of foreign enemies or rebellion. 
• any claim that arises directly or indirectly, in whole or in part, out of terrorism or out of any activity or decision of a government agency or other entity to prevent, respond to or terminate terrorism. This exclusion applies regardless of any other contributing or aggravating cause or event that contributes concurrently or in any sequence to the claim. 
• any portion of the benefits that require prior authorization and arrangement by Global Excel Management if such benefits were not pre-authorized and arranged by Global Excel Management. 
• expenses incurred for any medical condition or related condition that arises during a trip undertaken with the knowledge acquired prior to the day of departure, that the insured will require or seek treatment or surgery for that medical condition or related condition, whether or not recommended by a physician. 
• treatment or surgery for a specific medical condition, or a related condition, which: 
  - caused a physician to advise the insured not to travel; or
  - the insured contracted in a country during the trip when, before the date of departure, the Department of Foreign Affairs and International Trade of the Canadian government has issued an advisory not to travel within that country. 
• eye glasses, contact lenses, hearing aids or prescriptions for the same. 
• air travel, other than as a passenger in a commercial aircraft licensed to carry passengers for hire.
• when riding as a passenger on a common carrier which is not licensed for the transportation of passengers for compensation or hire.
• active participation in and/or voluntary exposure to any risk from: war or act of war, whether declared or undeclared; invasion or act of foreign enemy; declared or undeclared hostilities; civil war, riot, rebellion; revolution or insurrection; act of military power, or any service in the armed forces.

The terms of the Individual Policy as provided by the Plan Administrator, Johnson Inc., apply if any discrepancy exists between the policy and this booklet.
VOLUNTARY AUTOMOBILE & HOME INSURANCE

Auto & Home Insurance options are available to MEMBERS and their spouses through Johnson Inc. subject to certain eligibility requirements. The following information is meant to provide a summary; please check your own specific plan or call your Service Supervisor for further details.

Disability Waiver of Premium
In addition to “standard” coverages and endorsements, MEMBERS will have their home and auto premiums reimbursed for up to six (6) months if they are unable to work for more than thirty (30) consecutive days.

AIR MILES® Reward Miles
Johnson Inc. now offers AIR MILES® reward miles! You can earn one (1) AIR MILES® reward mile for every $20 in premium paid (including taxes) on your home and/or auto insurance through Unifund Assurance Company.

PS-PLAN Advantages
Members are also awarded valuable service advantages at no additional cost. The “Preferred Service Plan” (PS) for home or auto insurance offers competitive rates and is available through and administered by Johnson Inc. Premiums are paid through PAYROLL deduction with no down payment, interest or service charges.

Several PS-Plan Advantages:
• “Members Only” Website
• No Interest or Service Charges
• 24-Hour Customer Policy and Claim Service
• Automatic Renewal

Johnson Inc. is also pleased to be able to offer you the advantage of an extensive Branch Network across the province (please see below for a branch near you.)

Branch Locations
St. John’s: Johnson Building Memorial University
Mount Pearl Carbonear Whitbourne Clarenville
Marystown Gander Grand Falls Corner Brook
Stephenville Port aux Basques

Or call toll-free for a Quote: 1-800-563-0677
AUTOMOBILE INSURANCE – OPTION D
Current Underwriter – Unifund Assurance

Premiums are based on such things as your number of years licensed, claims and accident history, type and age of vehicle, where/how vehicle is used, and amount of coverage required. Discounts to your premium may be available.

The following valuable benefits are available to you as a Unifund Assurance Company auto policyholder (excluding Facility policies.)

PS-AUTO PLUS PLAN
The PS-Auto Plus option of the Preferred Service Plan provides, at a low monthly premium, extra insurance benefits including:

• Depreciation Addback – amount of depreciation applicable to the preceding 24 months will be added back to a claim on a vehicle you own;
• Accidental Death Benefit ($10,000) – if you or your spouse are fatally injured in a private passenger vehicle while wearing a seat belt;
• Accidental Death Benefit ($25,000) – if you or your spouse are fatally injured while riding on a public transport conveyance; and
• $1,000 Reward – for the recovery of your stolen automobile, conviction of thief, vandal or hit-and-run driver.

Other Coverage Options available include:
• Third Party Liability – limits from $500,000 to $2,000,000.
• Accident Benefits
• Physical Damage Coverage – including all perils, collision, comprehensive and specified perils coverage. Various deductibles are available.
• Standard Endorsement Forms
• Accident Forgiveness – in the event of a first at-fault accident, we’ll keep your driving record intact.

Note: Some limitations and conditions apply. Full details are available from Johnson Inc.

Call toll-free 1-800-563-0677 for a quote (quotations and cost comparisons are provided without obligation.)
HOME INSURANCE – OPTION E

Current Underwriter – Unifund Assurance

Premiums are based on such things as the age and location of the home, fire protection, type of heat, and amount of coverage required. Discounts to your premium may be available.

The following valuable benefits are available to you on your Unifund Assurance Company Homeowners, Condominiums, or Tenants policies covering your primary residence.

PS-HOME PLUS PROGRAM

The PS-Home Plus option of the Preferred Service Plan provides insurance benefits including:

**Damage from Airborne Perils** – $10,000 providing protection against damage to your home’s exterior due to such things as harmful precipitation.

**Waiver of Deductible** – if damage is $6,000 over deductible, deductible is waived.

**Additional Living Expenses** – $5,000 for unexpected additional costs incurred if you are officially ordered to evacuate your home.

**Home Security Benefits** – including rewards for recovery of stolen valuables and conviction of an arsonist or burglar.

**Personal Internet or Identity Theft** – to help you or your spouse with the cost involved if your identity is stolen.

PS-HOME PLUS “PLATINUM” PROGRAM

We are constantly looking for new ways to improve benefits to meet your needs. Along with the 21 PS-Home Plus Benefits, you can now receive a great new PS-Home Plus Platinum Benefit package! This plan is available at a low monthly premium or at no additional charge to our 50+ members. Some of the PS-Home Plus Platinum Benefits include:

**Critical Illness** – $2,000 coverage for Member or Spouse, who is age 64 or less, if diagnosed with a covered Critical Illness and survives for a specific period of time following the date of diagnosis.

**Single Deductible** – If you have a claim involving both home and auto, you would only have to pay a single deductible, which is the lower of the two.

**First Claims Forgiveness** – Any Claims-Free discount will not be lost as a result of the first home claim.

**Safety Deposit Box Protection** – Up to $20,000 for your personal property while stored in a Safety Deposit box at a bank or trust company for loss or damage caused by a peril insured under your policy.
Legal Assistance Hotline – Strictly confidential legal advice available in all Canadian jurisdictions at no extra cost.

Personal Property in a Nursing or other Long Term Care Home – Up to $15,000 for the personal property of the Member, spouse or parent who lives or resides in a nursing home for loss or damage caused by an insured peril under your policy.

PS-Home Plus Platinum benefits are supplemental to your PS-Home Plus policy and subject to the underlying policy conditions. PS-Home Plus Platinum Benefits may be added, amended, or deleted at any time. For more information, please contact your Service Supervisor.

PS-50+ ASSIST PLAN
Our PS-50+ Assist Plan is exclusive to Johnson Inc. clients that are 50+ policyholders who insure their primary residence with Unifund Assurance Company, and if you are eligible there are no additional charges. Some of the PS-50+ Assist Benefits include:

Morale Assistance – Professionals can assist you during a difficult time by providing you with moral support and by referring you to appropriate organizations or services as needed.

Nursing Assistance – If you are hospitalized for a period of at least five (5) consecutive days the services of a nurse will be provided at your home, maximum period of service per hospitalization will be 25 hours spread over a maximum of five (5) consecutive days following the hospitalization.

Housekeeping – If you are hospitalized for a period of at least five (5) consecutive days, the services of a housekeeper will be provided at your home for light housekeeping duties.

Companion Services – If you are hospitalized for a period of at least five (5) consecutive days the service of a companion will be provided at your home, maximum period of service will be 30 hours spread over a maximum of three (3) consecutive days per hospitalization.

Home Repair Referral Services – If you are in need of general repairs and maintenance around the house, the service will provide you with referrals of qualified and licensed (if applicable) home repair specialists in your area.

As a Johnson PS-50+ Assist Planholder, you can call our toll-free, 24-hour, 7-day hotline phone number at 1-800-265-6500 to access your PS-50+ Assist Benefits.
PREMIER/PREMIER PLUS COVERAGE RIDERS

The Premier and Premier Plus Coverage Riders (subject to eligibility) are additional products that allow your homeowner policy to be issued with a single overall limit of insurance. The Premier Plus Rider provides for further increased limits and additional coverages. Some examples of increased limits/additional coverage under the Premier Coverage Rider are:

- **Freezer Food** – Policy contents limits
- **Student Property** (away at school) – Policy contents limits
- **Money** – $1,000
- **Watercraft** – $5,000
- **TV Antennae, Satellite, etc.** – Includes damage done by hail, wind, and snow

Some examples of increased limits/additional coverages under the Premier Plus Coverage Rider are:

- **Money** – $2,000
- **Headstones** – $10,000
- **Watercraft** – $10,000
- **Tools pertaining to a Business, Profession or Occupation** – $10,000
- **Books pertaining to a Business, Profession or Occupation** – $25,000

Note: Some limitations and conditions apply. Full details are available from Johnson Inc.

Various Homeowners, Tenants and Condominium Policies, including all standard Policy extensions, are also available.

MEMBERS who are presently insured under these plans should contact their Service Supervisor for additional information or to make changes to their policies.

MEMBERS who do not have their auto or home insurance under these plans may wish to contact Johnson Inc. for more detailed information, (call toll-free: 1-800-563-0677). Quotations and cost comparisons are provided without obligation.

Home and auto insurance is available through Johnson Inc., a licensed insurance broker. Policies are primarily underwritten by Unifund Assurance Company. Unifund and Johnson Inc. share common ownership. Advantages and benefits are altered and replaced from time to time. In all matters the official wordings will prevail. Certain conditions may apply. ©Trademarks of AIR MILES International Trading B.V. used under license by Loyalty Management Group Canada Inc. and Johnson Inc. (for Unifund Assurance Company). AIR MILES® reward miles awarded on regular home and auto insurance policies underwritten by Unifund Assurance Company. At the time the premium is paid, one AIR MILES® reward mile is awarded for each $20 in premium (including taxes). (See www.johnson.ca/nlta for details.)
DEFINITIONS

“Accident” means a sudden and unexpected mishap or event in which an Insured Person is involved and which directly results in an Injury to the Insured Person.

“Accommodation” means lodging at a hotel, motel, inn, bed and breakfast or other like establishment as well as food reasonably required during the lodging, provided however that no indemnity will be paid for lodging at a private residence or for food not consumed as meals by the person seeking reimbursement of expenses.

“Assault” means an indictable offence, attempted indictable offence, felony, attempted felony, misdemeanour, attempted misdemeanour, summary conviction offence, attempted summary conviction offence, riot or attempted riot, including but not limited to robbery, theft, bombing, kidnapping, hijacking, larceny, sniping and murder or any attempt to commit any of the aforementioned. The laws of the jurisdiction where the Injury occurs will govern as to whether an act constitutes an Assault as hereby defined.

“Brain Damage” means irreversible physical damage to the brain causing complete incapacity of performing all the substantial and material functions and activities normal to everyday life.

“Burn” means a condition which a Physician has determined to be a 3rd degree burn.

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

“Commencement of Total Disability” means the date of commencement of the Insured Person’s Total Disability, as determined by a Physician, which date must be subject to the satisfaction of the Insurer that, on that date, the Insured Person has met all criteria for Total Disability.

“Common Accident” means a single Accident or multiple Accidents occurring within the same twenty-four (24) hour period.

“Daily Indemnity” means one-thirtieth of one percent (1/30 of 1%) of the Insured Person’s Principal Sum, subject to a maximum monthly indemnity of two thousand and five hundred dollars ($2,500).

“Day-Care Centre” means a facility, which is run according to the law, including laws and regulations applicable to day-care facilities, and which provides care and supervision for children in a group setting on a regular basis. A Day-Care Centre will not include a hospital, the child’s home or school if the only care at such school is provided during normal school hours while the Dependent Child is attending school from grades one (1) through twelve (12).
“Day of Hospitalization” means a necessary Period of Hospitalization in a Hospital as an inpatient for which a full day’s room and board is charged.

“Dentist” means a person who is duly licensed to practice dentistry.

“Denturist” means a person who is duly qualified to perform the services defined by the scope of his/her license. This includes any other practitioner practising under a similar license.

“Dependent Child” means a natural child, adopted child, stepchild or child who is in a parent-child relationship with you. The child must be dependant upon you for maintenance and support and:

1. under 21 years of age; or
2. under 25 years of age and in attendance at an Institution for Higher Learning on a full time basis; or
3. by reason of mental or physical infirmity, is incapable of self-sustaining employment and is totally dependent upon the Insured Member for support within the terms of the Income Tax Act.

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

“Earnings” are defined as gross monthly earnings including bonuses, but excluding overtime.

“Education or Training or Experience” means the employee’s formal education, training or experience and the equivalent education, training or experience he/she has obtained from his/her past or present occupation, job or work experience; his/her hobbies, social, recreational and other activities; and all the knowledge and skills the employee has obtained from his/her total life experience.

“Evidence of Insurability” means any statement made on forms approved for such purpose by the underwriter concerning medical evidence of a person’s physical condition and/or other factual information which affects his/her acceptability for coverage. Job or work experience; his/her hobbies, social, recreational and other activities; and all the knowledge and skills the employee has obtained from his/her total life experience.

“Fare” means the regular fare charged for:

1. an economy class seat on a regular flight by a domestic or international scheduled air carrier;
2. a coach seat on a passenger train;
3. a regular seat on a passenger bus;
4. an economy class accommodation on a boat.

Each of those carriers must hold a current and valid certificate issued by Transport Canada or, if subject to regulation in another country by a similar governmental authority having jurisdiction in that country.
“Functional Disability” means an irreversible and serious limitation of a person’s physical or mental capacity or of their skills that prevents the person from living independently.

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

“Hospital” means an institution licensed as a hospital within the jurisdiction in which it operates. To qualify under this definition, a hospital must be an active treatment hospital open at all times for the care and treatment of sick and injured persons, have a staff of one (1) or more Physicians available at all times, provide twenty-four (24) hour nursing service by graduate registered nurses and have organized facilities for diagnostics and surgery. A facility which is primarily a clinic, rest home, nursing home, convalescent hospital or similar establishment is not a Hospital. For the purposes of this definition, a Hospital will include a facility or part of a facility used for rehabilitative care.

“Injury” means bodily injury caused by an Accident occurring while the Policy is in force as to the Insured Person whose loss is the basis of claim and resulting directly and independently of all other causes in loss covered under the Policy, twenty-four (24) hours a day, anywhere in the world but in no event shall Injury mean Sickness or Disease howsoever caused unless caused by an Accident.

“Institution for Higher Learning” means and is limited to universities, colleges, CEGEPs and professional or vocational schools.

“Insurable Earnings” means that portion of the employee’s earnings that is used to determine the amount of benefit for which he/she is covered, those earnings on which premiums are being paid.

“Insurer”, “We”, “Us” means Insurance Company Inc.

“Insured Person” means you or your insured Spouse or your insured Dependant Children, while meeting the Spouse and Dependent Child definition criteria presented in this section, and before the date of individual coverage termination.

“Intoxicated” and “Under the Influence of Drugs” means that the driver has a blood alcohol content and/or is impaired due to the use of alcohol, narcotics or other drugs such that he could be subject to proceedings under provincial, state or federal law, even if he has not been subject to such proceedings.
“Loss of Life” means the death of the Insured Person.

“Loss” means:
(a) as used with reference to a hand or foot, the complete and irrecoverable severance through or above the wrist or ankle joint, but below the elbow or knee joint;
(b) as used with reference to an arm or leg, the complete and irrecoverable severance through or above the elbow or knee joint;
(c) as used with reference to a thumb, the complete and irrecoverable severance of one (1) entire phalanx of the thumb;
(d) as used with reference to a finger, the complete and irrecoverable severance of two (2) entire phalanges of the finger;
(e) as used with reference to toes, the complete and irrecoverable severance of one (1) entire phalanx of the big toe and irrecoverable severance of all phalanges of the other toes;
(f) as used with reference to an eye, the irrecoverable loss of the entire sight thereof, and determined by a Physician to be irrecoverable;
(g) as used with reference to speech, the complete and irrecoverable loss of the ability to utter intelligible sounds, and determined by a Physician to be irrecoverable;
(h) as used with reference to hearing, the complete and irrecoverable loss of hearing, and determined by a Physician to be irrecoverable.

“Loss of Use” means a total incapacity to use part of the body, which incapacity has been continuous for twelve (12) consecutive months and was determined by a Physician to be permanent at the end of such period.

“Member Only Plan” means a plan which provides insurance to the Member only.

“Member and Family Plan” means a plan which provides insurance to the Member and his/her Spouse and/or Dependent Children.

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

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

“Net Earnings” means your gross monthly salary less income tax.

“Normal Occupation” means the regular occupation, job or work (apart from any temporary assignment) an employee was performing at the time he/she became totally disabled by the condition which prevented him/her from working and led to a claim made under a policy.
“Nurse” means a graduate registered nurse (R.N.) or nurse who is licensed to practise nursing service by a governmental agency having jurisdiction over such licensing. For the purpose of this definition, nurse is neither the insured nor a member of the immediate family.

“Orthodontic Treatment” means dental treatment which has as its objective the correction or malocclusion of the teeth.

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

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

“Period of Hospitalization” means a single uninterrupted confinement in a Hospital or several successive confinements in a Hospital as a result of the same Accident, provided each such confinement is separated by a period of less than ninety (90) consecutive days and all such confinements occur within seven hundred and thirty (730) days of the date of the Accident.

“Physician” means an individual who is legally licensed to practice medicine and provide treatment within the scope of his licence by:
(a) a recognized medical licensing organization in the jurisdiction where the treatment is rendered, provided he is a member in good standing of such licensing body, or
(b) a governmental agency having jurisdiction over such licensing where the treatment was rendered.

The Physician must not ordinarily reside in the Insured Person’s residence. The Physician must not be an Insured Person, an Immediate Family Member or business associate of an Insured Person.

“Policy” means Policy as well as the Master Application, any endorsements and attached papers.

“Policyholder” means NEWFOUNDLAND AND LABRADOR TEACHERS’ ASSOCIATION.

“Principal Sum” means the amount indicated in the Master Application as being applicable to the Insured Person and stated on the Insured Person’s most recently signed individual enrollment card on file with the Policyholder, if any.

“Private School Teacher” means a certified teacher approved by the Department of Education, and teaching in a private school system (K-12) recognized and approved by the Government of Newfoundland and Labrador.

“Professional Counsellor” means a therapist or counsellor who is licensed or registered within the jurisdiction in which he practices to provide psychological treatment or counselling.
The Professional Counsellor must not ordinarily reside in the Insured Person’s residence. The Professional Counsellor must not be an Insured Person, an Immediate Family Member or business associate of an Insured Person.

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

“Qualifying Period” means an initial period of total disability before benefits become payable, as specified in the BENEFIT PLAN SUMMARY. If an employee ceases to be totally disabled during this period and then becomes totally disabled again within two (2) weeks due to the same cause, the qualifying period will be extended by the number of days during which total disability ceased.

“Regular Care and Attendance” means observation and treatment to the extent necessary under existing and recognized standards of medical practice.

“Rehabilitation Income” means income which the employee receives for work performed under a rehabilitation program, including self-employed activity.

“Residence” means the primary dwelling of which the insured is an occupant and the premises on which it is situated.

“Seat Belt” means a belt that forms a restraint system in a Motorized Vehicle.

For the purposes of this definition, a Seat Belt includes infant and child restraint systems used in Motorized Vehicles and the restraining belts which are part of a stretcher used in the transportation of sick or injured persons by ambulance.

“Sickness or Disease” means the alteration of a person’s state of health resulting from internal or external cause(s), creating objectively verifiable symptoms and/or signs, and revealing itself by the impairment of physiological or mental functions.

“Specific Loss” means Loss of Life, Loss, Loss of Use, Quadriplegia, Paraplegia or Hemiplegia, all as defined in the present section of this booklet.

“Spouse” means an individual:
(a) to whom you are legally married or in a civil union with; or
(b) although not legally married to the insured member, cohabits with the insured member in a conjugal relationship for a minimum of 12 continuous months. The term “conjugal relationship” shall be deemed to include a conjugal relationship between partners of the same sex.

However, when the individual is the biological or adoptive mother or father of at least one (1) of your children and is cohabitating with you, the individual shall be deemed a Spouse from the date of birth or adoption of that child, if that date precedes the end of the period of one year of cohabitation.
Only one (1) individual will qualify as your Spouse. If you are legally married or in a civil union but are also cohabiting with an individual as described under Item (b) above, you may elect in writing which one of the individuals will qualify as a Spouse under the Policy. This election must be filed with the Policyholder. The Insurer will not be bound by an election not filed before the occurrence of the event insured against. If an election is not filed, the Spouse will be the individual to whom you are legally married or in a civil union with.

“Totally Disabled Retired Employee” means wholly and continuously disabled by sickness or an accidental bodily injury which prevents one from engaging in duties or activities (household or otherwise) which could be considered to be normal for a person of the same age and sex.

“Totally Disabled Employee” means during the Qualifying Period and the succeeding 24 months, an employee is totally disabled when he/she is wholly and continuously disabled due to illness or bodily injury and, as a result, is not physically or mentally fit to perform the essential duties of his/her normal occupation.

“Total Disability” or “Totally Disabled”, as referenced in A3 and A4 Accidental Death and Dismemberment Policies means or directly refers to a continuous state of incapacity preventing the Insured Person from performing all of the usual and customary duties of his occupation.

An Insured Person will be deemed Totally Disabled only if he does not receive any income from any occupation after the Commencement of Total Disability, directly or indirectly, except in the context of a rehabilitation program approved by the Insurer.

For a Total Disability to be recognized, the state of the Insured Person must require Regular Care and Attendance by a Physician or an appropriate specialist. Proof of Regular Care and Attendance must be satisfactory to the Insurer.

“Transportation” means conveyance from one place to another by private or public motorized vehicle, bus, train, boat, ferry, airplane or helicopter.

“Travelling on Company Business” means any travel undertaken as part of the normal duties of the Insured Person’s occupation with the Policyholder, but excluding commuting to or from the Insured Person’s workplace.

“Waiting Period”, means a thirty-one (31) day period from the date the Insured Spouse and/or Dependent Child(ren) becomes comatose for which no benefits are payable.
Johnson offers special group discounts, better products, AIR MILES® reward miles* and the best customer service in the industry.

- Preferred insurance rates for NLTA members
- Interest free payroll or bank deduction
- 24/7 live customer support
- Accident Forgiveness on auto insurance†

1-855-516-5597 (Group ID Code: 61)
www.johnson.ca

Call for a no-obligation home or auto insurance quote today.

Home and auto insurance available through Johnson Inc., a licensed intermediary in Atlantic Canada. Policies are primarily underwritten by Unifund Assurance Company (Unifund). Unifund and Johnson Inc. share common ownership. Eligibility requirements, limitations and exclusions may apply. Policy wordings prevail. *AIR MILES® reward miles awarded on regular home and auto insurance policies underwritten by Unifund. At the time the premium is paid, one AIR MILES® reward mile is awarded for each $20 in premium (including taxes). AIR MILES® reward miles not available in SK, MB or QC. ™ Trademarks of AIR MILES International Trading B.V. Used under license by LoyaltyOne. Co. and Johnson Inc. (for Unifund). CAT.Mar.2014