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Voluntary Critical Illness Insurance Plan

Policy #1T920

In consideration of the statements set forth in the Master Application attached hereto and in the individual applications, if any, and in consideration of the payment of premium in accordance with Items 4, 5 and 6 of said Master Application,
SSQ, Life Insurance Company inc. (hereinafter called the "Insurer") agrees with:

NEWFOUNDLAND AND LABRADOR TEACHERS ASSOCIATION

(hereinafter called the "Policyholder")

to insure the following eligible persons: Members (hereinafter individually called "Insured Member") and their Spouses and Dependent Children, if any, (hereinafter individually called "Insured Spouse" and "Insured Dependent Child" respectively) for whom application is made, for coverage to the extent herein provided, and subject to all of the exceptions, limitations and provisions of the Policy.

Effective Date and Policy Term

The Policy takes effect as stated in Item 8 of the Master Application from which date all insurance years and months will be calculated. The Policy continues to be in force for the period for which premium has been paid. It may be renewed for further consecutive periods by payment of premium as provided in the Master Application, subject to the Insurer's right to decline renewal of the Policy on any Anniversary Date of the Policy stated in Item 9 of the Master Application, by giving written notice to the Policyholder of such non-renewal at least thirty (30) days prior to such date.

General Definitions

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

"Critical Illness" means a deterioration of health or bodily disorder which, while the individual's insurance is in force, leads to an initial Diagnosis of one of the illnesses or medical conditions covered under the insurance or to a covered surgery, according to the following list of Critical Illnesses. In addition, for the Diagnosed illness to be recognized as a Critical Illness for the purposes of the plan, the Diagnosis must be made by a Specialist and confirm that it meets the criteria indicated in the "Definitions of Covered Illnesses" section. For any covered surgery, a Specialist must confirm that it is medically necessary.

1. Aortic surgery
2. Aplastic anemia
3. Bacterial meningitis
4. Benign brain tumour
5. Blindness
6. Cancer (life-threatening)
7. Coma
8. Coronary angioplasty
9. Coronary artery bypass surgery
10. Crohn’s disease requiring surgery
11. Deafness
12. Dementia, including Alzheimer's disease
13. Dilated cardiomyopathy
14. Ductal carcinoma in situ of the breast
15. Fulminant viral hepatitis
16. Heart attack
17. Heart valve replacement or repair

18. Hip replacement surgery
19. Kidney failure
20. Knee replacement surgery
21. Liver failure of advanced stage
22. Loss of independent existence
23. Loss of limbs
24. Loss of speech
25. Major organ failure on waiting list
26. Major organ transplant
27. Motor neuron disease
28. Multiple sclerosis
29. Muscular dystrophy
30. Occupational HIV infection
31. Paralysis
32. Parkinson’s disease and specified atypical Parkinsonian disorders
33. Primary pulmonary hypertension
34. Progressive systemic sclerosis
35. Severe burns
36. Severe rheumatoid arthritis
37. Stage 1A malignant melanoma
38. Stage A (T1a or T1b) prostate cancer
39. Stroke
40. Systemic lupus erythematosus

Any Critical Illness or health problem which is not defined in the present provision is not covered according to this benefit and therefore, no benefit is payable in respect of such illness.

"Critical Illness" with respect to an Insured Dependent Child means one of the following illnesses, conditions or surgical operations which, while the individual's insurance is in force, leads to an initial Diagnosis of one of the illnesses or medical conditions covered under the insurance or to a covered surgery, according to the following list of Critical Illnesses. In addition, for the Diagnosed illness to be recognized as a Critical Illness for the purposes of the plan, the Diagnosis must be made by a Specialist and confirm that it meets the criteria indicated in the "Definitions of Covered Illnesses" section. For any covered surgery, a Specialist must confirm that it is medically necessary.

1. Benign brain tumour
2. Blindness
3. Cancer (life-threatening)
4. Cerebral palsy
5. Coma
6. Congenital heart disease requiring surgery
7. Cystic fibrosis
8. Deafness
9. Down's syndrome
10. Kidney failure
11. Loss of speech
12. Major organ failure on waiting list
13. Major organ transplant
14. Mental deficiency
15. Muscular dystrophy
16. Paralysis
17. Severe burns
18. Spina bifida cystica

Any Critical Illness or health problem which is not defined in the present provision is not covered according to this benefit and therefore, no benefit is payable in respect of such illness.

"Dependent Child" means a natural child, adopted child, stepchild or child otherwise in a parent-child relationship with the Insured Member. The child must be unmarried and dependent upon the Insured Member for maintenance and support, reside in Canada and:

(1) be under 21 years of age; or

(2) be under 25 years of age (26 in the Province of Quebec) and in attendance at an Institution for Higher Learning on a full-time basis; or

(3) no matter his age on the date of the claim, be residing with the Insured Member or Insured Spouse and be suffering from a severe, incurable and chronic physical or mental disability that began while the child met the conditions indicated in (1) or (2) above in this definition, and have remained continuously disabled since that date; the disability must render the child incapable of pursuing any gainful activity. The Insurer may require medical evidence of such as it seems necessary.

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

"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 or the United States by a Specialist licensed to practice in Canada or the United States. Furthermore, his area of practice must include the area of medicine directly related to the illness in question.

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

"Insured Person" means an Insured Active or Retired Member whose individual coverage under the Policy is in force, except where otherwise specified under the Policy.

"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.

"Life Support" means the Insured Person is under the regular care of a licensed Physician for nutritional, respiratory and/or cardiovascular support when Irreversible cessation of all functions of the brain has occurred.

"Member" means a salaried or retired Member of the Policyholder who is under the age of sixty-five (65) and resides in Canada, and whose usual place of work is in Canada.

"Physician" means an individual who is legally licensed to practice medicine in Canada or the United States and provides treatment within the scope of his licence. The Physician must not ordinarily reside in the Insured Person's residence. The Physician must not be the Insured Person, a relative of or business associate of the Insured Person.

"Policy" means Policy #1T920 as well as the attached Master Application, any endorsements and attached papers.

"Pre-existing Condition" means:

- the existence of symptom(s) within a twenty-four (24) month period preceding the Insured Person's effective date of individual coverage which would cause a reasonably prudent person to seek Diagnosis, care or treatment; or
- an illness or condition for which the Insured Person, during twenty-four (24) months prior to the effective date of his individual coverage, incurred medical expenses, received medical treatment, took prescribed or non-prescribed drugs or consulted a Physician.

"Principal Sum" means the amount indicated in Item 3 of the Master Application as being applicable to the Insured Person and stated on the Insured Member's most recently signed individual enrollment card on file with the Policyholder, if any.

"Specialist" means a licensed Physician who has been trained in the specific area of medicine relevant to the covered Critical Illness 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 or the United States. The Specialist must not ordinarily reside with the Insured Person. The Specialist must not be the Insured Person, a relative of or business associate of the Insured Person.

"Spouse" means an individual under the age of sixty-five (65) who resides in Canada and:

(a) who is legally married to or in a civil union with the Insured Member; or

(b) with whom the Insured Member has continuously cohabited in a conjugal relationship for a minimum of one (1) year immediately before the date of the event insured against.

However, if an individual is the biological or adoptive mother or father of at least one of the children of the Insured Member and is cohabiting with the Insured Member, the individual shall be deemed to be a Spouse from the date of birth or adoption of that child, if that date precedes the end of the period of one (1) year of cohabitation.

Only one (1) individual qualifies as the Spouse of any Insured Member. If the Insured Member is legally married or in a civil union but is also cohabiting with an individual as described under Item (b) above, the Insured Member 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 the Insured Member is legally married or in a civil union.

"Surgery" means that the Insured Person undergoes medically necessary surgery performed on the written advice of a Specialist. The Surgery must be performed by a Physician in Canada or the United States.

"Survival Period" means the fourteen (14) days following the date of Diagnosis or fourteen (14) days following the date of Surgery if applicable, except where otherwise specified under the Policy. The Survival Period does not include days on Life Support as defined in this section. The Insured Person must be alive at the end of the Survival Period and must not have experienced Irreversible cessation of all functions of the brain.

For those conditions which have a qualifying period, for example ninety (90) days for Bacterial meningitis and Paralysis, the Survival Period runs concurrently with that condition's qualifying period.

Eligibility for Coverage

All persons described as Eligible Persons under Item 2 of the Master Application are eligible for insurance coverage hereunder.

Definitions of Covered Illnesses

Other illnesses are also covered under this plan. They are defined under section "Complementary Benefit in Case of Certain Illnesses".

"Aortic Surgery" means the undergoing of Surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta refers to the thoracic and abdominal aorta but not its branches.

Exclusion: No benefit will be payable under this condition for any of the following: angioplasty; intra-arterial procedures; percutaneous trans-catheter procedures; non-surgical procedures.

"Aplastic anemia" means a definite Diagnosis of a chronic persistent bone marrow failure, confirmed by biopsy, which results in anemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one (1) of the following:

- marrow stimulating agents;
- immunosuppressive agents;
- bone marrow transplantation.

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

Exclusion: No benefit will be payable under this condition for viral meningitis.

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

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

In addition, no benefit will be payable under this condition if one of the following occurred to the Insured Person within the first ninety (90) days following the last time the Insured Person's coverage under this benefit became effective:

- signs, symptoms or investigations that lead to a Diagnosis of benign brain tumour (covered or not), regardless of when the Diagnosis was made; or
- a Diagnosis of benign brain tumour (covered or not).

Restriction: 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 within this period, the Insurer has the right to deny any claim for Benign brain tumour or any Critical Illness caused by any benign brain tumour or by its treatment.

"Blindness" means a definite Diagnosis of the total and Irreversible loss of vision in both eyes, evidenced by the corrected visual acuity being 20/200 or less in both eyes; or the field of vision being less than 20 degrees in both eyes.

"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 following types of cancer are included: carcinoma, melanoma, leukemia, lymphoma and sarcoma.

Exclusion: No benefit will be payable under this condition for any of the following:

- lesions described as benign, pre-malignant, uncertain, borderline or non-invasive, carcinoma in situ (Tis) or tumors classified as Ta;
- malignant melanoma skin cancer that is less than or equal to 1.0 mm in thickness, unless it is ulcerated or is accompanied by lymph node or distant metastasis;
- any non-melanoma skin cancer, without lymph node or distant metastasis;
- prostate cancer classified as T1a or T1b, without lymph node or distant metastasis;
- papillary thyroid cancer or follicular thyroid cancer, or both, that is less than or equal to 2.0 cm in greatest diameter and classified as T1, without lymph node or distant metastasis;
- chronic lymphocytic leukemia classified less than Rai stage 1;
- malignant gastrointestinal stromal tumours (GIST) and malignant carcinoid tumours, classified less than the American Joint Committee on Cancer (AJCC) stage 2.

In addition, no benefit will be payable under this condition if one of the following occurred to the Insured Person within the first ninety (90) days following the last time the Insured Person's coverage under this benefit became effective:

- signs, symptoms or investigations that lead to a Diagnosis of Cancer (covered or not), regardless of when the Diagnosis was made; or
- a Diagnosis of cancer (covered or not).

Restriction: 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 within this period, the Insurer has the right to deny any claim for Cancer or any Critical Illness caused by any Cancer or by its treatment.

References: For the purposes of the policy, the terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 2 are to be applied as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 7th Edition, 2010. Also for the purposes of the policy, the term Rai staging is to be applied as set out in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975

"Cerebral palsy" means the definite Diagnosis of a chronic disorder that appears in the first few years of life, caused by damage to the motor areas of the brain, characterized by varying degrees of limb weakness, involuntary movements and speech problems.

"Coma" means a definite Diagnosis of a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least ninety six (96) hours, and for which period the Glasgow coma score must be four (4) or less.

Exclusion: No benefit will be payable under this condition for any of the following:

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

"Congenital heart disease requiring surgery" means the definite Diagnosis of any serious cardiac malformation present at birth, for which corrective surgery has been performed.

"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).

Exclusions: No benefit will be payable under this condition for any of the following: angioplasty; intra-arterial procedures; percutaneous trans-catheter procedures or non-surgical procedures.

"Cystic fibrosis" means the definite Diagnosis of a genetic disease affecting the sweat and mucous glands particularly in the lungs and digestive system, characterized by excess production of thick mucous leading to chronic progressive respiratory disease and nutritional problems.

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

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

- aphasia (a disorder of speech);
- apraxia (difficulty performing familiar tasks);
- agnosia (difficulty recognizing objects);
- disturbance in executive functioning (e.g. inability to think abstractly and to plan, initiate, sequence, monitor, and stop complex behaviour) which is affecting daily life.

The following is also required:

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

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

"Dilated cardiomyopathy" means a condition of impaired ventricular function resulting in significant physical impairment of at least Class III of the New York Heart Association Classification of Cardiac Impairment. The Diagnosis of dilated cardiomyopathy must be confirmed by echocardiographic abnormalities demonstrating new abnormal cardiac function with a persistent low ejection fraction (less than 40%) for at least 3 months.

New York Heart Association Class III cardiomyopathy impairment means that the patient is comfortable at rest and is symptomatic during less than ordinary daily activities despite the use of medication and dietary adjustment, with evidence of abnormal ventricular function on physical examination and laboratory studies.

Exclusion: No benefit will be payable under this condition for ischemic and toxic causes (including alcohol, prescription and non-prescription drug use) of dilated cardiomyopathy.

"Down's syndrome" means the definite Diagnosis of a congenital condition caused by an extra copy of chromosome 21, primarily characterized by varying degrees of mental retardation, though other defects, particularly congenital heart disease, may be present.

"Fulminant viral hepatitis" means a definite Diagnosis of a sub-massive to massive necrosis of the liver caused by any virus leading precipitously to liver failure. Payment under this condition requires satisfaction of all of the following:

(a) a rapidly decreasing liver size as confirmed by abdominal ultrasound;
(b) necrosis involving entire lobules, leaving only a collapsed reticular framework to include histology, if available;
(c) rapidly deteriorating liver function tests;
(d) deepening jaundice.

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

- chronic hepatitis; or
- liver failure caused by alcohol, toxins and/or drugs.

"Heart attack" means a definite Diagnosis of the death of heart muscle due to obstruction of blood flow, that results in:

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.

Exclusions: No benefit will be payable under this condition for any of the following:

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

"Heart valve replacement or repair" means the undergoing of Surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities.

Exclusion: No benefit will be payable under this condition for any of the following: angioplasty; intra-arterial procedures; percutaneous trans-catheter procedures; non-surgical procedures.

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

"Liver failure of advanced stage" means a definite Diagnosis of Liver failure due to cirrhosis and resulting in all of the following:

(a) Permanent jaundice;
(b) Ascites;
(c) Encephalopathy.

Exclusion: No benefit will be payable under this condition for any liver failure secondary to alcohol or drug use (except those taken as prescribed by a Physician).

"Loss of independent existence" means a definite Diagnosis of the total inability to perform, by oneself, at least two (2) of the following six (6) Activities of Daily Living for a continuous period of at least ninety (90) days with no reasonable chance of recovery.

Activities of Daily Living are:

- Bathing - the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of assistive devices.
- Dressing - the ability to put on and remove necessary clothing, braces, artificial limbs or other surgical appliances, with or without the aid of assistive devices.
- Toileting - the ability to get on and off the toilet and maintain personal hygiene, with or without the aid of assistive devices.
- Bladder and Bowel Continence - the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained.

- Transferring - the ability to move in and out of a bed, chair or wheelchair, with or without the aid of assistive devices.
- Feeding - the ability to consume food or drink that already has been prepared and made available, with or without the aid of assistive devices.

"Loss of limbs" means a definite Diagnosis of the complete severance of two (2) or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation.

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

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

"Major organ failure on waiting list" means a definite Diagnosis of the Irreversible failure of the heart, both lungs, liver or bone marrow, and for which transplant must be medically necessary. To qualify under major organ failure on waiting list, the Insured Person must become enrolled as the recipient in a recognized transplant centre in Canada or the United States that performs the required form of transplant Surgery. For the purposes of the Survival Period, the date of Diagnosis is the date of the Insured Person's enrollment in the transplant centre.

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

Exclusion: No benefit will be payable under this condition for any organ transplant other than those described above.

"Mental deficiency" means the definite Diagnosis of an intellectual deficiency, as demonstrated by an intelligence quotient (IQ) on standardized testing of less than 70.

"Motor neuron disease" means a definitive Diagnosis of one (1) of the following:

- Amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease);
- Primary lateral sclerosis;
- Progressive spinal muscular atrophy;
- Progressive bulbar palsy; or
- Pseudo bulbar palsy.

"Multiple sclerosis" means a definite Diagnosis of at least one (1) of the following:

- two (2) or more separate clinical attacks, confirmed by magnetic resonance imaging (MRI) of the nervous system, showing multiple lesions or demyelination; or
- well-defined neurological abnormalities lasting more than six (6) months, confirmed by MRI imaging of the nervous system, showing multiple lesions of demyelination; or
- a single attack, confirmed by repeated MRI imaging of the nervous system, which shows multiple lesions of demyelination which have developed at intervals at least one (1) month apart.

"Muscular dystrophy" means a definite Diagnosis of all of the following:

(a) Clinical presentation including skeletal muscle weakness, muscle pain and myotonia;
(b) Characteristic electromyography changes;
(c) Muscle biopsy confirming Diagnosis of muscular dystrophy.

"Occupational HIV infection" means a definite Diagnosis of infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the Insured Person's normal occupation, which exposed the person to HIV contaminated body fluids. The accidental injury leading to the infection must occur while this coverage is in force.

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

(a) The accidental injury must be reported to the Insurer within fourteen (14) days of the accidental injury;
(b) A serum HIV test must be taken within fourteen (14) days after the accidental injury and the result must be negative;
(c) A serum HIV test must be taken between ninety (90) days and one hundred and eighty (180) days after the accidental injury and the result must be positive; the Insured Person must survive at least fourteen (14) days following the date of this second serum HIV test;
(d) All HIV tests must be performed by a duly licensed laboratory in Canada or the United States;
(e) The accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States workplace guidelines.

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

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

"Paralysis" means a definite Diagnosis of the total loss of muscle function of two (2) or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least ninety (90) days following the precipitating event.

"Parkinson's disease and specified atypical Parkinsonian disorders"

Parkinson's disease means a definite Diagnosis of primary Parkinson's disease, a permanent neurologic condition which is characterized by bradykinesia (slowness of movement) and at least one of: muscular rigidity or rest tremor.

Specified atypical Parkinsonian disorders (SAPD) means a definite Diagnosis of progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.

The Diagnosis of Parkinson's disease or specified atypical Parkinsonian disorder must be made by a neurologist. In all cases, the Insured Person condition must exhibit objective signs of a progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's disease.

Exclusion: No benefit will be payable under this condition for any other type of Parkinsonism.

In addition, no benefit will be payable under Parkinson's disease or specified atypical Parkinsonian disorders if one of the following occurred to the Insured Person within the year following the last time the Insured Person's coverage under this benefit became effective:

- signs, symptoms or investigations that lead to a Diagnosis of Parkinson's disease or atypical Parkinsonian disorders or any other type of Parkinsonism, regardless of when the Diagnosis was made; or
- a Diagnosis of Parkinson's disease, atypical Parkinsonian disorders or any other type of Parkinsonism.

Restriction: 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 during this period, the Insurer has the right to deny any claim for Parkinson's disease or specified atypical Parkinsonian disorder or any Critical Illness caused by Parkinson's disease or Parkinsonian disorders or by their treatments.

"Primary pulmonary hypertension" (idiopathic pulmonary arterial hypertension and familial pulmonary arterial hypertension) means a definite Diagnosis of primary pulmonary hypertension with a substantial right ventricular enlargement confirmed by investigations including cardiac catheterization, resulting in permanent Irreversible physical impairment to the degree of at least Class IV of the New York Heart Association Classification of Cardiac Impairment.

The New York Heart Association Classification of Cardiac Impairment (source: *Current Medical Diagnosis and Treatment-39th Edition*) states the following about Class IV:

> "Unable to engage in any physical activity without discomfort. Symptoms may be present even at rest."

Exclusion: No benefit will be payable under this condition for any other type of pulmonary arterial hypertension.

"Progressive systemic sclerosis" means a definite Diagnosis of Progressive systemic scleroderma with systemic involvement of the heart, lungs or kidneys. The Diagnosis must be unequivocally supported by clinical and serological evidence and with biopsy results when available.

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

- Localized scleroderma (linear scleroderma or morphea); or
- Eosinophilic fasciitis; or
- CREST syndrome.

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

"Spina bifida cystica" means the definite Diagnosis of a congenital defect caused by failure of the spine to close properly allowing the spinal cord and its protective covering (meninges) to protrude through the skin, characterized by varying degrees of the following:

(a) hydrocephalus;
(b) paralysis;
(c) bowel problems; and
(d) bladder problems.

Exclusion: No benefit will be payable under this condition for Spina Bifida Occulta.

"Stroke" 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.

Exclusion: No benefit will be payable under this condition for any of the following:

- transient ischaemic attacks; or
- intracerebral vascular events due to trauma; or
- lacunar infarcts which do not meet the definition of stroke as described above.

Complementary Benefit in Case of Certain Illnesses (applicable to an Insured Member and Insured Spouse)

In addition to the Critical Illnesses described under section "Definitions of Covered Illnesses", the following illnesses, as defined hereunder, are covered under the Complementary Benefit in Case of Certain Illnesses.

1. Coronary angioplasty
2. Crohn's disease requiring surgery
3. Ductal carcinoma in situ of the breast
4. Hip or knee replacement surgery
5. Severe rheumatoid arthritis
6. Stage A (T1a or T1b) prostate cancer
7. Stage 1A malignant melanoma
8. Systemic lupus erythematosus

"Coronary angioplasty" means the undergoing of an interventional procedure to unblock or widen a coronary artery that supplies blood to the heart to allow an uninterrupted flow of blood.

"Crohn's disease requiring surgery" means the unequivocal Diagnosis of Crohn's disease confirmed by results of typical endoscopy and histopathology findings. Also, the Insured Person must exhibit intra-abdominal or anal abscesses or fistulas, or intestinal obstruction or perforation, or intractable disease not responding to non-surgical management. In addition, symptoms must have persisted despite optimal non-surgical therapy and a surgical intervention including at least one bowel segment resection must be medically necessary.

"Ductal carcinoma in situ of the breast" means the Diagnosis of this illness, as confirmed by biopsy.

"Hip or knee replacement surgery" means an open Surgery resulting in the total prosthetic replacement of either the hip or the entire knee (known as total knee replacement), subject to the following:

- For hip replacement to qualify under this insurance, the femoral stem must be replaced. Also, this procedure should be performed in both total arthroplasty and hemiarthroplasty (both monopolar and bipolar).
- For knee replacement to qualify under this insurance, all three compartments of the knee (medial, lateral and patellofemoral) must be replaced.

Exclusions: No benefit will be payable under this condition for arthroscopic treatment of joint surfaces or revision of previous total hip or knee replacements.

"Severe rheumatoid arthritis" means the definite Diagnosis of severe seropositive rheumatoid arthritis, that must involve widespread joint destruction affecting at least 3 large joints (these are shoulders, elbows, hips, knees, and ankles), as well as 3 small joints (these are metacarpophalangeal joints, proximal interphalangeal joints, thumb interphalangeal joints, joints of the wrists and second through fifth metatarsophalangeal joints). The Diagnosis must be confirmed by clinical and radiological evidence of joints destruction and deformity.

"Stage A (T1a or T1b) prostate cancer" means the definite Diagnosis of this illness, as confirmed by pathological examination of prostate tissue.

"Stage 1A malignant melanoma" means the Diagnosis of a melanoma less than or equal to 1.0 mm in thickness, not ulcerated and without Clark level IV or V invasion. The Diagnosis of this illness must be confirmed by biopsy.

"Systemic lupus erythematosus" means the definite Diagnosis of systemic lupus erythematosus, that must involve renal system which requires corticosteroid treatment for a continuous period of six (6) months and permanent impairment of kidney function tests that show Glomerular Filtration Rate (GFR) below 30mL/min/1.73m^2. In addition, a positive ANA test must be present.

Exclusions: No benefit will be payable under this condition for any other forms of lupus, such as discoid lupus and those forms with only hematological and joint involvement.

If the Insured Member or Insured Spouse is Diagnosed with one of the illnesses indicated previously in this section while the benefit is in force and all conditions of the Survival Period have been met and subject to the limitations specified in the "Re-Entry Conditions" section, the Insurer will pay the Insured Member or the Insured Spouse:

(1) 10% of the Principal Sum, subject to a maximum of $25,000, for the following conditions:
- Coronary angioplasty
- Ductal carcinoma in situ of the breast
- Stage A (T1a or T1b) prostate cancer
- Stage A malignant melanoma

The payment of the Complementary Benefit in Case of Certain Illnesses in group (1) above comes in addition to the Principal Sum and can only be paid once in a lifetime, in accordance with the limitations specified in the "Re-Entry Conditions" section.

(2) 10% of the Principal Sum, subject to a maximum of $10,000, for the following conditions:
- Crohn's disease requiring surgery
- Severe rheumatoid arthritis
- Systemic lupus erythematosus

The payment of the Complementary Benefit in Case of Certain Illnesses in group (2) above comes in addition to the Principal Sum and can only be paid once in a lifetime, in accordance with the limitations specified in the "Re-Entry Conditions" section.

(3) 10% of the Principal Sum, subject to a maximum of $10,000, for the following conditions:
- Hip replacement surgery
- Knee replacement surgery

The payment of the Complementary Benefit in Case of Certain Illnesses in group (3) above comes in addition to the Principal Sum and can only be paid once in a lifetime, in accordance with the limitations specified in the "Re-Entry Conditions" section.

Cancer Recurrence Benefit (applicable to an Insured Member and Insured Spouse)

The Insurer will pay a Principal Sum amount if the Insured Member or Insured Spouse is Diagnosed a subsequent time with Cancer and that more than sixty (60) months have passed since the previous Cancer Diagnosis and no treatment relating directly or indirectly to Cancer has been received within that sixty (60) month period (treatment does not include preventive medications and follow up visits to the doctor).

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

Multiple Event Coverage (applicable to an Insured Member and Insured Spouse)

If an Insured Member or Insured Spouse is Diagnosed with a covered Critical Illness for which the Principal Sum (or 10% of the Principal Sum under the Complementary Benefit in Case of Certain Illnesses) has been paid and is then Diagnosed with another covered Critical Illness, the Insurer will pay a Principal Sum amount (or 10% of the Principal Sum thereof under the Complementary Benefit in Case of Certain Illnesses) subject to the limitations specified in the "Re-Entry Conditions" section.

To give rise to a benefit payment under Multiple Event Coverage, the subsequent Diagnosis must be made ninety (90) days or more after the date another covered condition was Diagnosed.

Re-Entry Conditions (applicable to an Insured Member and Insured Spouse)

If a benefit amount has already been received for a Covered Critical Illness of an Insured Member or Insured Spouse, coverage continues for that person, provided payment of premium is continued. Subsequent benefit payments are subject to the Re-entry Exclusions Appendix of this insurance.

Conditions for Payment

When the Insured Person is Diagnosed with a covered Critical Illness and the required Survival Period is completed, the Insurer shall pay the Principal Sum, unless otherwise provided under the contract and subject to all of the conditions and limitations of this Policy.

Beneficiary

Amounts payable under this Critical Illness benefit will be payable to the Insured Member or to the Insured Spouse if the latter is the one who is Diagnosed with the Critical Illness.

However, accrued benefits, if any, unpaid at the time of the beneficiary becoming unable to legally receive payment of benefits will be paid to the beneficiary's estate.

Effective Date of Coverage

Coverage of an Eligible Person as described under item 2 of the Master Application will take effect as indicated in Item 7 of Master Application.

Termination of Coverage

Coverage of an Insured Person provided under this Policy will immediately terminate on the earliest of the following dates:

A) With respect to an Insured Member:

1. the date the Policy is terminated;
2. the premium due date if the Policyholder fails to pay the required premium, except as the result of an inadvertent error;
3. the premium due date coincident with or following the date the Insured Member reaches sixty-five (65) years of age;
4. the premium due date coincident with or following the date the Insured Member ceases to be an active Member of the Policyholder on account of leave of absence, lay-off, maternity/parental leave, disability, resignation, dismissal, pension or retirement, except as provided under the following sections:
   - Continuation of Coverage during Approved Leaves
   - Extension of Coverage
5. the date the Insured Member dies;
6. the premium due date coincident with or following the date the Insured Member gives notice of cancellation to the Policyholder.

B) With respect to an Insured Spouse:

1. the date such person ceases to satisfy the criteria for definition of "Spouse" as presented in the Policy;
2. the premium due date coincident with or following the date the Insured Spouse reaches sixty-five (65) years of age;
3. the date the Insured Member's insurance coverage is terminated.

C) With respect to an Insured Dependent Child

1. the date such person ceases to satisfy the criteria for definition of "Dependent Child" as presented in the Policy;
2. the date the Principal Sum payment has been paid;
3. the date the Insured Member's insurance coverage is terminated.

Conversion of Member's and Spouse's Group Coverage to an Individual Insurance Contract

In the event an Insured Member's or Insured Spouse's coverage is terminated because:

(a) the Insured Member ceases to be an active Member 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) the Insured Member ceases to be an eligible person under the Policy, as described under item 2 of the Master Application; or

(c) the period of extension of his coverage as provided in the "Extension of Coverage" section ends,

the Insured Member or Insured Spouse who has not yet reached the age of sixty-six (66) may make a written application to the Insurer within thirty-one (31) days of said termination to obtain an individual Critical Illness policy. On reception of such application, the Insurer will, without evidence of insurability, issue an individual Critical Illness policy to the applicant that will consist of 4 illnesses [Cancer (life-threatening), Coronary artery bypass surgery, Heart attack and Stroke].

However, conversion will not be possible if the Policy is terminated at the time of the application. An Insured Member or Insured Spouse may only convert if he has never received a Critical Illness coverage payment and has never received a payment under the "Complementary Benefit in Case of Certain Illnesses" section in the past.

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 one hundred thousand dollars ($100,000) for all such conversions by any Insured Member.

Premiums for such individual Critical Illness policy being issued in compliance with the aforementioned condition will be calculated at the Insurer's rates in force for the attained age of such Insured Person at the date of conversion. Premiums will be payable annually in advance and the Critical Illness policy will be issued on an annually renewable basis.

Continuation of Coverage during Approved Leaves

Individual coverage under the Policy will be continued for an Insured Member and his Insured Spouse and/or his Insured Dependent Children during any approved leave of absence, temporary lay-off, maternity/parental leave or disability leave of the Insured Member, provided payment of premium is continued.

This continuation of coverage will terminate at 12:01 a.m., Standard Time:

1. with respect to any leave of absence approved by the Policyholder, on the first (1st) day of the month following the completion of a twelve (12) month period that started on the date such approved leave of absence began or on the date the Insured Member returns to work in any capacity for the Policyholder or any other employer, including self-employment, whichever is earlier. Continuation of coverage for periods in excess of twelve (12) months may be granted, provided written request is submitted by the Policyholder to the Insurer;

2. with respect to any temporary lay-off approved by the Policyholder, on the first (1st) day of the month following the completion of a six (6) month period that started on the date such approved temporary lay-off began or on the date the Insured Member returns to work in any capacity for the Policyholder or any other employer, including self-employment, whichever is earlier. Continuation of coverage for periods in excess of six (6) months may be granted, provided written request is submitted by the Policyholder to the Insurer;
3. with respect to strike, on the thirty-first (31st) day following the commencement of the strike, or later if approved by the Policyholder;
4. with respect to any maternity/parental leave approved by the Policyholder, on the date the Insured Member returns to work in any capacity for the Policyholder or any other employer, including self-employment; and
5. with respect to any disability leave approved by the Policyholder, on the date the Insured Member reaches seventy (70) years of age, qualifies for a waiver of premium or returns to work in any capacity, whichever is earlier.

The coverage which is provided as a result of continuation under this section will be subject to the terms and provisions of the Policy that were in effect as of the date of commencement of the leave, including any provision providing for reductions in amounts of insurance.

Notwithstanding anything contained to the contrary in the Policy, in no event will indemnities payable for any event insured against which occurs while individual coverage is being continued under this section exceed the amount that would have been payable to the Insured Person at the date of commencement of the leave of the Insured Member.

Extension of Coverage

Individual coverage under the Policy will be continued for a period of up to twelve (12) months for an Insured Member whose employment has been terminated by the Policyholder, provided such continuation of coverage is required by any applicable provincial or federal employment law or by a severance package agreement received by the Insured Member from the Policyholder and payment of premium in accordance with the Master Application is continued. Under such conditions, individual coverage for the Insured Person will also continue, provided payment of the appropriate premium is continued.

This extension of coverage will terminate at 12:01 a.m., Standard Time, on the first (1st) day of the month following either the completion of the twelve (12) month period or the date the Insured Member returns to work in any capacity, whichever is earlier.

Extensions of coverage for periods in excess of twelve (12) months may be granted, provided written request is submitted by the Policyholder to the Insurer or if required by any applicable law.

The coverage which is provided as a result of extension under this section will be subject to the terms and provisions of the Policy which were in effect as of the date of termination of employment, including any provision providing for reductions in amounts of insurance.

Notwithstanding anything contained to the contrary in the Policy, in no event will indemnities payable for any event insured against which occurs while coverage is being continued under this clause exceed the amount that would have been payable at the date of termination of employment.

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 effective date of the Insured Person's coverage:

   (a) Diagnosis of Cancer is made; or

   (b) The Insured Person has any signs, symptoms or investigations, that lead to a Diagnosis of cancer (covered or excluded under the Policy), regardless of when the Diagnosis is made.

2. Within ninety (90) days following the effective date of the Insured Person's coverage:

   (a) Diagnosis of Benign Brain Tumour is made; or

   (b) The Insured Person has any signs, symptoms or investigations that lead to a Diagnosis of Benign Brain Tumour, regardless of when the Diagnosis is made.

3. The Insured Person does not satisfy the Survival Period limitations.

4. The Insured Person suffers a self-inflicted injury, Sickness or Disease, regardless of the state of mind of the insured person 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 Person's effective date of individual coverage when the same cancer either recurs or metastasizes after such effective date unless all the requirements in the "Cancer Recurrence Benefit" section have been met.

7. The Insured Person operated a motor vehicle while concentration of alcohol in his blood exceeded the applicable legal limit where the events causing the Critical Illness occurred.

8. The Insured Person committed or attempted to commit a criminal offense or provoked an assault.

9. The Critical Illness results from an abuse of alcohol.

10. The Insured Person participated in any riot, war or any civil strife.

11. From a Pre-existing Condition, except if the Critical Illness being claimed for is Diagnosed at least twenty-four (24) months after the Insured Person's effective date of coverage and subject to all other provisions of the "Pre-existing Condition Exclusion" section.

Pre-existing Condition Exclusion

This Pre-existing Condition Exclusion applies to all portions of the Principal Sum that are obtained without evidence of insurability, as well as all Critical Illnesses newly covered without evidence of insurability.

If the Critical Illness Insurance directly replaces one with the insurer or another insurer providing similar benefits and that the previous policy was cancelled within thirty-one (31) days from the effective date of the new policy, an Insured Person who has satisfied the time period of the Pre-existing Condition Exclusion in a previous policy will be deemed to have satisfied the time period under the new policy, but only to the extent of the benefit amount and Critical Illnesses covered in the previous policy. Any additional benefit amount or new illness provided in the new policy and which is obtained without evidence of insurability will be subject to the terms of this exclusion.

An Insured Person who has not satisfied the time period of the Pre-existing Condition Exclusion in a previous policy will be allowed to apply any amount of time satisfied under the Pre-existing Condition Exclusion of the previous policy toward the satisfaction of the time period requirement of the Pre-existing Condition Exclusion of the new policy, but only to the extent of the benefit amount and Critical Illnesses covered in the previous policy and provided that the previous policy was cancelled within thirty-one (31) days from the effective date of the new policy. Any additional benefit amount or new illness provided in the new policy and which is obtained without evidence of insurability will be subject to the terms of this exclusion.

Limitation of Contractual Liability

If any amendment made to fiscal legislation, to a government plan, to an insurance plan provided for in Member working conditions or to an employer retirement plan has the effect of increasing liability under this benefit, then the provisions of the contract shall continue to apply as though such amendment had not been made, unless the parties expressly agree otherwise. If an increase in liability is required by law, however, then an additional premium shall be payable to the Insurer by the Policyholder. This additional premium shall be equal to the value of the increase in contractual liability.

Area of Diagnosis

Should an Insured Person claim for a Critical Illness which occurred or was diagnosed outside of Canada or the United States, 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.

Claims Provisions

Notice of Claim Written notice of Critical Illness on which claim is based must be given to the Insurer within thirty (30) days after the date of the Diagnosis resulting in such Critical Illness. Such notice must be given in writing by or on behalf of the Insured Person, his beneficiary or the person who is entitled the indemnity under the Policy, as the case may be, to the Insurer at 1225 St-Charles Street West, Suite 200, Longueuil QC J4K 0B9, or to any Regional Office of the Insurer or to any authorized agent of the Insurer, with particulars sufficient to identify the Insured Person whose Critical Illness is the basis of such notice. Failure to give such notice within the time provided in the Policy will not invalidate any claim if it is shown not to have been reasonably possible to give such notice during such time and that such notice was given as soon as was reasonably possible, but in no event later than one (1) year after the date of the Diagnosis.

Claim Forms The Insurer, upon receipt of such notice, agrees to furnish to the claimant such forms as are usually furnished by it for filing proof of Critical Illness. If such forms are not so furnished within fifteen (15) days after the Insurer's receipt of such notice, the claimant will be deemed to have complied with the requirements of the Policy as to proof of such Critical Illness upon submitting, within the time fixed in the Policy for filing proofs of Critical Illness, written proof covering the occurrence, character and extent of the Critical Illness for which claim is made.

Proof of Critical Illness Written proof of Critical Illness must be furnished to the Insurer within ninety (90) days after the date of Diagnosis resulting in such Critical Illness. Failure to furnish such proof within such time will not invalidate any claim if it is shown not to have been reasonably possible to furnish such proof during such time and that such proof was furnished as soon as was reasonably possible, but in no event later than one (1) year after the date of the Diagnosis.

Physical Examination and Autopsy The Insurer will have the right and opportunity to confirm the Diagnosis at its own expense by appointing a medical practitioner to examine the Insured Person whose Critical Illness is the basis of claim under the Policy, where and so often as it may reasonably require while it determines the validity of a claim hereunder, and in the case of death, the right and opportunity to require an autopsy where it is not forbidden by law.

Payment of Claims All indemnities provided in the Policy for Critical Illness will be paid after customary proof of Critical Illness satisfactory to the Insurer has been given in accordance with the requirements of the Policy. All moneys payable under the Policy are payable in the lawful money of Canada.

Legal Actions Legal action will not be taken to recover indemnities under the Policy until sixty (60) days after proof of Critical Illness has been submitted to the Insurer in accordance with the requirements of the Policy. Thereafter, the claimant must take any legal action based on the Policy within one (1) year period [three (3) years in the province of Quebec] following submission of a proof of Critical Illness to the Insurer.

Conformity with Provincial or Territorial Law If any time limitation specified in the Policy for giving notice of claim, or giving proof of Critical Illness, or undertaking legal action is less than that permitted by law of the province or territory in which the Insured Person is residing at the time of the Diagnosis resulting in Critical Illness, then the time limitation will not be less than that provided for by provincial or territorial law.

General Provisions

The Contract The Policy contains the entire contract of insurance. No statement made by the Policyholder or an Insured Person will void the insurance or reduce benefits hereunder unless contained in a written application signed by the Policyholder or an Insured Person. No agent has authority to change the Policy or to waive any of its provisions. No change in the Policy will be valid unless approved by an officer of the Insurer and such approval must be endorsed hereon or attached hereto.

All statements contained in any application for coverage under the Policy will be deemed representations and not warranties.

Certificate of Insurance The Policyholder shall not deliver to any Insured Person any written description of the benefits available under the Policy without first allowing the Insurer to review the description. The Insurer may at its discretion require the Policyholder to make changes to the description if the description contains a discrepancy with the wordings of the Policy. Where the Insurer has not been allowed to review the description, or where the Policyholder does not make a change to the description as required by the Insurer, then the Policyholder will indemnify and hold harmless the Insurer against all claims that may be paid by or made against the Insurer and which arise out of a discrepancy between the description and the wording of the Policy. In addition, the Policyholder will indemnify and hold harmless the Insurer from all losses, costs, charges and expenses, including but not limited to legal fees that the Insurer may incur as a result of any such claims.

Termination The Policy may be cancelled by the Policyholder by mailing to the Insurer written notice stating the date on which such cancellation will be effective. The Policy may be terminated by the Insurer by mailing to the Policyholder at the address shown in the Policy written notice stating when, not less than thirty (30) days prior to the Anniversary Date of the Policy, such cancellation will be effective. The mailing of such notice as aforesaid will be sufficient proof of notice and the effective date of cancellation stated in the notice will become the end of the Policy period. Delivery of such written notice either by the Policyholder or by the Insurer will be equivalent to mailing.

Inspection of Records The Insurer will be permitted to examine the Policyholder's records relating to the Policy at any reasonable time during the term of the Policy, and from time to time for two (2) years after expiration of the Policy or until final adjustment and settlement of all claims hereunder, whichever is the later.

IN WITNESS WHEREOF, SSQ, Life Insurance Company inc. by its Chief Executive Office and Senior Vice-President.

Jean-François Chalifoux
Chief Executive Officer

Eric Trudel
Senior Vice-President

Date: May 19, 2022

AXA Assistance Canada Inc.
Second Medical Opinion Program

SSQ, Life Insurance Company Inc., in cooperation with AXA Assistance Canada Inc. agrees to provide the Second Medical Opinion program to persons insured (hereinafter referred to as the "Insured Person") under the Critical Illness Insurance **Policy # 1T920** issued to: **NEWFOUNDLAND AND LABRADOR TEACHERS ASSOCIATION**

In accordance with this agreement:

1. The following services will be provided, free of charge unless stated otherwise, to any Insured Person diagnosed with one of the Critical Illnesses covered under the above mentioned Policy:

   a) Selection of the specialist best suited to provide medical services included in the Second Medical Opinion program pertaining to the Insured Person's diagnosed Critical Illness;

   a) Transmission, to the selected specialist, of necessary and pertinent medical documents received from the Insured Person or attending physician;

   b) Communication of the second medical opinon's schedule, as established after evaluation;

   c) Arrangements for a meeting with the selected specialist, if deemed necessary and if the Insured Person agrees to the meeting. The expenses incurred will be charged to the Insured Person;

   d) Analysis of the medical documents and rendering of a diagnosis by the selected specialist as well as recommendations on treatment options, all registered in a medical report;

   e) Transmission of the medical report to the Insured Person and the attending physician;

   f) At the Insured Person's request, referral to three (3) specialists medically qualified to treat the Insured Person.

2. The services listed below will be provided for out of country medical care to any Insured Person diagnosed with a Critical Illness covered under the Critical Illness Insurance Policy. Incurred expenses will be charged to the Insured Person:

   a) Arrangements to set up medical appointments with attending physicians or specialists outside Canada;

   b) Admission in medical clinics located outside Canada;

   c) Hotel reservations;

   d) Travel arrangements;

   e) Referrals for translation services or interpreter services when appropriate;

   f) Administrative assistance for settlement of medical fees and claims, relative to medical services or treatments received outside Canada, if such assistance is requested by the Insured Person.

Insured Persons requiring Second Medical Opinion Program services must contact AXA Assistance and must be prepared to give the following information:

- the name of the person calling, telephone # and relationship to the insured Member;
- the insured Member's name, and Policy #;
- the name, address and telephone number of the attending physician's workplace, and such information for specialists when applicable.

The telephone number to be used is **1-877-266-6550**.

AXA Assistance will help make arrangements for the Insured Person to get a second opinion or out of country care needed. However, neither SSQ, Life Insurance Company Inc. nor AXA Assistance will be responsible in any way for the availability, unavailability, quantity, quality or results of any medical services or treatment received or for the failure to obtain such services or treatment.

SSQ, Life Insurance Company Inc. may provide cards which show the telephone number to be used in order to access the services of the Second Medical Opinion program. The service is available 24 hours a day, 365 days a year.

The program is available to the Insured Persons provided **Policy # 1T920** remains in force with SSQ, Life Insurance Company Inc.

May 19, 2022

Date

This program does not form part of the contract with SSQ, Life Insurance Company Inc.

RE-ENTRY EXCLUSIONS APPENDIX

This appendix provides for all Critical Illnesses that may be included in all of the Insurer's Critical Illness insurance packages so that the policyholder and the Members are aware that these exclusions shall continue to apply even when the policyholder or Member has chosen any new Critical Illness insurance package offered by the Insurer. Please refer to the provisions of the Critical Illness benefit to know what Critical Illnesses and Surgeries are actually covered under your policy.

After a benefit has been claimed and adjudicated as payable for an individual other than a child with respect to a first event mentioned in the columns at the right of this schedule, no benefits can be paid for the same individual with respect to subsequent events mentioned on the lines of the left column hereunder, if the cell they have in common is marked with an X. Also, for an event to give rise to benefits, it must be included in the list of Covered Illnesses of the Insured Person's coverage or under the "Complementary Benefit in Case of Certain Illnesses" section, if any.

After a benefit has been claimed and adjudicated as payable for a child with respect to a covered event, no benefits can be paid for the same child with respect to any subsequent event.

RE-ENTRY EXCLUSIONS APPENDIX (Cont'd)

	If a claim has been paid for this event						
	Aortic surgery	Aplastic anemia	Bacterial meningitis	Benign brain tumour	Blindness	Cancer (life threatening)	Coma
No claim can be paid for this subsequent event							
Aortic surgery	X						
Aplastic anemia		X				X	
Bacterial meningitis			X	X			
Benign brain tumour				X			
Blindness			X	X	X		X
Cancer (life threatening)		X				X *	
Coma	X		X	X			X
Coronary angioplasty	X						
Coronary artery bypass surgery	X						
Crohn's disease requiring surgery							
Deafness			X	X			X
Dementia, including Alzheimer's disease	X						
Dilated cardiomyopathy							
Ductal carcinoma in situ of the breast		X				X	
Fulminant viral hepatitis							
Heart attack	X						
Heart valve replacement or repair	X						
Hip replacement surgery							
Kidney failure	X						
Knee replacement surgery							
Liver failure of advanced stage	X					X	
Loss of independent existence	X	X	X	X	X	X	X
Loss of limbs							
Loss of speech			X	X			X
Major organ failure on waiting list	X						
Major organ transplant	X						
Motor neuron disease							
Multiple sclerosis							
Muscular dystrophy							
Occupational HIV infection							
Paralysis			X	X			X
Parkinson's disease and SAPD							
Primary pulmonary hypertension							
Progressive systemic sclerosis							
Severe burns							
Severe rheumatoid arthritis							
Stage 1A malignant melanoma		X				X	
Stage A (T1a or T1B) prostate cancer		X				X	
Stroke	X		X	X			X
Systemic lupus erythematosus							

RE-ENTRY EXCLUSIONS APPENDIX (Cont'd)

	If a claim has been paid for this event						
	Coronary angioplasty	Coronary artery bypass surgery	Crohn's disease requiring surgery	Deafness	Dementia, including Alzheimer's disease	Dilated cardiomyopathy	Ductal carcinoma in situ of the breast
No claim can be paid for this subsequent event							
Aortic surgery		X				X	
Aplastic anemia							
Bacterial meningitis							
Benign brain tumour							
Blindness							
Cancer (life threatening)							
Coma		X				X	
Coronary angioplasty	X	X				X	X
Coronary artery bypass surgery		X				X	
Crohn's disease requiring surgery			X				
Deafness				X			
Dementia, including Alzheimer's disease		X			X	X	
Dilated cardiomyopathy						X	
Ductal carcinoma in situ of the breast	X						X
Fulminant viral hepatitis							
Heart attack		X				X	
Heart valve replacement or repair		X				X	
Hip replacement surgery							
Kidney failure		X	X			X	
Knee replacement surgery							
Liver failure of advanced stage		X	X			X	
Loss of independent existence		X	X	X	X	X	
Loss of limbs							
Loss of speech							
Major organ failure on waiting list		X	X			X	
Major organ transplant		X	X			X	
Motor neuron disease							
Multiple sclerosis							
Muscular dystrophy							
Occupational HIV infection							
Paralysis							
Parkinson's disease and SAPD							
Primary pulmonary hypertension							
Progressive systemic sclerosis							
Severe burns							
Severe rheumatoid arthritis			X				
Stage 1A malignant melanoma	X						X
Stage A (T1a or T1B) prostate cancer	X						X
Stroke		X				X	
Systemic lupus erythematosus			X				

RE-ENTRY EXCLUSIONS APPENDIX (Cont'd)

	If a claim has been paid for this event						
	Fulminant viral hepatitis	Heart attack	Heart valve replacement or repair	Hip replacement surgery	Kidney failure	Knee replacement surgery	Liver failure of advanced stage
No claim can be paid for this subsequent event							
Aortic surgery		X	X				X
Aplastic anemia							
Bacterial meningitis							
Benign brain tumour							
Blindness							X
Cancer (life threatening)	X						X
Coma		X	X		X		X
Coronary angioplasty		X	X				X
Coronary artery bypass surgery		X	X				X
Crohn's disease requiring surgery					X		
Deafness							
Dementia, including Alzheimer's disease		X	X				
Dilated cardiomyopathy							
Ductal carcinoma in situ of the breast	X						X
Fulminant viral hepatitis	X						
Heart attack		X	X		X		X
Heart valve replacement or repair		X	X				
Hip replacement surgery				X		X	
Kidney failure		X	X		X		X
Knee replacement surgery				X		X	
Liver failure of advanced stage	X	X	X		X		X
Loss of independent existence	X	X	X	X	X	X	X
Loss of limbs							
Loss of speech							
Major organ failure on waiting list	X	X	X		X		X
Major organ transplant	X	X	X		X		X
Motor neuron disease							
Multiple sclerosis							X
Muscular dystrophy							
Occupational HIV infection							
Paralysis							X
Parkinson's disease and SAPD							
Primary pulmonary hypertension							
Progressive systemic sclerosis							X
Severe burns							
Severe rheumatoid arthritis				X	X	X	
Stage 1A malignant melanoma	X						X
Stage A (T1a or T1B) prostate cancer	X						X
Stroke		X	X		X		X
Systemic lupus erythematosus					X		

RE-ENTRY EXCLUSIONS APPENDIX (Cont'd)

	If a claim has been paid for this event						
	Loss of independent existence	Loss of limbs	Loss of speech	Major organ failure on waiting list	Major organ transplant	Motor neuron disease	Multiple sclerosis
No claim can be paid for this subsequent event							
Aortic surgery	X						
Aplastic anemia	X			X	X		
Bacterial meningitis	X						
Benign brain tumour	X						
Blindness	X					X	X
Cancer (life threatening)	X			X	X		
Coma	X			X	X	X	X
Coronary angioplasty							
Coronary artery bypass surgery	X						
Crohn's disease requiring surgery	X						
Deafness	X					X	X
Dementia, including Alzheimer's disease	X						
Dilated cardiomyopathy	X						
Ductal carcinoma in situ of the breast				X	X		
Fulminant viral hepatitis	X						
Heart attack	X			X	X	X	
Heart valve replacement or repair	X						
Hip replacement surgery	X						
Kidney failure	X			X	X		X
Knee replacement surgery	X						
Liver failure of advanced stage	X			X	X		
Loss of independent existence	X	X	X	X	X	X	X
Loss of limbs	X	X					
Loss of speech	X		X			X	X
Major organ failure on waiting list	X			X	X		
Major organ transplant	X			X	X		
Motor neuron disease	X					X	
Multiple sclerosis	X						X
Muscular dystrophy	X						
Occupational HIV infection	X						
Paralysis	X					X	X
Parkinson's disease and SAPD	X						
Primary pulmonary hypertension	X						
Progressive systemic sclerosis	X						
Severe burns	X						
Severe rheumatoid arthritis	X						
Stage 1A malignant melanoma				X	X		
Stage A (T1a or T1B) prostate cancer				X	X		
Stroke	X			X	X	X	X
Systemic lupus erythematosus	X						

RE-ENTRY EXCLUSIONS APPENDIX (Cont'd)

	If a claim has been paid for this event						
	Muscular dystrophy	Occupational HIV infection	Paralysis	Parkinson's disease and SAPD	Primary pulmonary hypertension	Progressive systemic sclerosis	Severe burns
No claim can be paid for this subsequent event							
Aortic surgery					X		
Aplastic anemia							
Bacterial meningitis							
Benign brain tumour							
Blindness	X	X					
Cancer (life threatening)		X					
Coma	X	X	X	X	X	X	
Coronary angioplasty							
Coronary artery bypass surgery					X		
Crohn's disease requiring surgery							
Deafness	X	X					
Dementia, including Alzheimer's disease							
Dilated cardiomyopathy	X				X		
Ductal carcinoma in situ of the breast		X					
Fulminant viral hepatitis							
Heart attack	X				X	X	
Heart valve replacement or repair	X				X		
Hip replacement surgery							
Kidney failure	X	X			X	X	
Knee replacement surgery							
Liver failure of advanced stage	X	X				X	
Loss of independent existence	X	X	X	X	X	X	X
Loss of limbs							
Loss of speech	X	X	X	X			
Major organ failure on waiting list	X				X	X	
Major organ transplant	X				X	X	
Motor neuron disease							
Multiple sclerosis							
Muscular dystrophy	X						
Occupational HIV infection		X					
Paralysis	X	X	X	X			X
Parkinson's disease and SAPD				X			
Primary pulmonary hypertension					X		
Progressive systemic sclerosis						X	
Severe burns							X
Severe rheumatoid arthritis							
Stage 1A malignant melanoma		X					
Stage A (T1a or T1B) prostate cancer		X					
Stroke	X	X			X	X	
Systemic lupus erythematosus							

RE-ENTRY EXCLUSIONS APPENDIX (Cont'd)

	If a claim has been paid for this event				
	Severe rheumatoid arthritis	Stage 1A malignant melanoma	Stage A (T1a or T1B) prostate cancer	Stroke	Systemic lupus erythematosus
No claim can be paid for this subsequent event					
Aortic surgery				X	
Aplastic anemia					
Bacterial meningitis					
Benign brain tumour					
Blindness					
Cancer (life threatening)					
Coma				X	
Coronary angioplasty		X	X	X	
Coronary artery bypass surgery				X	
Crohn's disease requiring surgery	X				X
Deafness					
Dementia, including Alzheimer's disease				X	
Dilated cardiomyopathy					
Ductal carcinoma in situ of the breast		X	X		
Fulminant viral hepatitis					
Heart attack				X	
Heart valve replacement or repair				X	
Hip replacement surgery	X				
Kidney failure	X			X	X
Knee replacement surgery	X				
Liver failure of advanced stage	X			X	X
Loss of independent existence	X			X	X
Loss of limbs					
Loss of speech					
Major organ failure on waiting list	X			X	X
Major organ transplant	X			X	X
Motor neuron disease					
Multiple sclerosis					
Muscular dystrophy					
Occupational HIV infection					
Paralysis					
Parkinson's disease and SAPD					
Primary pulmonary hypertension					X
Progressive systemic sclerosis					
Severe burns					
Severe rheumatoid arthritis	X				X
Stage 1A malignant melanoma		X	X		
Stage A (T1a or T1B) prostate cancer		X	X		
Stroke				X	X
Systemic lupus erythematosus	X				X

* Following a life threatening Cancer claim, the Insured Person cannot claim again for Cancer, except for plans with a "Cancer Recurrence Benefit" section, when all of its requirements have been met.

1225 St-Charles Street West, Suite 200
Longueuil QC J4K 0B9

Master Application
For Critical Illness Insurance with Voluntary Enrolment

Application to SSQ, Life Insurance Company inc.
Attached to and made part of **Policy #1T920**

Application is hereby made for a policy of group Critical Illness insurance based on the following statements and representations:

1. **Name of the Policyholder**

   NEWFOUNDLAND AND LABRADOR TEACHERS ASSOCIATION

2. **Description of Eligible Persons**

   Class I: All active and retired Members of the Policyholder under age 65 and as per Eligibility guidelines in Appendix A.

   Class II: Spouses of all active and retired Members

   Class III: Dependent Children of all active and retired Members

   Dependent Children become eligible only when the Member or the Spouse enrols in the plan.

3. **Amount of Principal Sum**

   A) With respect to Class I:

   $10,000 minimum, in units of $ 10,000, to a maximum of $300,000.

   Guaranteed Issue Amount: $ 50,000

   B) With respect to Class II:

   $10,000 minimum, in units of $ 10,000, to a maximum of $300,000.

   Guaranteed Issue Amount: $ 50,000

   C) With respect to Class III:

   $5,000

4. **Premium Rates**

   Monthly rates for each $1,000 of Principal Sum:

   A) With respect to Classes I and II:

	Premium Rates ($)			
	Male		Female	
AGE	Non-Smoker	Smoker	Non-Smoker	Smoker
Under 35	$0.110	$0.138	$0.123	$0.162
35-39	$0.124	$0.172	$0.146	$0.223
40-44	$0.166	$0.271	$0.193	$0.350
45-49	$0.284	$0.552	$0.274	$0.559
50-54	$0.460	$1.022	$0.364	$0.778
55-59	$0.749	$1.809	$0.512	$1.074
60-64	$1.284	$3.166	$0.755	$1.452

   B) With respect to Class III:

   $2.02 /family

   Premium rates are guaranteed for 36 months from the Effective Date of the Policy.

   Except for Dependent Children, an Insured Person's rate is based on his attained age.

5. Premium Calculation

For each Insured Person, divide the Principal Sum by 1,000 and multiply the result by the rate applicable to the classification of the Insured Person stated in Item 4 of this Master Application.

Provincial sales tax on insurance premium must be added.

6. Premium Due Date and Payment

Premium is due on the first day of each month and payable monthly in arrears, within fifteen (15) days after the termination of the period to which it applies.

No prorated premium is due to the Insurer for the period from the effective date of an Insured Person's coverage until the next premium due date if such coverage becomes effective on a day other than a premium due date; and no prorated premium will be refunded by the Insurer if the Insured Person ceases to be insured under the Policy on a date other than a premium due date.

In the event of any change or administrative error affecting premiums, an equitable adjustment in premiums will be made on the premium due date following the date of such change or the discovery of such error. Any premium adjustment which involves the return of unearned premium to the Policyholder will be authorized only after the Insurer has received evidence that such adjustment should be made.

7. Evidence of Insurability and Effective Date of Insurance

Required evidence of insurability

Evidence of insurability to the satisfaction of the Insurer is required when the requested amount exceeds the Guaranteed Issue Amount.

For coverage obtained without evidence of insurability

Coverage as to each eligible Member or Spouse becomes effective on the latest of the following dates:

a. the Effective Date of the Policy with respect to an Member or Spouse who is eligible on or before the Effective Date of the Policy;

b. the date the Member returns to active full-time work if such Member is absent from full-time work on the Effective Date of the Policy for any reason other than: vacation or other paid leaves; maternity leaves; parental leaves;

c. the date of eligibility of the Member or the Spouse with respect to Member or Spouses who become eligible after the Effective Date of the Policy.

Coverage as to each eligible Dependent Child becomes effective on the latest of the following dates:

a. the effective date of the Member's or Spouse's insurance hereunder;

b. the date the Dependent Child becomes eligible with respect to those who become eligible after the effective date of the Member's or Spouse's insurance;

c. the date the enrolment of the eligible person is completed.

For coverage that can be obtained only upon approval of evidence of insurability by the Insurer

Coverage as to each eligible person becomes effective on the later of the Effective Date of the Policy or the date of approval of evidence of insurability, if approved by the Insurer. However, Dependent Children coverage cannot become effective before the Member's or Spouse's coverage.

8. Effective Date of the Policy

12:01 a.m., Standard Time, May 1st, 2022 at the address of the Policyholder.

9. Anniversary Date of the Policy

12:01 a.m., Standard Time, May 1st, 2023 at the address of the Policyholder and 12:01 a.m., Standard, May 1st of each subsequent year.

Signed for the Policyholder by:

Title: Administrative Officer NLTA

Date: May 10/22

ELIGIBILITY:

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, Basic Critical Illness plans and Long Term Disability for those eligible.

- 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

Option	Maximum Coverage
Basic Life (Member only)	$15,000
Basic AD&D (Member only)	$15,000
LTD	Not Eligible
Basic Critical Illness	Not Eligible
All other options	ame as Permanent Teacher

APPENDIX A

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; **if LTD benefits are payable, benefit paid only to the date contract ends.**
  - 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 the Administrator to pay by bank deduction for all their group insurance benefits, as well as the government's share (Life, Dependent 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 the administrator to pay by bank deduction for all their group insurance benefits, as well as the government's share (Life, Dependent 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 the administrator to pay by bank deduction for all their group insurance benefits, as well as the government's share (Life, Dependent 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 the administrator 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 by bank deduction both their share and the 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, Voluntary AD&D and Voluntary Critical Illness.

- **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, 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 a by 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 coverage under the NLTA Group Insurance Program. Teachers must arrange with the administrator 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.

- **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.