SISIP Financial and Manulife have duly executed the following Policy amendments to SISIP Policy #901102 as follows :	
Coming into force date	**Amendment**
7 August 2019	901102 – Part I – General Provisions **PART I** **GENERAL PROVISIONS** **1. Definitions** f. Policy Owner 1) The Deputy Minister of DND: a) Will serve as Policyholder for the portion of the SISIP policy #901102 that is publicly funded; b) Will be accountable for all public funds up to and including reporting; and, c) Will monitor solvency of the publicly funded plans and serve as lead liaison with central agencies in all issues related to SISIP policy #901102, most notably for matters related to funding and authority. 2) The Chief of the Defence Staff: a) Will serve as Policyholder for portion of the SISIP policy #901102 that is Non-Public Property (NPP) funded; b) Will establish appropriate internal controls including distribution and delegation of responsibilities and third party services (e.g., actuarial services, audit services); c) Will provide governance and management oversight; and, d) Will continue to exercise control as per the existing Memorandum of Agreement Regarding Effective control over the operation of SISIP policy #901102, dated 01 March 1990 and as amended.
1 July 2019	Non-Smoker Status a. To qualify as a non-smoker, the person insured under this Policy must submit evidence satisfactory to the Insurer that the Insured has not used any cigarettes, cigarillos, small or large cigars, pipes, chewing tobacco, or tobacco in any form within the one-year period preceding the date the person applies for Non-Smoker status. b. The Insurer reserves the right to request evidence of Non-Smoker Status at time of application or change of coverage.
1 July 2019	Limitation of Coverage In addition to the specific limitations applicable to Optional Group Term Insurance (OGTI), Reserve Term Insurance Plan (RTIP), Coverage After Release (CAR), and Insurance for Released Members (IRM), the insurance coverage in force on the life of an individual cannot, in aggregate, exceed $1,200,000 under any one or any combination of OGTI, RTIP, CAR and/or IRM.
1 January 2018	A more compassionate and progressive approach to move forward and reduce the life insurance suicide clause from two (2) years to one (1) year: **1. Amendment to Part IX – OGTI -** Subsection 125 repealed and replaced with a

SISIP Financial and Manulife have duly executed the following Policy amendments to SISIP Policy #901102 as follows :	
Coming into force date	**Amendment**
	new section (see underlined): 125. Limitations and Exclusions a. If a life insured's death results from suicide: i. no OGTI life insurance benefit shall be payable unless the life insurance became effective or was reinstated more than one (1) year prior to the date of death; ii. no increase in OGTI shall be payable unless that increase became effective or was reinstated more than one (1) year prior to the date of death; and, iii. if the coverage was obtained under OGTI by virtue of coverage transferred from SIB, RTIP, CAR or IRM, then notwithstanding Section 125.a.i and Section 125.a.ii, the benefit will be paid provided the combined continuous time the life insurance has been in force under these five (5) coverages is more than one (1) year, measuring from the later of the effective date and the last reinstatement date of each of the SIB, OGTI, RTIP, CAR and IRM coverages.
1 January 2018	**2. Amendment to Part X – CAR –** Subsection 137 repealed and replaced with a new section (see underlined): 137. Limitation of Coverage a. If a life insured's death results from suicide: i. no CAR life insurance benefit shall be payable unless the life insurance became effective or was reinstated more than one (1) year prior to the date of death; ii. no increase in CAR shall be payable unless that increase became effective or was reinstated more than one (1) year prior to the date of death; and, iii. the life insured obtained coverage under CAR by virtue of coverage transferred from SIB, OGTI or RTIP then notwithstanding 137.a.i and 137.a.ii, the benefit will be paid provided the combined continuous time the life insurance has been in force under these four coverages is more than one (1) year, measuring from the later of the effective date and the last reinstatement date of each of the SIB, RTIP, OGTI and CAR coverages.
1 January 2018	**3. Amendment to Part XII – RTIP -** Subsection 165 repealed and replaced with a new section (see underlined): 165. Limitations and Exclusions a. If a life insured's death results from intentionally self-inflicted injury or suicide: i. no RTIP life insurance benefit shall be payable unless the life insurance became effective or was reinstated more than one (1) year prior to the date of death; and ii. no increase in RTIP coverage shall be payable unless that increase in coverage became effective or was reinstated more than one (1) year prior to the date of death. iii. and the life insured obtained coverage under RTIP by virtue of coverage transferred from Survivor Income Benefit (SIB), Optional Group Term Insurance (OGTI), Coverage After Release (CAR) or Insurance for Released Members (IRM), then notwithstanding (i) and (ii) of this

SISIP Financial and Manulife have duly executed the following Policy amendments to SISIP Policy #901102 as follows :	
Coming into force date	**Amendment**
	subsection, the benefit will be paid provided the combined continuous time the life insurance has been in force under these five coverages is more than one (1) year, measuring from the later of the effective date and the last reinstatement date of each of the SIB, OGTI , RTIP, CAR and IRM coverages.
1 January 2018	**4. Amendment to Part XVI – IRM -** Subsection 219 repealed and replaced with a new section (see underlined): 219. Exclusions and Limitations a. If a life insured's death results from intentionally self-inflicted injury or suicide: i. no IRM life insurance benefit shall be payable unless the life insurance became effective or was reinstated more than one (1) year prior to the date of death. ii. no increase in IRM shall be payable unless that increase became effective or was reinstated more than one (1) year prior to the date of death. iii. and the life insured obtained coverage under IRM by virtue of coverage transferred from SIB, OGTI, MPRLIP, GOIP, RTIP, Res GOIP or CAR then notwithstanding (i) and (ii) of this subsection, the benefit will be paid provided the combined continuous time the life insurance has been in force under these coverages is more than one (1) year, measuring from the later of the effective date and the last reinstatement date of each of the SIB, OGTI, MPRLIP, GOIP, RTIP, Res GOIP, CAR and IRM coverages.
1 January 2018	The LTD benefits to be inclusive of mental issues: a. The existing wording states that no benefits are provided if the injury or illness was the result of an intentionally self-inflicted injury…. b. The change is to add the following inclusion to the definition: “unless medical evidence establishes that the injuries are related to a mental health issue: **1. Amendment to Part III (A) - PRE-DECEMBER 1, 1999 – LTD -** Subsection 58 repealed and replaced with a new section (see underlined): 58. c. No coverage is provided if total disability results from any of the following: i. injury sustained as a result of participation in the commission of a criminal offence; ii. intentionally self-inflicted injury or attempted self destruction, while sane or insane, unless medical evidence establishes that the injury is related to a mental health issue; or iii. total disability commencing during the first 12 months of coverage from injuries or illness for which the member consulted a physician during the six month period immediately preceding the date he became insured under this policy.
1 January 2018	2. **Amendment to Part III(B) – LTD -** Subsection 27 and 47 repealed and replaced with a new section (see underlined): 27. & 47. c. No coverage is provided if the injury or illness results from any of the

SISIP Financial and Manulife have duly executed the following Policy amendments to SISIP Policy #901102 as follows :	
Coming into force date	**Amendment**
	following: i. injury or illness sustained as a result of participation in the commission of a criminal offence; or ii. self-inflicted or as a result of attempted suicide; unless medical evidence establishes that the injury is related to a mental health issue; or, iii. an injury or illness commencing during the first 12 months of coverage from injuries or illness for which the member consulted a physician during the six (6) month period immediately preceding the date he became insured under this Policy.
1 January 2018	3. **Amendment to PART XIII - PRE-DECEMBER 1, 1999 – ResLTD -** Subsection 181 repealed and replaced with a new section (see underlined): 181. c. No coverage is provided if total disability results from any of the following: ii. intentionally self-inflicted injury or attempted self destruction, while sane or insane, unless medical evidence establishes that the injuries are related to a mental health issue,

SISIP POLICY 901102

Please note that in the case of conflict between this document and the insurance contract Policy #901102, the terms of the English contract will prevail. This document is provided for reference purposes only and shall not be considered to be definitive.

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PART I
GENERAL PROVISIONS

1. Definitions

The following terms shall have the meanings set forth below:

a. (i) "Member" shall mean a member of either the Canadian Forces (Regular) or the Canadian Forces (Primary Reserve) while on Class A or B or Reservists on Class C reserve service who fulfills the eligibility provisions and enrollment requirements of this policy, and, where appropriate, also includes a former member of the Canadian Forces who is eligible for Long Term Disability (LTD) benefits under this policy. In addition, it will include a former member of the Canadian Forces who is eligible to participate in either the Post Retirement Continuation Plan (PRCP), the Coverage After Release Plan (CAR), the Military Post Retirement Life Insurance Plan (MPRLIP) or the Insurance for Released Members plan (IRM).

(ii) Class "A" reserve service refers to the service of an individual who is employed on short periods of service not exceeding 16 days of continuous service and designated by military authority as being on Class "A" reserve service.

(iii) Short term Class "B" reserve service refers to the service of an individual who is employed on a full-time basis for 180 days or less and is designated by military authority as being on Class "B" reserve service.

(iv) Long Term Class "B" reserve service refers to the service of an individual who is a member of the Primary Reserve Force and is employed on a full-time basis for periods of more than 180 consecutive days and is designated by military authority as being on Class "B" reserve service.

(v) Class "C" reserve service refers to the service of an individual who is a member of the reserve force and is employed on a full time basis with the Canadian Forces Regular Force, and is designated by a military authority as being on Class "C" reserve service.

b. "Dependent" shall only include a "spouse" or "dependent child" as defined in this policy. "Dependent" shall not include "former spouse."

c. "Spouse" means a person married to a member or a beneficiary as a result of a valid civil or religious ceremony. In addition, the spouse of a member shall include a person for whom the member has made a written declaration that such person is the member's spouse. The spouse of a member or a beneficiary shall also include a person for whom it can be established that for at least 12 consecutive months such person has resided continuously with the member or the beneficiary, as the case may be. The onus will rest with the member or the beneficiary to prove to the satisfaction of the Insurer that a common law relationship exists and has continued for the prescribed period. If the member or the beneficiary has more than one spouse applying the above criteria, only the most recent shall be considered a "spouse" for purposes of this policy.

d. "Former Spouse" means a person who was once a spouse of the member, as defined in subsection 1(c) and is legally divorced from the member; or, in the case of a spouse who resided with the member for at least 12 consecutive months, has ceased to co-habit with the member.

e. “Dependent child”, unless stated otherwise, means a child who is:

(i) unmarried and not employed on a regular and full-time basis; and
(ii) ineligible to be insured as a member under this policy ; and
(iii) dependent upon:
1. a living member; or
2. a living member and
1) the member’s spouse or former spouse; or
2) a legal guardian or, in the absence of a legal guardian, a relative of either the member or the member’s spouse or former spouse; or
3. the member’s spouse, former spouse, legal guardian or, in the absence of a legal guardian, a relative of either the member or the member’s spouse or former spouse, if the member is deceased and the child was dependent upon the member immediately prior to his death.

The term Dependent Child shall apply from the time of such child’s live birth until the child’s 25th birthday. However, there shall be no maximum age limit applied if the Dependant Child has a demonstrable, significantly disabling medical illness/condition, is unable to provide for his own maintenance as a result of this incapacity and is continuously and wholly dependent upon one of the parties delineated in Section 1(e)(iii) (1) to (3), above.

f. "Policyowner" means the Chief of the Defence Staff for the Canadian Forces.

g. "Beneficiary" means the individual or individuals designated in writing by the member to receive benefits under this policy. Such beneficiary designation shall be valid when filed with the Policyowner or the Insurer.

h. (i) For the purposes of Part III and VII, "total disability" and "totally disabled" shall mean that the individual has been released from the Canadian Forces and has been incapacitated by a medically determinable physical or mental impairment which prevents him from performing any and every duty of any substantially gainful occupation or employment for which he is reasonably qualified by education, training or experience.

(ii) For the purposes of Part XIII, "total disability" and "totally disabled," for the first 24 consecutive months of benefit payment, shall mean that the individual has been released from the Canadian Forces and has been incapacitated by a medically determinable physical or mental impairment which prevents him from performing any and every duty of any substantially gainful occupation or employment for which he is reasonably qualified by education, training or experience.

In order for benefits to continue beyond such 24 month period, the disability must be a physical or mental impairment that is both severe and prolonged. A disability will be considered severe where the individual is not able to regularly pursue any substantially gainful occupation. A disability will be considered prolonged where such disability is of indefinite duration or is likely to result in death. Such disability must result from a medically determinable physical or mental impairment.

i. (i) "Monthly pay" or "monthly salary" shall mean the member's rate of pay specified in QR and O Chapter 204 pay tables for Regular Force Personnel.

(ii) "Annual pay" shall mean the member's actual annual rate of pay being paid within the ranges specified in QR and O Chapter 204 pay tables for Regular Force Personnel except that while a member is on any period of service without pay, as granted by the appropriate authority of the Canadian Forces, such rate of pay shall be that which was in effect for the member on the last day of paid service immediately preceding said period of service without pay.

(iii) "Reserve Daily Rate of Pay" shall mean the Reserve member's rate of pay specified in QR and O Chapter 204 for Reserve Force personnel.

j. "Pension Act" shall mean Pension Act, R.S.C. 1970, Chapter 207, as amended.

k. "General Officer" shall mean a person who holds the substantive rank of Colonel or higher, or an officer holding the substantive rank of Lieutenant Colonel in the Legal Classification.

l. "Duty" and "normal duties" shall mean those duties of the position to which a member has been transferred and includes such other duties as have been assigned to the member by military authority.

m. "Consumer Price Index for Canada" means the average for that year of the Consumer Price Index, as published by Statistics Canada, for each month in the 12 month period ending on 30 September in the immediately preceding year.

n. "Retirement Leave" means leave granted to a member of the Regular Force immediately prior to release or transfer from the Regular Force and can include accumulated leave, annual leave, special leave on release, and/or rehabilitation leave.

o. "Loss of use" means total and irrecoverable loss of use.

p. "Pooled product" shall refer to any insurance products which are underwritten by the Insurer on a non-experience rated basis, and therefore not subject to an experience rating credit.

q. "Cash flow interest rate" means the interest rate applicable to SISIP monthly cash flows in accordance with the interest crediting procedures established by mutual agreement between the Policyowner and the Insurer and as amended from time to time.

r. "Conversion Value for SIB" shall mean fifty (50) times the member's monthly pay, rounded to the next highest multiple of $10,000.

s. Wherever a masculine noun or pronoun is used in this policy it shall be deemed to include the feminine gender.

t. “Evidence of insurability” shall include evidence of medical insurability and evidence of the financial need of the proposed insured for the coverage applied for.

u. “Child” as used in this policy, means a member’s:

(i) natural children, including stillborn children. Stillborn means any fetus which, after having been completely expulsed or extracted from its mother, demonstrates no breathing, beating of the heart, pulsation of the umbilical cord, or unmistakable movement of the voluntary muscle, and
(1) where the expulsion or extraction occurs after pregnancy of at least 20 weeks; or
(2) where the product weighs 500 grams or more;

(ii) dependent step-children;

(iii) legally adopted children;

(iv) children to whom the member stands *in loco parentis* by order of a Court or other government authority;

(v) “Orphan”, for the purposes of Part II of this policy, means a Dependent Child who is survived neither by the member, nor the surviving spouse, or where a separated member has designated his dependent children as beneficiaries of his Survivor Income Benefit, under Part II of this policy.

2. Eligibility

a. A member may apply for insurance under this policy subject to the provisions of this Part and subject to the provisions outlined in the respective Parts of this policy.

b. Any former Member who is insured under either the Post Retirement Continuation Plan (PRCP), Coverage After Release (CAR) Plan or Insurance for Released Members Plan (IRM) plan shall be required, upon re-enrollment in the Canadian Forces, to reconvert his after release coverage to the Optional Group Term Insurance Plan (OGTI) Plan or Reserve Term Insurance Plan (RTIP) Plan, as applicable, up to the face amount of the after release coverage, without evidence of insurability.”

3. Service Without Pay

An eligible member on an authorized period of service without pay, may either become or remain insured for LTD, Reserve LTD (Res LTD), Survivor Income Benefit (SIB), Dependent Life (DL) insurance, OGTI, GOIP, RTIP and/or Reserve GOIP (Res GOIP), subject to the provisions of this policy. Such a member shall be responsible for making payment of the required premium contributions as specified by the Policyowner.

4. Enrollment Requirements

Unless coverage is provided for automatically as specified in this policy, an eligible member may apply for coverage by filing the following with the Policyowner or the Insurer:

a. a written application for all insurance coverages applicable to himself, and to his dependents; and,

b. the required premium, through pay allotment authorization, or such other payment form or forms acceptable to the Insurer and Policyowner; and

c. if required under this policy by furnishing evidence of the member's insurability and, if applicable, by furnishing evidence of the spouse's and/or dependent children's insurability, satisfactory to the Insurer and without expense to the Insurer.

5. Effective Date of Coverage or Increase in Coverage

a. The insurance applied for by a member shall be effective on the latest of the following dates:
(i) where evidence of insurability is required, the date of approval by the Insurer; or
(ii) the date the member satisfies the enrollment requirement(s) specific to the particular coverage.

b. The insurance of a dependent shall be effective on the latest of the following dates:
(i) the date the dependent becomes eligible, where such eligibility is defined in the particular coverage; or
(ii) the date the member's insurance becomes effective; or
(iii) where evidence of insurability is required, the date of approval by the Insurer.

6. Eligibility of Dependents

Each person who is a dependent of a member shall become eligible for insurance under this policy on the latest of the following dates:

a. the date the member becomes eligible for his personal coverages; or
b. the date the person becomes a dependent.

7. Discontinuance of Insurance

The insurance of a member, dependent or former spouse shall cease on the earliest of the following dates:

a. 60 days after the member ceases to be a full-time member of the Canadian Forces (Regular or Reserve) unless such member qualifies for LTD benefits or transfers coverage to the CAR option if his date of release is prior to 1 October 2005, or to the

IRM option if his date of release is on or after 1 October 2005, within the time specified in this policy; or

b. The date on which the Insurer or the Policyowner receives notification that the member has withdrawn authorization for the required premium contribution; or

c. With respect to the Survivor Income Benefit option,
   (i) the end of the 90 day period during which a member must authorize a change in his pay allotment for the acquisition of a dependent; or
   (ii) the date the member ceases to have dependents; or

d. The date of termination of this policy; or

e. For coverage on dependents, the earlier of:
   (i) any of the dates specified in subsections a, b, c or d of this Section 7; and
   (ii) for former spouses, the date the Policyowner or Insurer receives an application for life insurance coverage on a new spouse; or
   (iii) for a child, the date such person ceases to be a dependent child; or

f. Such date as may be peculiar to the particular coverage option under this policy; or

g. The date on which the Insurer or the Policyowner receives a written request to terminate coverage from the member.

In the event any or all of the coverages are cancelled or terminated there shall be no refund of the premium paid or any portion of the premium paid.

8. Conversion Privilege at Release

Prior to October 1, 2005, a member, spouse or former spouse who has life insurance in force and whose coverage exceeds the maximum amount of insurance available under CAR or a former dependent child who is not eligible for continued coverage under CAR, is entitled to purchase an individual life insurance policy issued by the Insurer, subject to the conditions outlined below ("a" through "f"):

On or after October 1, 2005, a member, spouse or former spouse who has life insurance in force and whose coverage exceeds the maximum amount of insurance available under Insurance for Released Members (IRM) or a former dependent child who is not eligible for continued coverage under IRM, is entitled to purchase an individual life insurance policy issued by the Insurer, subject to the following conditions ("a" through "f"):

a. The amount of the individual policy shall not exceed the amount of life insurance coverage which the member, spouse or former spouse or former dependent child had when coverage was discontinued, less the maximum amount available under CAR or IRM.

b. Written application for the individual policy and the first premium must be delivered or mailed to the Insurer within 60 days of the date on which the insurance coverage was discontinued.

c. The individual policy shall be, at the member's, spouse's, former spouse's or former dependent child's option, in any one of the forms then customarily offered for conversion by the Insurer. This individual policy shall be without dividends and without disability waiver or other supplementary benefits.

d. The premium for the individual policy shall be determined by the Insurer according to:
   (i) the Insurer's current rates for the member's, spouse's, former spouse's or former dependent child's then attained age at the birthday immediately prior to the date of issue of the individual policy; and
   (ii) the form and amount of the individual policy.

e. Evidence of insurability shall not be required.

f. Non-smoker rates are not available on converted policies.

9. Conversion Privilege Prior to Release

a. A member whose conversion value for SIB exceeds the maximum amount of insurance allowable for transfer to OGTI is entitled to purchase an individual life insurance policy issued by the Insurer. The amount of such policy shall not exceed the amount of insurance coverage the member had in force when coverage was discontinued, less the maximum amount available under OGTI, whether taken or not.

b. A member whose entire amount of GOIP or Res GOIP coverage is discontinued because he ceases to be eligible for coverage for any reason other than release from the Canadian Forces is entitled to purchase an individual policy issued by the Insurer. The amount of such policy shall not exceed the amount of insurance coverage the member had in force when coverage was discontinued, less the maximum amount available under OGTI, or RTIP, as applicable, whether taken or not.

c. Save and except dependent coverage under IRM, a dependent whose entire amount of dependent life insurance is discontinued because he ceased to be an eligible dependent, or because the member ceased to be eligible for coverage for any reason other than death or release from the Canadian Forces, will be entitled to purchase an individual life insurance policy issued by the Insurer. The amount of such policy shall not exceed the amount of the life insurance coverage which was discontinued, and shall not be less than the minimum amount for which the selected Insurer then customarily issues such individual policies.

d. Effective 1 July, 1990, dependent life coverage cannot be converted to any life insurance option under this policy or to an individual policy where the effect is to increase the level

of coverage by circumventing the evidence of insurability requirement through successive conversion actions. In such cases, the additional conversions are null and void.

e. Insurance coverage with respect to dependent children may be provided by a rider to an individual policy issued on the life of a member or member's spouse provided coverage for such a dependent is not continued under this policy.

f. The individual policies specified above are subject to the conditions specified in Section 8.

10. Conversion Privilege At Policy Termination

If the policy or one or more coverages within the policy terminate and a member, spouse and/or former spouse have been continuously insured under the life insurance options of this policy for at least five years, the member, spouse and/or former spouse have the same conversion privileges as described in Section 8; provided that the maximum amount of insurance the member, spouse and/or former spouse may convert shall be three times the member's, spouse's or former spouse's Maximum Pensionable Earnings for the year as established under the Canada Pension Plan less any amount of insurance coverage the member, spouse and/or former spouse become eligible for under another group policy within 31 days of the date of termination.

Note: The Conversion Privilege for the Post Retirement Continuation Plan is described in Section 107.

11. Benefit For Death During Coverage After Release Eligibility Period

If the member dies prior to October 1, 2005, and within the 60 day period during which the member could have made application for CAR, the Insurer shall pay the applicable amount under SIB, OGTI, RTIP, GOIP and/or Res GOIP. If the member dies on or after October 1, 2005, and within the 60 day period during which the member could have made application for IRM, the Insurer shall pay the applicable amount under SIB, OGTI, RTIP, GOIP and/or Res GOIP. If a CAR or IRM certificate and/or an individual policy have already been issued, no payment shall be made under this provision unless the certificate for CAR or IRM and any individual converted policy are surrendered without payment of claim. Upon surrender, the Insurer shall refund premiums paid on the CAR or IRM insurance and the individual policy. A beneficiary designated in any conversion application form shall be the beneficiary under this provision.

12. Waiver of Premium Benefit

a. If a member becomes totally disabled while insured under the Regular Force LTD and has coverage under the SIB, OGTI or the GOIP, the Insurer will waive the payment of premiums applicable to these coverage(s), commencing with the premium for the first full policy month for which benefits under LTD become payable and continuing thereafter for each policy month for which the member remains totally disabled. When a member who is insured under SIB, OGTI and/or GOIP for which premiums are being waived attains age 55, the amount of coverage under the SIB, OGTI and/or GOIP will be automatically transferred to CAR, and the premium for the CAR coverage will be

waived. This is subject to a maximum allowable amount for transfer to CAR from SIB of 50 times the member's monthly rate of pay at date of release from the Canadian Forces. This is also subject to the maximum coverage amount available under CAR.

b. If the member ceases to receive LTD benefits (subject to the Extension of Coverage provision in Part III), Waiver of Premium benefits will cease and any insurance under SIB, OGTI and/or GOIP may be converted/transferred to CAR as outlined above.

c. With respect to SIB, if the member no longer meets the eligibility rules to be insured because he no longer has any dependents, Waiver of Premium benefits will cease and any insurance under SIB will terminate. However, at the member's option, coverage under SIB may be converted to OGTI and in such case the Waiver of Premium benefit will continue in effect.

d. Effective 01 March 1992, if the member has made application for LTD benefits within 12 months of receipt by the Policyowner or the Insurer of an application for life insurance coverage or an increase in life insurance coverage, the Waiver of Premium benefit under such life insurance coverage shall be null and void, unless the member can prove the disabling condition occurred subsequent to the application for the life insurance coverage.

e. Termination of this policy will not affect the rights of a member who is entitled to benefits by reason of becoming totally disabled or dismembered prior to such termination. Benefits provided in accordance with this provision after the date of termination of this policy will not affect that termination nor continue this policy in force after that date.

f. There is no Waiver of Premium in the event a spouse, former spouse or dependent child becomes disabled.

g. For the life insurance coverages with Waiver of Premium benefit, the Waiver of Premium benefit is applicable to the dependent life coverage.

13. Data Required

a. The Policyowner shall furnish to the Insurer all available information which the Insurer may require to enable it to administer the insurance, to adjudicate claims and to determine the premiums required.

b. The Policyowner or the Insurer shall maintain insurance records sufficient to establish the insurance status of each person insured under any coverage provided by this policy.

c. All records of the Policyowner relating to this policy or any insurance under this policy shall be open to inspection by the Insurer at all reasonable times, and vice versa.

d. Clerical error shall not prejudice the rights of the Insurer.

14. Premium Grace Period - Pooled Products

a. With respect to pooled products, unless otherwise agreed to in writing by the parties, if any premium after the first premium is not paid in full by the Policyowner on or prior to the due date of such premium, and if the Policyowner has not given written notice to the Insurer on or prior to that due date that this policy is to terminate, a grace period shall be granted to the Policyowner for the payment of that premium without interest charge.

b. The grace period shall be for 31 days, beginning with the premium due date.

c. The Policyowner shall be liable to the Insurer for all premiums remaining unpaid on the date of termination of this policy.

15. Insurer's Right to Change Premium Rates - Pooled Products

a. The Insurer reserves the right to fix new premium rates for pooled products. Notice of any new premium rates shall be given to the Policyowner a minimum of 90 days before the effective date specified by the Insurer.

b. The Insurer shall not increase the premium rate more than once in any 12 month period, unless the Policyowner consents to the increase in writing.

16. Member's Certificate

Certificates will be issued to insured members.

17. Misstatement Of Age

If the age classification of any member has been misstated there shall be an equitable adjustment of premiums for the insurance of the member.

18. Non-Smoker Status

a. To qualify as a non-smoker, the member must submit evidence satisfactory to the Insurer that the member has not smoked any cigarettes within the one-year period preceding the date the member applies for Non-Smoker status.

b. The Insurer reserves the right to request evidence of Non-Smoker Status at time of application or change of coverage.

19. Contestability

Where the insurance coverage or increase in insurance coverage has been in effect for two years during the lifetime of the person whose life is insured, a failure to disclose or a misrepresentation of a fact material to the risk does not, in the absence of fraud, render the contract voidable.

20. Conformity With Applicable Law

Any provision of this policy which is in conflict with the applicable law of the jurisdiction of issue (Province of Ontario) is hereby amended to conform with the minimum requirements of that law, where possible, and where not possible is severed from the rest of the policy without affecting the validity of the remaining provisions of the policy.

21. Amendment, Renewal and Termination

a. This policy may be amended at any time by written agreement of the Insurer and the Policyowner.

b. Written agreement(s) between the Insurer and the Policyowner which are in place prior to and subsequent to amendments of this policy continue in effect unless cancelled or otherwise amended by mutual agreement or in accordance with the terms of the agreement(s).

c. The Policyowner may terminate this policy (in accordance with the Amended Terminal Accounting Agreement effective 01 January 1990 as amended) at any time by giving written notice of termination to the Insurer at its Head Office, but the date of termination shall not be less than 180 days after the date the Insurer receives such notice unless an earlier date is mutually agreed to in writing by the Insurer and the Policyowner.

d. The Insurer may terminate this policy effective the last day of any policy month after the first policy anniversary if the Insurer determines that fewer than 25% of the eligible members are then Insured under this policy. Termination shall be by written notice to the Policyowner delivered at least 180 days prior to the date of termination.

e. This policy shall automatically renew for a further term of one policy year on each policy anniversary, unless the Policyowner or the Insurer has given written notice of termination to the other in accordance with the foregoing paragraphs.

f. No amendment, renewal or termination of this policy shall require the consent of or notice to any member, dependent, beneficiary or other person.

g. Only the President, a Vice President, the Secretary or the Actuary has power on behalf of the Insurer to amend or terminate this policy. No agent has authority to change this policy or to waive any of its provisions.

h. Only the President of SISIP FS or a more senior authority specifically authorized by the Policyowner has power on behalf of the Policyowner to amend or terminate this policy. No agent has authority to change this policy or to waive any of its provisions.

22. Physical Examination and Autopsy

The Insurer, at its own expense, shall have the right to have the individual whose injury or sickness is the basis of claim examined by a physician designated by it, when and as often as it may reasonably require and to have an autopsy completed, where not forbidden by law.

23. Legal Action

No action at law or in equity shall be brought to recover on this policy prior to the expiration of 30 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of one year after the time written proof of loss has been furnished in accordance with the requirements of this policy or more than six years after the happening of the event upon which the insurance money becomes payable, whichever period first expires.

If any time limitation of this policy with respect to bringing an action at law or in equity to recover on this policy is less than that permitted by the law of the jurisdiction in which the member resides at the time the disability on which claim is based commences, or the death of the member occurs, that limitation is hereby extended to agree with the minimum period permitted by that law.

24. Canadian Funds

All amounts payable under this policy shall be payable in Canadian currency.

25. Non-Waiver of Policy Provisions

Failure of the Insurer to insist upon compliance with any provision of this policy at any time shall not operate to waive or modify such provision, or in any manner render it unenforceable at any other time.

26. Policyowner Not Insurer's Representative

The Policyowner is not the representative or agent of the Insurer for any purpose under this policy. The Insurer is not the Policyowner's representative or agent.

27. Entire Contract

This policy, the application of the Policyowner, the individual applications of the members insured and any written agreements between the Insurer and the Policyowner which are in place prior to and subsequent to amendment of this policy shall constitute the entire contract between the Policyowner and the Insurer.

28. Settlement Options

Any amount of insurance proceeds payable for life insurance coverage shall normally be payable in a lump sum; however, an individual beneficiary may elect a settlement option offered by the Insurer. Settlement options are not available to a corporation, partnership, or association.

29. Limitation of Coverage

In addition to the specific limitations applicable to OGTI, RTIP, CAR, and IRM, the insurance coverage in force on the life of an individual cannot, in aggregate, exceed $600,000 under any one or any combination of OGTI, RTIP, CAR and/or IRM.

30. Annual Experience Rating

On each policy anniversary, and in accordance with procedures agreed to by the Policyowner and Insurer regarding "experience rating," the Insurer may declare an experience credit in such amount as the Insurer may determine. The amount of each experience credit declared by the Insurer will be left on deposit with the Insurer and earn interest in accordance with the Insurer's regulations concerning such deposits in effect at that time, or, with 90 days prior written notice from the Policyowner, will be refunded to the Policyowner. The payment of such credit by the Insurer to the Policyowner shall completely discharge the

Insurer of all responsibility with respect to the amount so paid.

30A. No Duplication of Dismemberment Benefit

a. Where a member has coverage under the GOIP or the Res GOIP of SISIP Policy No. 901102, then such member must submit his claim for an accidental dismemberment under one of those plans, and is not entitled to apply for or receive any benefit under SISIP Accidental Dismemberment Policy No. 906906, or any of the LTD dismemberment provisions of Policy No. 901102.

b. Where a member suffers an accidental dismemberment that is not Attributable to Military Service, as that term is defined in Policy No. 906906, and where such member is not covered under the GOIP or Res GOIP provisions of Policy No. 901102, then such member must submit his claim for an accidental dismemberment under the applicable LTD dismemberment provisions of Policy No. 901102, and is not entitled to submit an accidental dismemberment claim under Policy No. 906906.

c. Where a member suffers an accidental dismemberment that is Attributable to Military Service, as that term is defined in Policy No. 906906, and such member is not covered under the GOIP or Res GOIP provisions of Policy No. 901102, then such member must submit his claim for an accidental dismemberment under Policy No. 906906, and is not entitled to submit an accidental dismemberment claim under Policy No. 901102.

d. Where a member has more than one accidental dismemberment coverage available to him under two or more of OGTI, RTIP, GOIP or Res GOIP, then the accidental dismemberment benefit payable to such member will be that which is the greater, under all of the coverages the member has in place. The accidental dismemberment benefit is limited in all circumstances to one benefit per dismemberment.

Where a member has both CAR and IRM coverage in force, providing this does not exceed the maximum of $600,000, the accidental dismemberment coverage available to him will be the combined dismemberment coverage under both plans.

PART II(B) - SURVIVOR INCOME BENEFIT INSURANCE (SIB)

The effective date of this Part II (B) is January 1, 1999

1. Eligibility

The Survivor Income Benefit (SIB) insurance coverage under this Part II (B) is available only to members of the Canadian Forces (Regular), or members of the Canadian Forces (Reserve) on Class "C" reserve service:

a. With dependents, and
b. with a date of death on or after January 1, 1999.

2. How An Eligible Member Becomes Insured

An eligible member must have been insured, and paying premiums, under Part II (A), on January 1, 1999, or had an approved Waiver of Premium claim in effect under Part II (A), of this Policy, on January 1, 1999, in order to become insured under this Part II (B).

3. Benefits In Event of Member's Death

a. Upon receipt at its Head Office of due proof that a member died on or after January 1, 1999, while insured under this coverage, the Insurer shall pay Survivor Income Benefits in accordance with the terms and conditions of this policy.

b. The Insurer shall have the right to require satisfactory evidence:

(i) that the person or persons to whom Survivor Income Benefits are payable is either ineligible for or has made application for all other income benefits referred to in Section 7(a) of this Part II (B), and
(ii) that all required proofs for such income benefits have been provided, and
(iii) of the amount of such other income benefits payable.

4. Entitlement to Survivor Income Benefits

The beneficiary shall be entitled to the benefit provided in Section 7 of this Part II (B).

5. Payment of Benefits

a. This benefit shall be payable on the last day of each calendar month following the month in which the member died.

b. Survivor Income Benefits shall be paid to the surviving spouse of the member for life or ten years, whichever is greater. In the event that the surviving spouse dies before expiry of the ten year guarantee period, then the commuted value of any remaining benefits during the ten year guarantee period shall be paid to the Estate of the surviving spouse.

c. Subject to Section 5(d) of this Part II (B), where the deceased member has no common-law spouse at the time of his death, then a surviving spouse who is separated but not divorced from the member will remain the beneficiary for Survivor Income Benefits. Payment shall be made to the separated surviving spouse of the member for life, or ten years, whichever is greater. In the event that the separated surviving spouse dies before expiry of the ten year guarantee period, then the commuted value of any remaining benefits during the remainder of the ten year guarantee period shall be paid the Estate of the surviving separated spouse.

d. Where the deceased member has no surviving spouse or common law spouse at the time of his death, or where the member has made a valid beneficiary designation naming his dependent children (as defined in Part I, section 1(e) of this Policy), as recipient of this Survivor Income Benefit, then those children who meet the definition of dependent children shall, in aggregate, become the beneficiary of the Survivor Income Benefit, and shall receive payments of the benefit, in aggregate, for a minimum of ten years. At the end of this minimum ten-year period, those children of the deceased member who no longer meet the definition of dependent children (as defined n part I, section 1(e) of this Policy), shall no longer be entitled to receive benefits under this Part II(B), and the payment of this benefit shall continue to be made to the remaining dependent children, in aggregate, until the last dependent child ceases to be a dependent.

e. In the event that a member who has acquired coverage under this Part II(B), dies, leaving no eligible dependents, as such are described under this Section 5, then the Policyholder will reimburse the estate of the member any premiums that were paid for coverage under this Part II(B), while he had no such eligible dependents.

6. Amount of Benefits

The amount of the monthly benefit shall be determined as of the date of death of the member, in accordance with Section 7 of this Part II(B). No cost of living increase will be applied to the Survivor Income Benefit under this Part II(B).

7. Amount of Insurance

a. The benefit payable to a beneficiary under Section 5 of this Part II(B) will be 50% of the member's monthly pay on the date of death, reduced by any benefit amounts payable to the beneficiary under:

(i) the Pension Act (including dependents' benefits) and/or

(ii) the primary benefit amount under the Canadian Forces Superannuation Act determined at the member's date of death. Without limiting the generality of the foregoing, any retroactive payments received by a beneficiary under Section 5 of this Part II(B), either under the terms of the Pension Act and/or the Canadian Forces Superannuation Act, shall be used in any reduction calculations under this Section.

b. Where a member is in receipt of long-term disability benefits under this policy, and has a Waiver of Premium for SIB in effect at the time of his death, then the benefit payable to any of the beneficiaries under Section 5 of this Part II(B) shall be calculated on the basis of the member's monthly pay as of the date of his release from the Canadian Forces. For the purposes of calculating the benefit payable under this Part II(B), the member's monthly pay as of the date of release from the Canadian Forces shall be increased annually on each January 1st, between the date of the member's release and date of his death, in proportion to the Consumer Price Index increases during that period. However, such increases shall be rounded to the next highest ¼ of 1%, if not already a multiple thereof, and limited to a maximum of 2% per year.

8. Subrogation

Where the death of the insured member, which gives rise to benefits under this Part II(B), is caused by any actionable wrong of a third party, the beneficiary subrogates any right of action which he may have against such third party, to the insurer, and agrees to execute any documents required, and to take all steps required, to perfect the subrogation.

9. Reimbursement of Insurer

If a claim by, or on account of, a deceased member's surviving dependent, for benefit amounts under the Canadian Forces Superannuation Act or the Pension Act, as a result of the death of a member, is denied, the benefits under this Part II(B) shall become payable in accordance with the terms and conditions of this Part II(B). However, this is provided that the beneficiary agrees with the Insurer, in writing, that if benefit amounts are subsequently awarded to the beneficiary under any of the said Acts, whether retroactively or otherwise, the beneficiary will reimburse the Insurer any excess amount of benefits as calculated under Section 7(a) of this Part II(B).

10. Transfer Of Coverage

A member may transfer coverage under the Survivor Income Benefit insurance to Optional Group Term Insurance at any time, by submitting the required application to the Policyholder/Insurer. The member may transfer, without evidence of insurability, any amount up to the conversion value for Survivor Income benefit, subject to the maximum amount of insurance allowable under Optional Group Term Insurance coverage.

11. Conversion Privileges

See Part I, subsection 9.

12. Coverage After Release

A member whose entire amount of Survivor Income Benefit insurance is discontinued because he ceases to be a full-time member of the Canadian Forces (Regular), may elect to continue to be insured under the Coverage After Release plan, as outlined in Part X of this Policy.

13. Benefit For Death During Coverage After Release Eligibility Period

See Part I, subsection 11.

14. Waiver of Premium Benefit

There is no Waiver of Premium Benefit under this Part II(B).

15. Major Medical Insurance

There is no Major Medical Insurance under this Part II(B).

16. Assignment

Except as otherwise prescribed by law, no spouse or child shall have the right to assign, alienate, encumber, or commute any payments of Survivor Income Benefits.

17. Proof of Entitlement

Payment of each monthly Survivor Income Benefit shall be subject to the condition that proof of entitlement be submitted by or on account of the person claiming such benefit, at such times and in such form as the Insurer may require.

18. Limitations and Exceptions

None.

PART III (B) POST-NOVEMBER 30, 1999
LONG TERM DISABILITY INSURANCE (LTD) PLAN

DIVISION 1

General Provisions

DIVISION 2

Regular Force Long Term Disability Plan

DIVISION 3

Reserve Force Long Term Disability Plan

DIVISION 4

Major Medical Plan

NOTE: Part III (B) applies to insured members of the Canadian Forces who were released from the Forces after November 30, 1999. Part III (B) has not been numbered sequentially with the other Parts of Policy 901102. The individual sections within Part III (B) have been assigned numbers from 1 through 65. Any references to section numbers within Part III (B) pertain only to sections within Part III (B).

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DIVISION I
GENERAL PROVISIONS

DIVISION I
GENERAL PROVISIONS

1. Definitions

For the purposes of this Part III (B), the following terms shall have the meanings set forth below:

a. "Consumer Price Index for Canada" (CPI) means the average for that year of the Consumer Price Index, as published by Statistics Canada, for each month in the 12 month period ending on 30 September in the immediately preceding year.

b. "Eligible Dependents" shall include:

(i) "Dependent child", unless stated otherwise, means a child who is:

(a) unmarried and not employed on a regular and full-time basis; and
(b) ineligible to be insured as a member under this Policy; and
(c) dependent upon:
    1. a living member; or
    2. a living member and
        (a) the member's spouse or former spouse; or
        (b) a legal guardian or, in the absence of a legal guardian, a relative of either the member or the member's spouse or former spouse; or
    3. a member's spouse, former spouse, legal guardian or, in the absence of a legal guardian, a relative of either the member or the member's spouse or former spouse, if the member is deceased and the child was dependent upon the member immediately prior to his death.

The term Dependent Child shall apply from the time of such child's live birth until the child's 25th birthday. However, there shall be no maximum age limit applied if the Dependant Child has a demonstrable, significantly disabling medical illness/condition, is unable to provide for his own maintenance as a result of this incapacity and is continuously and wholly dependent upon one of the parties delineated in Section 1(b)(iii) (1) to (3), above.

(ii) "Spouse" means a person married to a member as a result of a valid civil or religious ceremony. In addition, the spouse of a member shall include a person for whom the member has made a written declaration that such person is the member's spouse. The spouse of a member shall also include a person for whom it can be established that for at least 12 consecutive months such person has resided continuously with the member. The onus will rest with the member to prove to the satisfaction of the Insurer that a common law relationship exists and has continued for the prescribed period. If the member has more than one spouse applying the above criteria, only the most recent shall be considered a "spouse" for the purposes of this policy.

c. “Evidence of Insurability” shall include evidence of medical insurability and evidence of the financial need of the proposed insured.

d. "Loss of use" means total and irrecoverable loss of use.

e. “Medical release” and “medically released” shall mean that the member’s military employment with the Canadian Forces has been terminated under Queens Regulations and Orders, article 15.01 Items 3(a) or 3(b). For the purposes of this policy, if, subsequent to the date of release, the Item of release is changed to QR and O Article 15.01, Item 3(a) or 3(b), such change is not relevant.

f. “Member” shall mean:
   (i) a person of the Canadian Forces (Regular) who fulfills the eligibility provisions and enrollment requirements of this policy; or
   (ii) a person on Class “A” Primary Reserve Service who is employed on short periods of service not exceeding 16 days of continuous service and designated by military authority as being on Class “A” Reserve Service; or
   (iii) a person on short term Class “B” Primary Reserve Service who is employed on a full-time basis for 180 days or less and is designated by military authority as being on Class “B” Reserve Service; or
   (iv) a person on long term Class “B” Primary Reserve Service who is a member of the Reserve Force and is employed on a full-time basis for periods of more than 180 consecutive days and is designated by military authority as being on Class “B” Reserve Service; or
   (v) a person on Class “C” Reserve Service who is a member of the Reserve Force and is employed on a full-time basis with the Canadian Forces Regular Force, and is designated by military authority as being on Class “C” Reserve Service.

g. (i)a For members defined at. Section 1.f.(i) , "monthly pay" or "monthly salary" shall mean the monthly pay in effect on the date of release from the Canadian Forces, and shall include all retroactive pay increases with an effective date on or before the member’s date of release from the Canadian Forces.
   (i)b For members defined at Section l.(f)(v), “monthly pay” or “monthly salary” shall mean the monthly pay in effect when the injury or illness occurred.
   (ii) For members defined at Section 1.f.(iv), “calculated monthly salary” shall mean the Reserve Force daily rate of pay in effect when the injury or illness occurred, equivalent to the daily rate of pay o the member’s date of release from the Canadian Forces, multiplied by thirty (30) days.
   (iii) "Annual pay" shall mean the member's actual annual rate of pay being paid within the ranges specified in the pay tables for Regular Force personnel. While a member is on any period of service without pay, as granted by the appropriate authority of the Canadian Forces, such rate of pay shall be that which was in effect for the member on the last day of paid service immediately preceding said period of service without pay.

(iv) For members as defined at Section 1.f.(i) and Section l.f.(v), “commensurate salary” shall mean that, for the purposes of benefit calculation, the minimum salary for a Private or Officer Cadet, will be that of a Senior Private in the standard pay group.

h. (i) A member defined at Section 1.f.(ii) and Section l.f.(iii) will be considered “on duty” during the performance of Reserve Service for which the member is authorized and entitled to pay, including:

(a) Reserve Force training or duty at a local headquarters including parades local demonstrations or local exercises, including the necessary travelling time to proceed directly to and return directly from the place where the activities are to be performed. The travel time will be deemed to take place immediately prior to and immediately after the required duty times;

(b) Reserve Force training/duty at other than the designated local area. The member is deemed to be “on duty” for Reserve Service while proceeding directly to the duty location, during the performance of authorized activities at the duty location, and returning directly from the duty location; and

(c) Periods of continuous Reserve Service. In these instances, “on duty” coverage will equate to 24-hour full-time coverage provided the member is authorized for such service and is receiving the entitled pay for such continuous service.

(ii) The Reserve Force member defined at Section 1.f.(iv) will be considered “on duty” 24 hours, 7 days a week.

i. "Pension Act" shall mean Pension Act, R.S.C. 1970, Chapter 207, as amended.

j. “Primary benefits” under the Canada Pension Plan (CPP) or Quebec Pension Plan (QPP) mean the benefits associated with the member only.

k. "Policyowner" means the Chief of the Defence Staff for the Canadian Forces.

l. “Total disability” and “totally disabled” shall mean that the individual has been released from the Canadian Forces and that there is clear , objective medical evidence , satisfactory to the Insurer , which confirms that the individual is incapacitated by an active, medically determinable physical or mental impairment which prevents him from performing any and every duty of any substantially gainful occupation or employment for which he is reasonably qualified by education, training or experience.

m. Wherever a masculine noun or pronoun is used in this policy it shall be deemed to include the feminine gender.

n. “Child” as used in this policy, means a member’s:

(i) natural children, including stillborn children. Stillborn means any fetus which, after having been completely expulsed or extracted from its mother, demonstrates no breathing, beating of the heart, pulsation of the umbilical cord, or unmistakable movement of the voluntary muscle, and
  (1) where the expulsion or extraction occurs after pregnancy of at least 20 weeks; or
  (2) where the product weighs 500 grams or more;
(ii) dependent step-children;
(iii) legally adopted children;
(iv) children to whom the member stands *in loco parentis* by order of a Court or other government authority.

2. Enrollment Requirements

Unless coverage is provided for automatically as specified in this policy, an eligible member may apply for coverage by filing the following with the Policyowner or the Insurer:

a. a written application form for LTD coverage applicable to himself ; and

b. the required premium, through pay allotment authorization , or such other payment form or forms acceptable to the Insurer and Policyowner; and

c. by furnishing evidence of the member's insurability, satisfactory to the Insurer and without expense to the Insurer.

3. Effective Date of Coverage

The insurance applied for by a member under Section 2 shall be effective on the latest of the following dates:

(i) where evidence of insurability is required, the date of approval by the Insurer; or
(ii) the date the member satisfies the enrollment requirement(s) specific to Section 2.

4. Discontinuance of Insurance

Insurance on a member shall cease on the earliest of the following:

a. The date on which the Insurer or the Policyowner receives notification that the member has withdrawn authorization for the required premium contribution; or

b. The date of termination of this policy; or

c. The end of the term for which the premium has been paid; or

d. The date and time that a member of the Primary Reserve on Class A or Class B Reserve
Service ceases to be “on duty”; or

e. The date that a member on Class “C” Reserve Service completes his Class “C” contract;

f. The date on which the member is released from the Canadian Forces; or

g. The date on which the Insurer or the Policyowner receives a written request of termination of coverage from the member.

5. Conversion Privilege

There is no conversion privilege associated with this policy.

6. Waiver of Premium Benefit

There is no Waiver of Premium benefit under this policy.

7. Data Required

a. The Policyowner shall furnish to the Insurer all available information which the Insurer may require to enable it to administer the insurance, to adjudicate claims and to determine the premiums required.

b. For members defined at Section 1.f.(i) the Policyowner or the Insurer shall maintain insurance records sufficient to establish the insurance status of each person insured under this Policy.

c. All records of the Policyowner relating to this policy or any insurance under this Policy shall be open to inspection by the Insurer at all reasonable times, and vice versa.

d. Clerical error shall not prejudice the rights of the Insurer.

8. Annual Experience Rating

On each policy anniversary, and in accordance with procedures agreed to by the Policyowner and Insurer regarding “experience rating”, the Insurer may declare an experience credit in such amount as the Insurer may determine. The amount of each experience credit declared by the Insurer will be left on deposit with the Insurer and earn interest in accordance with the Insurer’s regulations concerning such deposits in effect at that time, or, with 90 days prior written notice from the Policyowner, will be refunded to the Policyowner. The payment of such credit by the Insurer to the Policyowner shall completely discharge the Insurer of any responsibility with respect to the amount so paid.

9. Member's Certificate

Certificates will not be issued to insured members.

10. Service Without Pay

a. A member defined at Section 1.f.(i) on an authorized period of service without pay, may either become or remain insured for Long Term Disability, subject to the provisions of this policy. Such a member shall be responsible for making payment of the required premium contributions as specified by the Policyowner.

b. A member defined at Section 1.f.(iv) or Section 1.f.(v) on an authorized period of service without pay for maternity or parental leave purposes and who has completed six months of continuous full-time service immediately prior to the commencement of such leave shall retain the Long Term Disability coverage for the relevant maternity or parental leave period which was authorized by military authorities.

11. Contestability

Where the insurance coverage has been in effect for two years during the lifetime of the person who is insured, a failure to disclose or a misrepresentation of a fact material to the risk does not, in the absence of fraud, render the contract void.

12. Conformity with Applicable Law

Any provision of this policy which is in conflict with the applicable law of the jurisdiction of issue (Province of Ontario) is hereby amended to conform with the minimum requirements of that law, where possible, and where not possible is severed from the rest of the policy without affecting the validity of the remaining provisions of the policy.

13. Amendment, Renewal and Termination

a. This policy may be amended at any time by written agreement of the Insurer and the Policyowner.

b. Written agreement(s) between the Insurer and the Policyowner which are in place prior to and subsequent to amendments of this policy continue in effect unless cancelled or otherwise amended by mutual agreement or in accordance with the terms of the agreement(s).

c. The Policyowner may terminate this policy (in accordance with the Amended Terminal Accounting Agreement effective 1 January, 1990 as amended) at any time by giving written notice of termination to the Insurer at its Head Office, but the date of termination shall not be less than 180 days after the date the Insurer receives such notice unless an earlier date is mutually agreed to in writing by the Insurer and the Policyowner.

d. The Insurer may terminate this policy (in accordance with the Amended Terminal Accounting Agreement effective 1 January, 1990 as amended) effective the last day of any policy month after the first policy anniversary. Termination shall be by written notice to the Policyowner delivered at least 180 days prior to the date of termination.

e. This policy shall automatically renew for a further term of one policy year on each policy anniversary, unless the Policyowner or the Insurer has given written notice of termination to the other in accordance with the foregoing paragraphs.

f. No amendment, renewal or termination of this policy shall require the consent of or notice to any member, dependent, beneficiary or other person.

g. Only the President, a Senior Vice President, the Corporate Secretary or the Appointed Actuary has power on behalf of the Insurer to amend or terminate this policy. No agent has authority to change this policy or to waive any of its provisions.

Only the President of SISIP or a more senior authority specifically authorized by the Policyowner has power on behalf of the Policyowner to amend or terminate this policy. No agent has authority to change this policy or to waive any of its provisions.

14. Physical Examination

The Insurer, at its own expense, shall have the right to have the individual whose injury or illness is the basis of claim examined by a physician designated by it, when and as often as it may reasonably require.

15. Legal Action

a. No action at law or in equity shall be brought to recover on this policy prior to the expiration of 30 days after written proof of loss has been furnished in accordance with the requirements of this policy. No such action shall be brought after the expiration of one year after the time written proof of loss has been furnished in accordance with the requirements of this policy or more than six years after the happening of the event upon which the insurance money becomes payable, whichever period first expires.

b. If any time limitation of this policy with respect to bringing an action at law or in equity to recover on this policy is less than that permitted by the law of the jurisdiction in which the member resides at the time the disability on which claim is based commences, or the death of the member occurs, that limitation is hereby extended to agree with the minimum period permitted by that law.

16. Canadian Funds

All amounts payable under this policy shall be payable in Canadian currency.

17. Policyowner Not Insurer's Representative

The Policyowner is not the representative or agent of the Insurer for any purpose under this policy. The Insurer is not the Policyowner's representative or agent.

18. Entire Contract

This policy, the application of the Policyowner, and, if applicable, the individual applications of the members insured and any written agreements between the Insurer and the Policyowner which are in place prior to and subsequent to amendment of this policy shall constitute the entire contract between the Policyowner and the Insurer.

19. Non-Waiver of Policy Provisions

Failure of the Insurer to insist upon compliance with any provision of this policy at any time shall not operate to waive or modify such provision, or in any manner render it unenforceable at any other time.

19A. No Duplication of Dismemberment Benefit

a. Where a Member has coverage under the General Officers' Insurance Plan ("GOIP") or the Reserve General Officers' Insurance Plan ("Res GOIP") of SISIP Policy No. 901102 ("Policy No. 901102"), then such Member must submit his claim for an accidental dismemberment under one of those plans, and is not entitled to apply for or receive any benefit under SISIP Accidental Dismemberment Policy No. 906906 ("Policy No. 906906"), or any of the Long Term Disability dismemberment provisions of Policy No. 901102.

b. Where a Member suffers an accidental dismemberment that is not Attributable to Military Service, as that term is defined in Policy No. 906906, and where such Member is not covered under the GOIP or Res GOIP provisions of Policy No. 901102, then such Member must submit his claim for an accidental dismemberment under the applicable Long Term Disability dismemberment provisions of Policy No. 901102, and is not entitled to submit an accidental dismemberment claim under Policy No. 906906.

c. Where a Member suffers an accidental dismemberment that is Attributable to Military Service, as that term is defined in Policy No. 906906, and such Member is not covered under the GOIP or Res GOIP provisions of Policy No. 901102, then such Member must submit his claim for an accidental dismemberment under Policy No. 906906, and is not entitled to submit an accidental dismemberment claim under Policy No. 901102.

DIVISION 2

REGULAR FORCE AND RESERVE FORCE CLASS "C" LONG TERM DISABILITY INSURANCE (LTD) PLAN

DIVISION 2
Long Term Disability INSURANCE (LTD) Plan
Regular Force and Reserve Force Class "C"

20. Eligibility

Long Term Disability insurance coverage under this Division 2 is only available to the following CF members:

a. Members as defined at Section 1.f.(i)-(Regular Force); and

b. Members as defined at Section 1.f.(v)-(Reserve Force-Class "C").

21. How an Eligible Member Becomes Insured

An eligible member becomes insured under this Division 2:

a. In the case of a Regular Force member who joined the Canadian Forces on or after April 1, 1982, coverage is automatic and continues subject to Section 4. No application form is required.

b. In the case of a Regular Force member who joined the Canadian Forces prior to April 1, 1982 and had LTD coverage under Policy #901102 on November 30, 1999, coverage is automatic and continues, subject to Section 4. No application form is required.

c. In the case of a Class "C" Reserve member, coverage is automatic and starts on the first day of each period of Class "C" Reserve service subsequent to November 30, 1999 and continues, subject to Section 4 until the completion of each Class "C" contract period. No application form is required.

d. In circumstances other than outlined above when the member acquires LTD coverage in accordance with Section 2 and Section 3.

22. Benefit Eligibility

a. An insured member will be eligible to receive a monthly benefit for up to twenty-four months, immediately following his date of release from the Canadian Forces , if:

(i) the insured member is medically released from the Canadian Forces on or after December 1, 1999; and
(ii) there is clear , objective medical evidence , satisfactory to the Insurer that , at the time of release , the insured member suffers from an active , medically determinable physical or mental impairment.

b. Where an insured member has received monthly benefits under Section 22 a., then , for monthly benefits to continue beyond the initial twenty-four months , the member must be totally disabled, as defined in Section 1(*l*).

c. Where an insured member is not medically released from the Canadian Forces , then such member will be eligible to receive a monthly benefit if he is totally disabled , as defined in Section 1(*l*) , for thirteen consecutive weeks , or more, and has been released from the Canadian Forces while still totally disabled.

23. Amount of Monthly Income Benefits

a. Subject to Section 1.g.(iv) and Section 24, the monthly income benefit shall be 75% of the member's monthly pay in effect on the date of release from the Canadian Forces or, in the case of a Class "C" member, 75% of the monthly pay in effect when the injury was incurred or the illness was contracted; and

b. Benefits for part months shall be based pro rata on a 30 day month; and

c. Benefits shall be increased annually on January 1st. Increases will be proportionate to the Consumer Price Index (CPI) increases from the date the benefit commenced. The benefit increases shall be rounded to the next ¼ of 1%, if not already a multiple thereof, and limited to a maximum of 2% per year.

24. Other Relevant Sources of Income

a. The monthly benefit payable at Section 23 shall be reduced by the sum of:

(i) the monthly income benefits payable to the member under the Canadian Forces Superannuation Act; and
(ii) the Primary monthly income benefits payable to the member under the Canada or Quebec Pension Plans (including retroactive payments covering the period during which such benefits were prefunded under this Division 2); and
(iii) the employment income of the member unless the member is participating in a rehabilitation program approved by the Insurer in which case the monthly benefit will be reduced in accordance with Section 28; and
(iv) the total monthly income benefits payable to the member under the Pension Act (including dependant benefits and retroactive payments covering the period during which such benefits were prefunded under this Division 2).

b. For the purposes of Section 24.a., any cost of living increases in the monthly income benefits from the sources indicated shall not be considered relevant to the monthly income benefit payable under the Policy.

25. Duration of Benefits

a. Subject to Section 22 a., an insured member who is medically released from the Canadian Forces becomes eligible for benefits on the day after the date of release from the Canadian Forces. The benefit will be payable for each succeeding month, or part month up to 24 months or the member's 65th birthday, whichever first occurs. In the event of the death of a member, the monthly benefit shall be payable for the entire month in which death occurs.

b. Subject to Section 22 c., for an insured member who is not medically released from the Canadian Forces, he becomes eligible for benefits on the day after the date of release from the Canadian Forces. The benefit will be payable for each month, or part month, that such total disability continues or the member's 65th birthday, whichever first occurs. In the event of death of the member, the monthly benefit shall be payable for the entire month in which death occurs. The Insurer reserves the right to require evidence of continuing disability satisfactory to the Insurer and at no expense to the Insurer.

c. For a member who has been in receipt of benefits under Section 25.a., and is not 65 years of age, and is totally disabled, benefits are payable beyond the 24th month, for each succeeding month or part month that such total disability continues or the member's 65th birthday, whichever first occurs. In the event of the death of the member, the monthly benefit shall be payable for the entire month in which death occurs. The Insurer reserves the right to require evidence of continuing total disability satisfactory to the Insurer and at no expense to the Insurer.

26. Subrogation

If the injury or illness giving rise to benefits under this Division 2 is caused by any actionable wrong of a third party, the insured member subrogates his right of action against such third party to the Insurer and agrees to execute any documents required to perfect the subrogation.

27. Exceptions and Limitations

a. No benefits are payable for that portion of any period during which the member is not under the care and treatment of a legally qualified physician or specialist other than himself, if the Insurer so requires. The member shall be required to be under the care of an appropriate specialist if the condition necessitates such treatment. The member bears the onus of proving that he is under the care and treatment of a legally qualified physician or specialist, or alternatively that the injury or illness does not require the ongoing care and treatment of a legally qualified physician or specialist.

b. Where the injury or illness does not necessitate periodic examination of the member by a legally qualified physician who treats him, the Insurer may require the member to be examined by such physician or a physician of its' choice, at such intervals as the Insurer may deem necessary for optimal treatment and/or assessment of the member's condition. If the member fails to be examined as required by the Insurer, the Insurer shall have the right to suspend payment of all benefits until such examination of the member is completed, and the report submitted to the Insurer. Nothing in this Section prevents the Insurer from discontinuing the payment of benefits upon completion of the required examination if such examination demonstrates that the member no longer qualifies for benefits under Section 22 of this Policy.

c. No coverage is provided if the injury or illness results from any of the following:
   (i) injury or illness sustained as a result of participation in the commission of a criminal offence; or
   (ii) intentionally self-inflicted injury or attempted self-destruction, while sane or insane; or
   (iii) an injury or illness commencing during the first 12 months of coverage from injuries or illness for which the member consulted a physician during the six (6) month period immediately preceding the date he became insured under this Policy.

d. No benefits are payable to an insured member after he reaches the age of 65.

e. No benefits are payable if subsequent to the date of release from the Canadian Forces, the member’s item of release under QR & O Article 15.01 is changed to Item 3(a) or 3(b), unless the change occurs within 12 months of the member’s date of release from the Canadian Forces, and such change relates to a psychiatric and/or psychological condition.

f. No benefits are payable to an insured member who applies for benefits under this Policy more than 120 days following his date of release from the Canadian Forces.

g No benefits are payable for total disability unless there is clear, objective medical evidence satisfactory to the Insurer , which confirms that the individual is incapacitated by an active, medically determinable physical or mental impairment which prevents him from performing any and every duty of any substantially gainful occupation or employment for which he is reasonably qualified by education, training or experience.

h. No benefits are payable for an injury or illness that commenced prior to November 30, 1999, for which a medical underwriting exclusion was in effect under Part III(A) of this contract.

28. Rehabilitation Program and Employment Earnings

A member in receipt of a monthly benefit shall be encouraged to enter an approved rehabilitation program. If a member earns income while participating in a rehabilitation program approved by the Insurer, the member's benefit will be reduced by 50% of the employment income, or 50 cents for each dollar earned, until the member's total income from all sources reaches 100% of his monthly salary at release or, in the case of a Class "C" member, the monthly pay in effect when the injury was incurred or the illness was contracted, adjusted to the present value by application of the "CPI" for each year benefits are payable. Thereafter, the member's benefit will be reduced by one dollar for each dollar earned.

29. Extension of Coverage

a. For those who qualify as totally disabled, Extended Coverage for 36 months duration shall be provided by the Insurer after final payment of monthly income benefits. This extension shall commence on the earlier of the following dates:
   (i) the date upon which the monthly income benefit payable under this Division 2 is zero; or
   (ii) the date the member ceases to be totally disabled.

b. In the event that the member was entitled to Major Medical benefits under Division 4, at the commencement and through the duration of the claim, such entitlement will continue for the extension of coverage period. If, during the 36 month period, the member becomes totally disabled as a result of the cause for which benefits were originally paid, the benefit will be reinstated in accordance with Section 23.

c. No monthly income benefit will be payable under this extension as a result of a cause separate and unrelated to that of the original claim.

LONG TERM DISABILITY-DISMEMBERMENT BENEFIT

30. Payment of Benefit-Dismemberment

a. The dismemberment benefit under this Division 2, is an integral part of the benefits potentially payable; however, if a member qualifies for monthly benefits under Section 22, and has suffered a loss as outlined in Section 32, then Sections 30 to 33, will take precedence for benefit purposes. If a member is disqualified under Section 33, then Section 22 shall prevail.

b. Upon receipt of due proof that an insured member has suffered a dismemberment within 365 days of and as a result of an accident, and has been released from the Canadian Forces, the Insurer will pay a monthly income benefit to the member for a fixed period as provided at Section 32 or until death, whichever first occurs. The member must be released within three (3) years of the accident date. No benefit is payable for the first 13 weeks following the accident date.

c. If a monthly income benefit is not payable under Section 30.a. or a monthly income benefit has been paid for the fixed period at Section 32, then the claim shall be further assessed under Section 22, giving effect to the benefits already paid and the length of time benefits have been paid.

31. Amount of Monthly Income Benefit - Dismemberment

The amount of the monthly income benefit for dismemberment shall be calculated in accordance with Section 23; for the purposes of calculating the benefit under this section, Section 24.a.(iii) does not apply for the relevant fixed period at Section 32.

32. Schedule of Benefits - Dismemberment

a. The income benefit payable will be:

Loss	Fixed Benefit Period
Loss of both hands or feet	36 months
Loss of one hand and one foot	36 months
Loss of sight of both eyes	36 months
Loss of one hand or one foot and sight of one eye	36 months
Loss of hearing or speech	36 months
Loss of one hand or one foot	24 months
Loss of sight of one eye	12 months
Loss of thumb and index finger of the same hand	12 months

b. "Loss" as used above shall also include total and irrecoverable loss of use.

c. "Loss of sight" shall mean total and irrecoverable loss of sight.

d. In the event more than one of the losses described above results from the same accident, only one benefit period shall apply and that will be the longest period.

33. Exceptions and Limitations - Dismemberment

No monthly income benefits are payable for dismemberment;

a. sustained while participating in the commission of a criminal offence; or

b. intentionally self-inflicted or attempted self destruction, whether sane or insane; or

c. resulting from an accident occurring prior to coverage under this Policy; or

d. of a member who left the Canadian Forces voluntarily or retired from the Canadian Forces at compulsory retirement age; or

e. occurring prior to December 1, 1999, where the member did not have LTD coverage under Part III (A). of Policy #901102 in effect on November 30, 1999.

PROVISIONS APPLICABLE TO BOTH LONG TERM DISABILITY AND DISMEMBERMENT BENEFITS

34. Assignment

No member has the right to assign, alienate, encumber, or commute any monthly income benefit.

35. Reimbursement of Insurer

If a member's claim for benefits under the Canadian Forces Superannuation Act, the Canada Pension Plan, the Quebec Pension Plan or the Pension Act is denied, the benefits under this coverage shall become payable in accordance with the terms and conditions of this Division 2, provided the member agrees, in writing, that if benefits are subsequently awarded to the member under any of the said Authorities, the member will reimburse the Insurer to the extent that the benefits paid under this coverage exceed the benefits that would otherwise be payable.

36. Proof of Claim

a. Written proof of claim in a form satisfactory to the Insurer, covering the occurrence, character and extent of loss for which a claim for benefits is made, must be furnished to the Insurer within 120 days after the member's date of release from the Canadian Forces. Upon receipt of such proof, satisfactory to the Insurer, the Insurer will commence payment.

b. Written proof of the continuance of such claim must be furnished, to the Insurer, at such intervals as it may reasonably require and at no cost to the Insurer.

c. The Insurer shall have the right to require, as part of the proof of claim, satisfactory evidence:
   (i) that the member either is not eligible or has made application for all benefits referred to in Section 24; and
   (ii) that he has furnished all required proofs for such benefits; and
   (iii) of the amount of such benefits payable.

37. Payment of Claim

a. Benefits payable under this Division 2 shall be payable on the last day of each month during the period for which the Insurer is liable.

b. If any benefit under this Division 2 becomes payable to the estate of the member, the Insurer, at its option, may pay such benefit, not exceeding one month's benefit, to any relative by blood or marriage. Any payment made by the Insurer, in good faith, pursuant to this Section shall fully discharge the Insurer to the extent of such payment.

38. Major Medical Insurance

See Division 4.

DIVISION 3
RESERVE FORCE CLASS "A" AND CLASS "B" LONG TERM DISABILITY INSURANCE PLAN
(Res LTD)

DIVISION 3
RESERVE FORCE LONG TERM DISABILITY INSURANCE PLAN (RES LTD)
RESERVE FORCE CLASS "A" AND CLASS "B"

39. Eligibility

Reserve Long Term Disability insurance coverage under this Division 3 is only available to the following CF members who are released from the CF:

a. Members defined at Section 1.f.(ii)-(Primary Reserve Class A); and

b. Members defined at Section 1.f.(iii)-(Primary Reserve Class B, Short-Term); and

c. Members defined at Section 1.f.(iv)-(Primary Reserve Class B, Long-Term).

40. How an Eligible Member Becomes Insured

An eligible member becomes insured under this Division 3

a. In the case of a Reserve Force member on Class "A" or Class "B" Reserve Service and subject to Section 4, coverage is automatic for each period that he is on duty.

   (i) Eligible members defined at Section 1.f.(ii) (Class "A") and Section 1.f.(iii) (short-term Class "B"), acquire basic coverage which is based on a deemed monthly salary of $2,000 and effective October 3, 2011 $2,700; or

   (ii) Eligible members defined at Section 1.f.(ii) (Class "A") and Section 1.f.(iii) (short-term Class "B"), may acquire optional coverage which is based on a deemed monthly salary of $3,000 or $4,000 and effective October 3, 2011 $3,700 or $4,700, subject to the Sections 2 and 3 except that only evidence of financial need will be required. If the member applies for the optional coverage he shall provide to the Insurer, or the Policyowner, arms-length written substantiation of employment income, other than income earned through Reserve Service, which income, combined with the income earned through Reserve Service, merits a deemed monthly salary nearest to $3,000 or $4,000 and effective October 3, 2011 $3,700 or $4,700. Such substantiation must be satisfactory to the Insurer or the Policyowner and without expense to the Insurer or the Policyowner; or

   (iii) Eligible members defined at Section 1.f.(iv) (long-term Class "B"), acquire coverage based on the calculated monthly salary.

41. Benefit Eligibility

a. An insured member will be eligible to receive a monthly benefit for up to twenty-four months, immediately following his date of release from the Canadian Forces, if:

(i) the insured member is medically released from the Canadian Forces on or after December 1, 1999; and
(ii) there is clear , objective medical evidence , satisfactory to the Insurer that , at the time of
release , the insured member suffers from an active , medically determinable physical or mental impairment; and
(iii) the injury was incurred or the illness was contracted while the member was on duty.

b. Where an insured member has received monthly benefits under Section 41 a., then, for monthly benefits to continue beyond the initial twenty-four months, the member must be totally disabled, as defined in Section 1(*l*).

c. Where an insured member is not medically released from the Canadian Forces , then such member will be eligible to receive a monthly benefit if the injury was incurred or the illness was contracted while the member was on duty and if he is totally disabled , as defined in Section 1(*l*), for thirteen consecutive weeks , or more, and has been released from the Canadian Forces while still totally disabled.

42. Amount of Monthly Income Benefits

a. Subject to Section 44, the monthly income benefit shall be 75% of the deemed monthly salary as defined in 40(a)(i) and 40(a)(ii) or calculated monthly salary as defined in 1.(g)(ii) applicable when the injury or illness occurred; and

b. Benefits for a part month shall be based pro rata on a 30 day period; and

c. Benefits shall be increased annually on January 1st. Increases will be proportionate to the Consumer Price Index (CPI) increases from the date the benefit commenced. The benefit increases shall be rounded to the next ¼ of 1%, if not already a multiple thereof, and limited to a maximum of 2% per year.

43. Duration of Benefits

a. Subject to Section 41 a., an insured member who is medically released from the Canadian Forces becomes eligible for benefits on the day after the date of release from the Canadian Forces. The benefit will be payable for each succeeding month, or part month up to 24 months or the member's 65th birthday, whichever first occurs. In the event of the death of a member, the monthly benefit shall be payable for the entire month in which death occurs.

b. Subject to Section 41 c., for an insured member who is not medically released from the Canadian Forces, he becomes eligible for benefits on the day after the date of release from the Canadian Forces. The benefit will be payable for each month, or part month, that such total disability continues or the member's 65th birthday, whichever first occurs. In the event of death of the member, the monthly benefit shall be payable for the entire month in which death occurs. The Insurer reserves the right to require evidence of continuing disability satisfactory to the Insurer and at no expense to the Insurer.

c. For a member who has been in receipt of benefits under Section 43 a., and is not 65 years of age, and is totally disabled, benefits are payable beyond the 24th month, for each succeeding month or part month that such total disability continues or the member's 65th birthday, whichever first occurs. In the event of the death of the member, the monthly benefit shall be payable for the entire month in which death occurs. The Insurer reserves the right to require evidence of continuing total disability satisfactory to the Insurer and at no expense to the Insurer.

44. Other Relevant Sources of Income

a. The monthly benefit payable at Section 42 shall be reduced by the sum of:

(i) the monthly income benefits payable to the member under the Canadian Forces Superannuation Act; and
(ii) the Primary monthly income benefits payable to the member under the Canada or Quebec Pension Plans (including retroactive payments covering the period during which such benefits were prefunded under this Division 3); and
(iii) the employment income of the member unless the member is participating in a rehabilitation program approved by the Insurer in which case the monthly benefit will be reduced in accordance with Section 45; and
(iv) the total monthly income benefits payable to the member under the Pension Act (including dependant's benefits and retroactive payments covering the period during which such benefits were prefunded under this Division 3); and
(v) the monthly income benefits payable under a similar coverage provided through another employer or as a result of different employment, Workers' Compensation benefits, benefits received under any regulation concerning automobile insurance and employer pension plans; and
(vi) the monthly income benefits payable to the member under the Government Employee Compensation Act (GECA).

b. For the purposes of Section 44.a.,any cost of living increases in the monthly income benefits from the sources indicated shall not be considered relevant to the monthly income benefit payable under this Policy.

45. Rehabilitation Program and Employment Earnings

A member in receipt of a monthly benefit shall be encouraged to enter an approved rehabilitation program. If a member earns income while participating in a rehabilitation program approved by the Insurer, the member's benefit will be reduced by 50% of the employment income, or 50 cents for each dollar earned, until the member's total income from all sources reaches 100% of the deemed monthly salary or calculated monthly salary applicable at Section 42 adjusted to the present value by application of the "CPI" for each year benefits are payable. Thereafter, the member's benefit will be reduced by one dollar for each dollar earned.

46. Subrogation

If the injury or illness giving rise to benefits under this Division 3 is caused by any actionable wrong of a third party, the insured member subrogates his right of action against such third party to the Insurer and agrees to execute any documents required to perfect the subrogation.

47. Exceptions and Limitations

a. No benefits are payable under Section 41.a. if subsequent to the date of release from the Canadian Forces the Item of release under QR & O Article 15.01 is changed to Item 3(a) or 3(b).

b. Where the injury or illness does not necessitate periodic examination of the member by a legally qualified physician who treats him, the Insurer may require the member to be examined by such physician or a physician of its' choice, at such intervals as the Insurer may deem necessary for optimal treatment and/or assessment of the member's condition. If the member fails to be examined as required by the Insurer, the Insurer shall have the right to suspend payment of all benefits until such examination of the member is completed, and the report submitted to the Insurer. Nothing in this Section prevents the Insurer from discontinuing the payment of benefits upon completion of the required examination if such examination demonstrates that the member no longer qualifies for benefits under Section 41 of this Policy.

c No coverage is provided if the injury or illness results from any of the following:
(i) injury or illness sustained as a result of participation in the commission of a criminal offence; or
(ii) intentionally self-inflicted injury or attempted self-destruction, while sane or insane; or
(iii) an injury or illness commencing during the first 12 months of coverage from injuries or illness for which the member consulted a physician during the six (6) month period immediately preceding the date he became insured under this Policy.

d No benefits are payable to an insured member after he reaches the age of 65.

e. No benefits are payable if subsequent to the date of release from the Canadian Forces, the member's item of release under QR & O Article 15.01 is changed to Item 3(a) or 3(b), unless the change occurs within 12 months of the member's date of release from the Canadian Forces, and such change relates to a psychiatric and/or psychological condition.

f. No benefits are payable to an insured member who applies for benefits under this Policy more than 120 days following his date of release from the Canadian Forces.

g. No benefits are payable for total disability unless there is clear, objective medical evidence satisfactory to the Insurer , which confirms that the individual is incapacitated by an active, medically determinable physical or mental impairment which prevents him from performing any and every duty of any substantially gainful occupation or employment for which he is reasonably qualified by education, training or experience.

h. No benefits are payable for an injury or illness incurred or contracted prior to December 1, 1999 where the member did not have LTD coverage under this Policy on November 30, 1999.

48. Extension of Coverage

a. For those who qualify as totally disabled, Extended Coverage for 12 months duration shall be provided by the Insurer after final payment of monthly income benefits. This extension shall commence on the earlier of the following dates:

(i) the date upon which the monthly income benefit payable under this Division 3 is zero; or
(ii) the date the member ceases to be totally disabled.

b. In the event that the member was entitled to Major Medical benefits under Section 57, at the commencement and through the duration of the claim, such entitlement will continue for the extension of coverage period. If, during the 12 month period, the member becomes totally disabled as a result of the cause for which benefits were originally paid, the benefit will be reinstated in accordance with Section 42.

c. No monthly income benefit will be payable under this extension as a result of a cause separate and unrelated to that of the original claim.

RESERVE LONG TERM DISABILITY - DISMEMBERMENT BENEFIT

49. Payment of Benefit-Dismemberment

a. The dismemberment benefit under this Division 3, is an integral part of the benefits potentially payable; however, if a member qualifies for monthly benefits under Section 41, and has suffered a loss as outlined at Section 51, then Sections 49 to 52 will take precedence for benefit purposes. If a member is disqualified under Section 52 then Section 41 shall prevail.

b. Upon receipt of due proof that an insured member has suffered a dismemberment within 365 days of and as a result of an accident, and has been released from the Canadian Forces, the Insurer will pay a monthly income benefit to the member for a fixed benefit period as provided in Section 51 or until death, whichever first occurs. The member must be released within three (3) years of the accident date. No benefit is payable for the first 13 weeks following the accident date.

c. If a monthly income benefit is not payable under Section 49 (a) or a monthly income benefit has been paid for the fixed period at Section 51, then the claim shall be further assessed under Section 41 giving effect to the benefits already paid and the length of time benefits have been paid.

50. Amount of Monthly Income Benefit - Dismemberment

The amount of the monthly income benefit for dismemberment shall be calculated in accordance with Section 42 for the purposes of calculating the benefits under this Section. Section 44.a.(iii), does not apply for the relevant fixed period at Section 51.

51. Schedule of Benefits-Dismemberment

a. The income benefit payable will be:

Loss	Fixed Benefit Period
Loss of both hands or feet	36 months
Loss of one hand and one foot	36 months
Loss of sight of both eyes	36 months
Loss of one hand or one foot and sight of one eye	36 months
Loss of hearing or speech	36 months
Loss of one hand or one foot	24 months
Loss of sight of one eye	12 months
Loss of thumb and index finger of the same hand	12 months

b. "Loss" as used above shall also include total and irrecoverable loss of use.

c. "Loss of sight" shall mean total and irrecoverable loss of sight.

d. In the event more than one of the losses described above results from the same accident, only one benefit period shall apply and that will be the longest period.

52. Exceptions and Limitations - Dismemberment

No monthly income benefits are payable for dismemberment:

a. sustained while participating in the commission of a criminal offence; or

b. intentionally self-inflicted or attempted self destruction, whether sane or insane; or

c. resulting from an accident occurring prior to coverage under this Policy; or

d. of a member who left the Canadian Forces voluntarily or retired from the Canadian Forces at compulsory retirement age; or

e. occurring prior to December 1, 1999, where the member did not have LTD coverage under Part XIII of Policy #901102 in effect on November 30, 1999.

PROVISIONS APPLICABLE TO BOTH DISABILITY AND DISMEMBERMENT BENEFITS

53. Assignment

No member has the right to assign, alienate, encumber, or commute any monthly income benefit.

54. Reimbursement of Insurer

If a member's claim for benefits under the Canadian Forces Superannuation Act, the Canada Pension Plan, the Quebec Pension Plan, the Government Employee Compensation Act, the Pension Act, other employer disability insurance, Workers' Compensation, any regulation concerning automobile insurance or employer pension plan is denied, the benefits under this coverage shall become payable in accordance with the terms and conditions of this Division 3, provided the member agrees, in writing, that if benefits are subsequently awarded, under any of said Authorities, the member will reimburse the Insurer to the extent the benefits paid under this coverage exceed the benefits that would otherwise be payable.

55. Proof of Claim

a. Written proof of claim in a form satisfactory to the Insurer, covering the occurrence, character and extent of loss for which a claim for benefits is made, must be furnished to the Insurer within 120 days after the member's date of release from the Canadian Forces. Upon receipt of such proof satisfactory to the Insurer, the Insurer will commence payment.

b. Written proof of the continuance of such claim must be furnished to the Insurer at such intervals as it may reasonably require and at no cost to the Insurer.

c. The Insurer shall have the right to require, as part of the proof of claim, satisfactory evidence:
   (i) that the member either is not eligible or has made application for all benefits referred to in Section 44; and
   (ii) that he has furnished all required proofs for such benefits, and;
   (iii) of the amount of such benefits payable.

56. Payment of Claim

a. Benefits payable under Division 3 this shall be payable on the last day of each month during the period for which the Insurer is liable.

b. If any benefit under Division 3 this becomes payable to the estate of the member, the Insurer, at its option, may pay such benefit, not exceeding one month's benefit, to any relative by blood or marriage. Any payment made by the Insurer in good faith pursuant to this Section shall fully discharge the Insurer to the extent of such payment.

57. Major Medical Insurance

See Division 4

DIVISION 4

MAJOR MEDICAL INSURANCE

58. Eligibility

59. Deductible

60. Maximum Lifetime Benefit

61. Payment of Benefits

62. Definitions

63. Hospital Benefits

64. Extended Health Care Benefits

65. Exclusions

DIVISION 4
MAJOR MEDICAL INSURANCE

58. Eligibility

a. The Insurer shall pay a benefit for covered expenses incurred as a result of injury or illness during a calendar year by eligible Long Term Disability claimants, Reserve Long Term Disability claimants, or eligible dependents, provided that:
   (i) none are eligible for major medical benefits from any other source, or any plan or program of any government or the Crown or of any subdivision or agency of the government or the Crown, including any plan or program established pursuant to provincial automobile insurance legislation, and
   (ii) the insured member's eligibility under this Division 4 was established subsequent to 30 November, 1999.

b. Benefits shall be classified as either Hospital Benefits or Extended Health Care Benefits.

59. Deductible

There shall be an annual deductible amount of $60 per insured person and $100 per family unit to be satisfied first as covered expenses are incurred for Extended Health Care. The deductible applies per calendar year to the combined eligible expenses.

60. Maximum Lifetime Benefit

The maximum lifetime benefit will be $1,000,000, for each insured person, representing the gross amount of benefit each insured person can receive during his lifetime, including all single, broken, and extended periods of claims.

61. Payment of Benefit

The Insurer will reimburse:
   (i) 100% of the eligible expenses under Section 63;
   (ii) 80% of the eligible expenses under Subsections 64 (a) to (d);
   (iii) 100% of the eligible expenses under Paragraph 64 (e) (i);
   (iv) 80% of the eligible expenses under Paragraph 64 (e) (ii);
   when proof satisfactory to the Insurer has been received that the insured person has incurred any of the eligible expenses defined in these provisions for medically necessary services.

62. Definitions

a. "calendar year" means January 1 to December 31.

b. "chiropractor" means a member of the Canadian Chiropractic Association or of a provincial association affiliated with it, or in the absence of such association, a person with comparable qualifications as determined by the Insurer.

c. "chiropodist/podiatrist" means a person licensed by the appropriate provincial licensing authority or in those provinces where there is no licensing authority, members of the Canadian Association of Foot Professionals, or in the absence of such association, a person with comparable qualifications as determined by the Insurer.

d. "dentist" means a person licensed to practice dentistry by the provincial licensing authority, or in the absence of such authority, a person with comparable qualifications as determined by the Insurer.

e. "electrologist" means a person who, as determined by the Insurer, qualifies as a certified electrologist.

f. "family unit" means a member and his covered dependants.

g. 'Hospital" means a legally licensed hospital which provides facilities for diagnosis, major surgery and the care and treatment of a person suffering from disease or injury on an in-patient basis, with 24 hour services by registered nurses and physicians. This includes legally licensed hospitals providing specialized treatment for mental illness, drug and alcohol addiction, cancer, arthritis and convalescing or chronically ill persons. This does not include nursing homes, homes for the aged, rest homes or other places providing similar care.

h. "Hospital charges" shall mean the following expenses:
   (i) charges made by a hospital for room and board; and charges of the hospital for other hospital services and supplies furnished to the claimant, beneficiary, or dependent, as the case may be, for use while confined therein (but not including charges for special nursing services or for the services of physicians or surgeons and excluding hospital charges referred to as co-insurance charges or user fees);
   (ii) charges for anaesthetics and the administration thereof when incurred during hospital confinement; and
   (iii) charges for local use of an ambulance when incurred in connection with hospital confinement.

i. "Insurer" means The Manufacturers Life Insurance Company.

j. "medical charges" shall mean expenses incurred for radioactive isotope therapy and for any other radiotherapy which does not qualify as a surgical procedure, including those other covered expenses which are not hospital charges, or surgical charges as defined above.

k. "naturopath" means a member of the Canadian Naturopathic Association or any provincial association affiliated with it, or in the absence of such association, a person with comparable qualifications as determined by the Insurer.

l. "nurse" means a registered nurse, registered nursing assistant, licensed practical nurse, and certified nursing assistant who is listed on the appropriate provincial registry and in the absence of such registry, a nurse with comparable qualifications as determined by the Insurer.

m. "osteopath" means a person who holds the degree of doctor of osteopathic medicine from a college of osteopathic medicine approved by the Canadian Osteopathic Association, or in the absence of such association, a person with comparable qualifications as determined by the Insurer.

n. "ophthalmologist" means a person licensed to practice ophthalmology.

o. "optometrist" means a member of the Canadian Association of Optometrists or of a provincial association associated with it, or in the absence of such association, a person with comparable qualifications as determined by the Insurer.

p. "physician" means a doctor of medicine (M.D.) legally licensed to practice medicine.

q. "physiotherapist" means a member of the Canadian Physiotherapy Association or of a provincial association affiliated with it, or in the absence of such association, a person with comparable qualifications as determined by the Insurer.

r. "psychologist" means a permanently certified psychologist who is listed on the appropriate provincial registry in the province where the service is rendered, or in the absence of such registry, a person with comparable qualifications as determined by the Insurer.

s. "registered massage therapist" means a person licensed by the appropriate provincial licensing body or in the absence of a provincial licensing body, a person whose qualifications the Insurer determines to be comparable with those required by a licensing body.

t. "reasonable and customary charges" mean those which are usually made to a person without coverage for the items of expense listed which do not exceed the general level of charges in the area where the expense is incurred, as determined by the Insurer.

u. "speech language pathologist" means a person who holds a master's degree in speech language pathology and is a member or is qualified to be a member of the Canadian Speech and Hearing Association or any provincial association affiliated with it, or in the absence of such registry, a person with comparable qualifications as determined by the Insurer.

v. "surgical charges" shall mean the expenses incurred for a surgical procedure and for necessary post-operative treatment in connection with the surgical procedure.

63. Hospital Benefits

The Insurer shall pay claims from insured persons for charges made for any of the following items, which shall be considered covered hospital expenses, but subject to the condition that the charges are reasonable, customary and not covered by any provincial government medical insurance allowances; and such further limitations of coverage as provided in this section:

(i) hospital charges for an insured person residing outside Canada mean the reasonable and customary charges for hospital room and board other than standard ward charges (i.e.: semi-private accommodation) up to the maximum of $100 per day of hospitalization excluding hospital charges referred to as coinsurance charges or user fees.

(ii) hospital charges for all other insured persons mean the reasonable and customary charges for semi-private hospital room and board charges in excess of the charges for public ward up to the maximum of $100 per day of hospitalization, excluding hospital charges referred to as coinsurance charges or user fees.

64. Extended Health Care Benefits

The Insurer shall pay claims from insured persons for all reasonable and customary charges for medical services and supplies to the extent that such charges are not covered by provincial government medical insurance allowance, and subject to the limitations of coverage provided in this section, including the following:

a. Drug Benefit: Drugs and medicines obtainable only on a dentist's or physician's prescription, including, but not limited to:

(i) oral contraceptives;

(ii) injectable drugs, including allergy serums administered by injection;

(iii) needles, syringes and chemical diagnostic aids for the treatment of diabetes;

(iv) drug delivery devices to deliver asthma medication, which are integral to the product, and approved by the Insurer.

b. Vision Care Benefit: The reasonable and customary charges for the following items of vision care expense:

(i) eye examinations by an optometrist limited to one examination in a 24 month period; and

(ii) eye glasses and contact lenses that are necessary for the correction of the vision and are prescribed by an ophthalmologist or optometrist, and repairs to them, limited to a maximum of $200.00 every 24 month period.

c. Paramedical Practitioner's Benefit: To be eligible, the expenses must be medically necessary for the treatment of disease or injury. Services of those practitioner's designated require a prescription. Eligible expenses for the services of a practitioner include only those services which are within his area of expertise and require the skills and qualifications of such a practitioner. Eligible expenses are the reasonable and customary charges for the services of the following practitioners limited to the maximum eligible expense specified for each practitioner:

(i) a physiotherapist on the prescription of a physician;
(ii) a registered massage therapist to a maximum of $300.00 in a calendar year;
(iii) a speech language pathologist on the prescription of a physician to a maximum of $500.00 in a calendar year;
(iv) a psychologist on the prescription of a physician to a maximum of $1000.00 in a calendar year;
(v) a chiropractor to a maximum of $500.00 in a calendar year;
(vi) an osteopath to a maximum of $300.00 in a calendar year;
(vii) a naturopath to a maximum of $300.00 in a calendar year;
(viii) a podiatrist or chiropodist to a maximum of $300.00 in a calendar year; and
(ix) an electrologist on the prescription of a psychiatrist or psychologist and limited to treatment for removal of excessive hair from exposed areas of the face and neck when the patient suffers from severe emotional trauma as a result of this condition and limited to a maximum of $20.00 per visit. This also includes treatment when performed by a physician.

d. Miscellaneous Expense Benefits: To be eligible, the expenses must be medically necessary for the treatment of disease or injury and prescribed by a physician, unless otherwise specified. Eligible expenses are the reasonable and customary charges for the items of expense listed below:

(i) private duty nursing services where such services are rendered in the patient's private residence or elsewhere by a nurse or attendant care in the home for quadriplegics, provided that such nurse or attendant does not ordinarily reside in the home of the insured person and is not related to the insured person by blood or marriage, and subject to a maximum of $15,000.00 in a calendar year;

(ii) dental services:
  (a) the services of a dental surgeon and charges for dental prosthesis required for the treatment of a fractured jaw or for the treatment of accidental injuries to natural teeth if the fracture or injury was caused by external, violent and accidental injury or blow other than an accident associated with normal acts such as cleaning, chewing and eating, provided the treatment occurred within 12 months following the accident.
  (b) for the excision of impacted unerupted teeth or of a tumour or cyst, or incision and drainage of an abscess or cyst.
  (c) for any other oral surgical procedure not involving any tooth structure, alveolar process or gingival tissues.

(iii) the initial purchase of eye glasses, contact lenses or hearing aids if required as a direct result of surgery or an accident when the purchase is made within six months of such surgery or accident. This time limit may be extended if, as determined by the Insurer, the purchase could not have been made within the time frame specified.

(iv) licensed ground ambulance service to the nearest hospital equipped to provide the required treatment when the physical condition of the patient prevents the use of another means of transportation.

(v) emergency air ambulance service to the nearest hospital equipped to provide the required treatment when the physical condition of the patient prevents the use of another means of transportation.

(vi) orthopaedic shoes which are an integral part of a brace or specifically constructed for the patient including modifications to such shoes, provided the shoes or modifications is prescribed in writing by a physician or a pediatrist, subject to a maximum total eligible expense in any one calendar year of the lesser of:
  (a) the total charges less the average cost of regular footwear as determined by the Insurer, or
  (b) $150.00 in a calendar year.

(vii) hearing aids and repairs to them, excluding batteries, limited to a maximum of $500.00 every 60 month period.

(viii) trusses, crutches, splints, casts and cervical collars.

(ix) braces which contain either metal or hard plastic excluding dental braces and braces used primarily for athletic use.

(x) orthopaedic brassieres limited to a maximum of $100.00 per calendar year.

(xi) breast prosthesis following mastectomy and a replacement limited to once every 24 month period.

(xii) wigs, when the patient is suffering from total hair loss as a result of an illness or disease limited to a maximum expense of $500.00 per lifetime.

(xiii) colostomy, ileostomy, and tracheostomy supplies and catheters and drainage bags for incontinent, paraplegic or quadriplegic patients.

(xiv) temporary artificial limbs.

(xv) artificial eyes and permanent artificial limbs to replace temporary artificial limbs and replacements thereof but not within

(a) 60 months of the last purchase in the case of a member or dependent over 21 years of age, or

(b) 12 months of the last purchase in the case of a dependent 21 years of age or less,

(c) unless medically proven that growth or shrinkage of surrounding tissue requires replacement of the existing prosthesis.

(xvi) oxygen and its administration.

(xvii) insulin pumps and associated equipment for insulin dependent diabetes, when prescribed for a patient by a physician associated with a recognized centre for the treatment of diabetes at a university teaching centre in Canada, excluding repair or replacement during the 60 month period following the date of purchase of such equipment.

(xviii) blood glucose monitors for insulin dependent diabetes and for non-insulin dependent diabetes if legally blind or colour blind, excluding repair or replacement during the 60 month period following the date of purchase of such equipment.

(xix) rental, or purchase at the Insurer's option, of durable equipment manufactured specifically for medical use and which is required for temporary and therapeutic use in the patient's private residence. Eligible equipment must be approved by the Insurer and includes, but is not limited to, items such as

(a) walkers,

(b) hospital beds,

(c) apnea monitors,

(d) alarms systems for eneuritic patients.

Reimbursement will be limited to the cost of non-motorised equipment unless specifically proven that the patient requires motorized equipment.

(xx) rental, or purchase at the Insurer's option, of a wheelchair required for therapeutic use in the patient's private residence. Reimbursement will be limited to the cost of non-motorized equipment unless specifically proven that the patient requires motorized equipment.

Repairs and maintenance of a purchased wheelchair are eligible expenses but limited to a maximum expenditure of $500 per calendar year for a manual wheelchair and $1000 per calendar year for a power wheelchair.

(xxi) physician services where such services are not eligible for reimbursement under the participant's provincial health insurance plan, but where such services would be eligible for reimbursement under one or more other provincial health insurance plans.

(xxii) bandages and surgical dressings required for the treatment of an open wound or ulcer.

(xxiii) elasticized support stockings and elasticized apparel for burn victims manufactured to individual patient specifications or having a minimum compression of 30mm.

(xxiv) orthotics, limited to one pair in a calendar year.

(xxv) acupuncture treatments performed by a physician.

(xxvi) electrolysis treatments performed by a physician limited to (i) treatment for removal of excessive hair from exposed areas of the face and neck when the patient suffers from severe emotional trauma as a result of this condition, and (ii), a maximum of $20.00 per visit.

e. Out-of-Province Benefit

(i) Emergency Benefit While Travelling: The Insurer shall pay claims from insured persons for the reasonable and customary charges in excess of the amount payable by a provincial health insurance plan, for the following items of expense if they are required for emergency treatment of an injury or disease which occurs while travelling on vacation or business outside the province of residence for a period not exceeding 40 days from the date of departure from the province of residence limited to the maximum eligible expense of $100,000 per period of travel:

(a) public ward accommodation and auxiliary hospital services in a general hospital;

(b) services of a physician;

(c) one way economy air fare for the patient's return to his province of residence. One way economy air fare for a professional attendant accompanying the participant is also included where medically required;

(d) medical evacuation, which may include ambulance services, when suitable care, as determined by the Insurer, is not available in the area where the emergency occurred;

(e) family assistance benefits, including reimbursement for the cost of:

(i) return transportation for covered dependent children under age 16 who are left unattended because the participant or the participant's covered spouse is hospitalized. If necessary an escort will be provided to accompany the dependent children. The maximum payable is the cost of economy air fare;

(ii) return transportation if a family member is hospitalized and as a result the family members are unable to return home on the originally scheduled flight, and must purchase new return tickets. The extra cost of the return air fare is payable, to a maximum of the cost of economy air fare;

(iii) a visit of a relative if the family member is hospitalized for more than seven days while travelling alone. This includes economy air fare, meals and accommodations to a maximum of $150 per day, for a spouse, parent, child, brother or sister. This benefit also covers expenses incurred if it is necessary to identify a deceased family member prior to release of the body;

(iv) meals and accommodations if the participant or a covered dependant's trip is extended due to hospitalization of a family member. The additional expenses incurred by accompanying family members for accommodations and meals are provided to a maximum of $150 per day;

The combined maximum payable for family assistance benefits is $2,500 for any one travel emergency;

(f) (i) return of the deceased in the event of death of a family member. The necessary authorizations will be obtained and arrangements made for the return of the deceased to the province of residence. The maximum payable for the preparation and return of the deceased is $3,000.

(ii) Referral Benefit: The Insurer shall pay claims from insured persons for the reasonable and customary charges in excess of the amount payable by a provincial health insurance plan, for the following items of expense provided they are performed following written referral by the attending physician in the patient's province of residence and are not offered in the province of residence, subject to the annual deductible and limited to the maximum eligible expense of $25,000 per illness:

(a) public ward accommodation and auxiliary hospital services in a general hospital;

(b) services of a physician or surgeon.

65. Exclusions

No benefit shall be payable for:

a. Medical examinations including those for insurance, school, camp, association, employment, passport or similar purposes;
b. Dental treatment, except as indicated above;
c. Services not approved or prescribed by a physician where required;
d. Treatment or prescriptions resulting from declared or undeclared war, riot or insurrection;
e. Expenses not normally incurred when a person is not insured or for services or products normally rendered without charge;
f. Services or products for cosmetic purposes only, or for conditions not detrimental to health, except those required as a result of accidental injury;
g. Treatments resulting from an intentionally self-inflicted injury or illness;
h. Items purchased primarily for athletic use;
i. Expenses for services and supplies rendered or prescribed by a person who is ordinarily a resident in the patient's home, or who is related to the patient by blood or marriage;
j. Experimental products or treatments for which substantial evidence provided through objective clinical testing of the product's or treatment's safety and effectiveness for the purpose and under the conditions of the use recommended does not exist to the Insurer's satisfaction;
k. Benefits which are legally prohibited by the government from coverage;
l. Any single purchase of drugs which would not reasonably be used within 90 days from date of purchase;
m. Vitamins (except injectables), vitamin supplements, minerals, protein supplements, dietary supplements or diet foods, except as specifically included above;
n. Infant foods;
o. Sugar or salt substitutes;
p. Lozenges, mouth washes, non-medicated shampoos, contact lens care products and skin cleansers, protectives, or emollients;
q. Transport or travel, other than as specifically provided;
r. Services provided by a physician licensed and practising in Canada where the insured person is eligible to be insured under a provincial health insurance plan, except for such services which are specifically included above;
s. The portion of charges which are payable under a provincial health insurance plan or a provincially sponsored program;
t. The portion of charges for services rendered or supplies provided in a hospital outside of Canada, that would normally be payable under a provincial health or hospital plan if the services or products had been rendered in a hospital in Canada. This limitation does not apply to the "Out-of-Province Benefit";
u. The portion of charges which is the legal liability of any other party;
v. Contraceptives, other than oral;

w. Expenses incurred outside the insured person's province of residence if they are required for the emergency treatment of an injury or disease which occurred more than 40 days after the date of departure from the province of residence;

x. "Emergency Benefit While Travelling" incurred by an insured person who is temporarily or permanently residing outside Canada; and,

y. Expenses for the regular treatment of an injury or disease which existed prior to the insured person's departure from his province of residence.

PART IV - DEPENDENT LIFE INSURANCE

72. Death Benefits

73. How Insurance Obtained and When Effective

74. Amount of Insurance

75. Benefits for Death During Coverage After Release

76. Beneficiary

77. Paid-Up Insurance

78. Conversion Privileges

79. Waiver of Premium

PART IV

DEPENDENT LIFE INSURANCE

72. Death Benefits

The Insurer will pay to the member the amount of life insurance in force on the dependent's life at the time of the dependent's death, upon receipt of due proof at its Head Office that the dependent died while insured under this coverage.

73. How Insurance Obtained and When Effective

A member who has been approved for Survivor Income Benefit (SIB), Optional Group Term Insurance (OGTI), Reserve Term Insurance (RTIP), Coverage After Release (CAR) or Insurance for Released Members (IRM) shall automatically obtain Dependent Life (DL) insurance. Upon completion of the application form for any of these types of coverage and approval by the Insurer, DL insurance coverage will come into effect.

74. Amount of Insurance

a. The amount of life insurance on each dependent will be as follows:
   (i) The DL spousal coverage under SIB is $20,000.
   (ii) The DL children's coverage under SIB, OGTI, RTIP, CAR and IRM is $10,000. The maximum amount of insurance available under all these plans is $10,000 per dependent child. The DL coverage of $10,000 per dependent child is limited in all circumstances to one life, one benefit.

b. DL insurance is associated with the relevant life insurance plans in force on the member's life except that where the member does not have life insurance coverage in force under OGTI, RTIP, CAR and IRM and the spouse does have such life insurance in force, the spouse shall be deemed to be the member solely for purposes of this Part of the policy. The member, however, remains the beneficiary.

75. Benefits For Death During CAR/IRM Eligibility Period

a. Upon receipt of due proof at its Head Office of the death of the spouse or dependent child during the 60-day period within which the member could have made application for CAR (where the date of release from the CF is before 1 October 2005), or for IRM (where the date of release from the CF is on or after 1 October 2005), the Insurer will pay to the member the maximum amount for which such individual certificate could have been issued to him whether or not such application for CAR or IRM had been made.

b. In the event CAR or IRM has been issued on the dependent's life in accordance with Part X and Part XVI, no payment shall be made under this provision unless the appropriate CAR or IRM certificate is surrendered to the Insurer without payment of any claim, except for the refund of any premium paid thereon.

76. Beneficiary

a. The member shall be the beneficiary for all the life insurance provided under this Part, except that in the case of a service couple, each having dependent life coverage, the benefit will be payable to the couple jointly.

b. Insurance becoming payable as a result of the death of a dependent will be paid to the member's estate if he has not survived the dependent.

77. Paid-Up Dependent Life Insurance

a. If a member's dependents cease to be insured hereunder by reason of the death of the member, or by reason of the death of the spouse or former spouse, each dependent insured on the date of the member's death shall be entitled to receive from the Insurer a certificate of Paid-Up Life Insurance equal to the amount of insurance in effect immediately prior to the member's death. Children whose dependent life insurance is continued under CAR (prior to October 1, 2005) or IRM (on or after October 1, 2005) in conjunction with spousal CAR or spousal IRM shall not be entitled to Paid-Up Life Insurance under this section.

b. Coverage for a dependent under such certificate shall be provided for life.

c. Issue of such certificates shall be subject to all of the following conditions:
   i. No evidence of insurability shall be required;
   ii. Written application for the certificate must be delivered or mailed to the Insurer;
   iii. The paid-up insurance provided shall be without cash values;
   iv. The paid-up insurance benefits shall be without disability or other supplementary benefits.

78. Conversion Privileges

See Section 9.

79. Waiver of Premium

See Section 12.

PART V - MILITARY POST RETIREMENT LIFE INSURANCE PLAN (MPRLIP)

PART V

MILITARY POST RETIREMENT LIFE INSURANCE PLAN (MPRLIP)

80. Eligibility

All Lieutenant-Colonels in the Legal Classification and all Colonels and above who retire from the Canadian Forces on or after 1 January, 1989 with an immediate continuing annuity (reduced or unreduced) under the Canadian Forces Superannuation Act (CFSA) are eligible for the MPRLIP if, immediately prior to release, the member had life insurance coverage under the General Officers' Insurance Plan (GOIP). Those members who have opted out of the GOIP must qualify for the GOIP prior to release in order to be eligible for MPRLIP.

81. How Eligible Members Become Insured

All eligible members will be automatically insured under MPRLIP on the 61st day following the member's release date unless a member indicates to the Policyowner, in writing, that he does not wish to participate in MPRLIP.

82. Suspension of Coverage

a. MPRLIP coverage is suspended under the following conditions:
   i. When, subsequent to retirement from the Canadian Forces, an eligible member secures employment or re-employment in the Federal Public Service of Canada; and/or
   ii. An eligible member is in receipt of Long Term Disability (LTD) benefits under this policy or the Public Service Management Insurance Plan (PSMIP) when a Waiver of Premium benefit is in effect.

b. Eligibility for MPRLIP coverage in the future is unaffected by a suspension of coverage.

83. Resumption of Coverage

a. MPRLIP coverage shall be reinstated on the latest of the following dates:
   i. if the member was employed by the Federal Public Service and was not entitled to life insurance coverage under the PSMIP, the day following the date employment ceased.
   ii. if the member was employed by the Federal Public Service and was entitled to coverage under PSMIP, the 32nd day following the date employment ceased.
   iii. on the 61st day following the termination of the Waiver of Premium benefit or the denial of LTD benefits.

b. When the MPRLIP coverage resumes, the level of coverage will be the greater of either the final adjusted annual salary at the time the suspension took effect or the final adjusted annual salary just prior to reinstatement of the MPRLIP.

84. Life Insurance Benefit

a. Upon receipt of due proof at its Head Office that the member died while insured under this coverage, the Insurer will pay the amount of life insurance to that member's beneficiary, or in the absence of a designated beneficiary, to the member's estate, determined in accordance with the Schedule of Benefits which follows:

b. Schedule of Benefits

Year After Retirement	% of Adjusted Annual Salary*
1	100%
2	75%
3	50%
4	25%
(and for life thereafter)	

* Adjusted annual salary is defined as the member's annual salary adjusted to the next highest multiple of $250 if it is not already a multiple thereof.

85. Cancellation of Coverage

If a member cancels MPRLIP life insurance coverage, it cannot be reinstated.

86. Conversion Privilege

a. MPRLIP life insurance coverage decreases at established intervals as defined by Subsection 84(b), beginning in the second year of coverage. Prior to 1 October 2005, the coverage lost by virtue of the decrease may be converted to Coverage After Release (CAR), in accordance with Part X of this policy. On or after 1 October 2005, the coverage lost may be converted to Insurance for Released Members (IRM), in accordance with Part XVI of this policy, without evidence of insurability, within 60 days of the change in MPRLIP coverage.

b. Unless the member has exercised the conversion privilege by submitting the required application form to the Insurer or the Policyowner within the time allotted and prior to his death, there is no benefit for death during the conversion eligibility period.

87. Retroactive Change of Salary

Retroactive increases in salary do not apply to the determination of the amount of MPRLIP coverage.

88. Waiver of Premium

There is no Waiver of Premium benefit under the MPRLIP.

PART VI - GENERAL OFFICERS' INSURANCE PLAN (GOIP)

MEMBER LIFE INSURANCE

89. Eligibility

90. How Eligible Member Becomes Insured

91. Life Insurance Benefit

92. Coverage After Release

93. Benefit for Death During Coverage After Release Eligibility Period

94. Conversion Privileges

95. Waiver of Premium Benefit

ACCIDENTAL DEATH AND DISMEMBERMENT INDEMNITY FOR MEMBER

96. Accidental Death and Dismemberment Indemnity For Member

97. Beneficiary - Member AD&D

98. Exceptions and Limitations - Member AD&D

98A. No Duplication of Dismemberment Benefit

DEPENDENT LIFE INSURANCE

99. Dependent Life Insurance

100. Coverage After Release - Dependents

DEPENDENT ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

101. Dependent Accidental Death and Dismemberment Insurance

102. Exceptions and Limitations - Dependents AD&D

PART VI
GENERAL OFFICERS' INSURANCE PLAN
MEMBER LIFE INSURANCE

89. Eligibility

Regular Force officers and Reserve Force Class "C" officers in the substantive rank of Colonel and above in all classifications, and Lieutenant-Colonel in the legal classification are automatically enrolled in the General Officers' Insurance Plan (GOIP) on the date of promotion, or for Class "C" officers, the date of employment.

90. How Eligible Member Becomes Insured

a. An eligible member may become insured under the GOIP for Basic Life Insurance, Accidental Death and Dismemberment Insurance, Dependent Life Insurance and Dependent Accidental Death and Dismemberment Insurance on the first day of eligibility, without submitting an application.

b. A member may apply for Optional Life Insurance by submitting a written application for insurance to the Insurer or the Policyowner, making the required pay allotment authorization, and providing evidence of insurability satisfactory to the Insurer where required and without expense to the Insurer. The Insurer only requires evidence of insurability if the member applies for the Optional Life Insurance more than 60 days after he becomes eligible for such coverage. Coverage will be effective when approved by the Insurer.

c. If a member is absent from normal duties by reason of illness or injury, he shall become insured under the GOIP on the later of:
   (i) the first day of the calendar month coincidental with or following completion of 31 consecutive days of return to normal duties, or
   (ii) the date evidence of insurability is approved by the Insurer at its Head Office.

91. Life Insurance Benefit

a. Upon receipt of due proof at its Head Office that the member died while insured under this coverage, the Insurer will pay to a member's beneficiary the amount of life insurance in force on the member's life at the time of his death as determined in accordance with the Schedule of Benefits which follows.

b. Schedule of Benefits:

i. Basic Life Insurance: The Insurer will pay an amount equal to two (2) times the member's annual pay at time of death, rounded to the nearest $1,000.

ii. Optional Life Insurance: In addition to the Basic Life Insurance indicated above, the Insurer will pay the amount of optional life insurance purchased by the member, if any, equal to one (1) time the member's annual pay at time of death, rounded to the nearest $1,000.

92. Coverage After Release

A member whose entire amount of GOIP insurance is discontinued because he ceases to be a full-time member of the Canadian Forces (Regular), or ceases Class C reserve service before 1 October 2005 may elect to convert up to the entire amount of his GOIP coverage, subject to any limitations set out in this Policy, to the Coverage After Release (CAR) plan as outlined in Part X. After 1 October 2005 members may only elect to convert up to the entire amount of their GOIP coverage, subject to any limitations set out in this Policy, to the Insurance for Released Members (IRM) plan as outlined in Part XVI.

93. Benefit for Death During Coverage After Release Eligibility Period

See Section 11.

94. Conversion Privileges

See Section 9.

95. Waiver of Premium Benefit

See Section 12.

ACCIDENTAL DEATH AND DISMEMBERMENT INDEMNITY FOR MEMBER

96. Accidental Death and Dismemberment Indemnity for Member

a. Subject to Section 98, if a member suffers any of the losses listed below as a result of an injury suffered from accidental, external, and violent means, the Insurer will pay the amount of insurance specified for the loss in the Schedule of Indemnities below, upon receipt of due proof that satisfies the Insurer that:

i. the injury occurred while the member was insured under this coverage;

ii. the loss occurred within 90 days of the injury; and

iii. the loss resulted directly and solely from the injury and independently of all other causes.

b. Schedule of Indemnities

$250,000 of insurance for loss of:
Life
Both Hands
Both Feet
One Hand and One Foot
Sight of Both Eyes
One Hand and Sight of One Eye
One Foot and Sight of One Eye
Hearing (bilateral)
Speech

$125,000 of insurance for loss of:
Sight of One Eye
One Hand
One Foot

$62,500 of insurance for loss of:
Thumb and Index Finger of the Same Hand Hearing (unilateral)

c. "Loss" as used above shall also mean loss of use.

d. "Loss of sight" shall mean total and irrecoverable loss of sight.

e. The total amount payable for all losses suffered by any one member and resulting from any one accident shall not exceed $250,000.

97. Beneficiary - Member AD&D

a. In the case of accidental death, the benefit will be paid to the member's named beneficiary. If no beneficiary is named or if the beneficiary predeceases the member, the benefit will be paid to the member's estate.

b. In the case of dismemberment, the benefit will be paid to the member.

98. Exceptions and Limitations - Member AD&D

a. No accidental death and dismemberment benefit will be payable for any loss caused wholly or partly, directly or indirectly, by:
   (i) disease, or bodily or mental infirmity, or medical or surgical treatment thereof; or
   (ii) Ptomaines or bacterial infections, except infection introduced through a visible wound accidentally sustained; or
   (iii) self-destruction or self-inflicted injury, whether the member be sane or insane.

b. Where a member suffers an accidental dismemberment that is Attributable to Military Service, as that term is defined in Policy No. 906906, and such member is not covered under the GOIP or Res GOIP provisions of Policy No. 901102, then such member must submit his claim for an accidental dismemberment under Policy No. 906906, and is not entitled to submit an accidental dismemberment claim under Policy No. 901102.

c. Accidental deaths Attributable to Military Service, occurring subsequent to 31 March 2006, and which are eligible for the lump sum death benefit under the New Veteran's Charter ("NVC"), will not be paid under the Accidental Death and Dismemberment portion of this policy.

98A. No Duplication of Dismemberment Benefit

a. Where a member has coverage under the GOIP or the Reserve GOIP (Res GOIP) of SISIP Policy No. 901102, then such member must submit his claim for an accidental dismemberment under one of those plans, and is not entitled to apply for or receive any benefit under SISIP Accidental Dismemberment Policy No. 906906 ("Policy No. 906906"), or any of the Long Term Disability (LTD) dismemberment provisions of Policy No. 901102.

b. Where a member suffers an accidental dismemberment that is not Attributable to Military Service, as that term is defined in Policy No. 906906, and where such member is not covered under the GOIP or Res GOIP provisions of Policy No. 901102, then such member must submit his claim for an accidental dismemberment under the applicable LTD dismemberment provisions of Policy No. 901102, and is not entitled to submit an accidental dismemberment claim under Policy No. 906906.

c. Where a member suffers an accidental dismemberment that is Attributable to Military Service, as that term is defined in Policy No. 906906, and such member is not covered under the GOIP or Res GOIP provisions of Policy No. 901102, then such member must submit his claim for an accidental dismemberment under Policy No. 906906, and is not entitled to submit an accidental dismemberment claim under Policy No. 901102.

d. Where a member has more than one accidental dismemberment coverage available to him under two or more of OGTI, RTIP, GOIP or Res GOIP, then the accidental dismemberment benefit payable to such member will be that which is the greater, under all of the coverages the member has in place. The accidental dismemberment benefit is limited in all circumstances to one benefit per dismemberment.

Where a member has both CAR and IRM coverage in force, providing this does not exceed the maximum of $600,000, the accidental dismemberment coverage available to him will be the combined dismemberment coverage under both plans.

DEPENDENT LIFE INSURANCE

99. Dependent Life Insurance

A member with GOIP coverage will be paid the following life insurance benefit by the Insurer upon receipt of proof satisfactory to the Insurer that a dependent has died while the member was insured under this Part.

(a)	Spouse	$5,000
(b)	Each Child	$2,500

100. Coverage After Release - Dependents

The Dependent Life Insurance coverage provided by this Part shall remain in force while the member is insured under GOIP. Termination of GOIP coverage shall terminate the Dependent Life insurance coverage. If the dependents' insurance terminates because the member is released from the Canadian Forces prior to October 1, 2005, then a dependent may continue to be insured as outlined under CAR, Part X. In the case of a release on or after October 1, 2005, then a dependent may continue to be insured as outlined under the IRM, Part XVI.

DEPENDENT ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

101. Dependent Accidental Death and Dismemberment Insurance

a. Subject to Section 102, if a dependent suffers any of the losses listed below, the Insurer will pay to the member the amount of insurance specified for the loss in the Schedule of Indemnities below. The loss must result from an injury suffered by accidental, external and violent means. The Insurer requires satisfactory proof that:

   i. the injury occurred while the dependent was insured under this coverage;
   ii. the loss occurred within 90 days of the injury; and
   iii. the loss resulted directly and solely from the injury and independently of all other causes.

b. Schedule of Indemnities

Dependent	Amount of Insurance
Spouse	$5,000
Each Child	$2,500

Full amount of Insurance for Loss of:

Life
Both Hands
Both Feet
One Hand and One Foot
Sight of Both Eyes
One Hand and Sight of One Eye
One Foot and Sight of One Eye
Hearing (bilateral)
Speech

One half of the full amount of insurance for loss of:

Sight of One Eye
One Hand
One Foot

One-Quarter of the full amount of insurance for loss of: Thumb and Index Finger of the same Hand Hearing (unilateral)

c. "Loss" as used above shall also mean loss of use.

d. "Loss of Sight" shall mean total and irrecoverable loss of sight.

e. The total amount payable for all losses resulting from any one accident shall not exceed the dependent's full amount of insurance.

102. Exceptions and Limitations - Dependent AD&D

No accidental death and dismemberment benefit will be payable for any loss caused wholly or partly, directly or indirectly, by:

a. disease, or bodily or mental infirmity, or medical or surgical treatment thereof; or
b. Ptomaines or bacterial infections, except infection introduced through a visible wound accidentally sustained; or
c. self-destruction or self-inflicted injury, whether the dependent be sane or insane; or
d. where a member claims accidental dismemberment for a dependent child and has more than one accidental dismemberment coverage available to him under two or more of OGTI, RTIP, IRM, GOIP or Res GOIP, then the accidental dismemberment benefit payable to such member will be that which is the greater, under all of the coverages the member has in place. The accidental dismemberment benefit is limited in all circumstances to one benefit per dismemberment.

PART IX - OPTIONAL GROUP TERM INSURANCE (OGTI)

PART IX

OPTIONAL GROUP TERM INSURANCE (OGTI)

119. Eligibility

Optional Group Term Insurance (OGTI) is available to:

a. members of the Canadian Forces (Regular);

b. members of the Canadian Forces (Reserve) on Class "C" reserve service; and

c. spouses or former spouses of the above members upon application by the member.

120. How Eligible Member or Spouse Becomes Insured

a. An eligible member may apply for OGTI coverage in accordance with Section 4.

b. Evidence of insurability will not be required for insured members who elect to replace their Survivor Income Benefit (SIB) coverage with OGTI including, at the member's option, the Dependent Life spousal insurance.

c. A member who applies for OGTI, or a member who applies to increase the amount of such life insurance shall provide evidence of insurability satisfactory to the Insurer or the Policyowner and at no expense to the Insurer or the Policyowner.

d. A member may apply for OGTI coverage or an increase in coverage on his life or the life of his spouse or if the member does not currently have a spouse, on the life of a former spouse. Evidence of insurability satisfactory to the Insurer or the Policyowner and at no expense to the Insurer or the Policyowner shall be required in all cases.

121. Life Insurance Benefit

a. An eligible member may request OGTI for himself, his spouse and/or former spouse in units of $10,000 to a maximum of sixty units or $600,000 per person.

b. See Part IV for Dependent Life Insurance on a dependent child.

c. If the member should die while OGTI coverage is in force, the Insurer shall pay the benefit to the designated beneficiary, if any, after receipt of due proof of the member's death. If a member's spouse or former spouse should die while OGTI coverage is in force, the Insurer shall pay the benefit to the beneficiary after receipt of due proof of the spouse's or former spouse's death.

122. Transfer or Continuation of Coverage

Members may elect to transfer their SIB coverage and Dependent Life (DL) insurance to OGTI, as described in Section 42.

Members may elect to maintain OGTI coverage on a spouse who becomes a former spouse as defined in Subsection 1.d., subject to the limitation set out in Subsection 7.e.(ii).

123. Beneficiary

A member may designate a beneficiary, in writing, at any time. Such a designation shall be entered into the records of the Policyowner. If no beneficiary has been designated or if none is living at the member's death, the Insurer shall pay the benefits to the member's estate upon receipt of due proof of the member's death. The member shall always be the beneficiary of the spousal or former spouse's life insurance, unless he has indicated otherwise, in writing.

124. Assignment

A member shall not assign any rights or benefits under this coverage.

125. Limitations and Exclusions

a. If a life insured's death results from self-destruction while the life insured is sane or insane:
   i. no OGTI life insurance benefit shall be payable unless the life insurance became effective or was reinstated more than two years prior to the date of death.
   ii. no increase in OGTI shall be payable unless that increase became effective or was reinstated more than two years prior to the date of death.
   iii. and the life insured obtained coverage under OGTI by virtue of coverage transferred from SIB, Reserve Term Insurance (RTIP), Coverage After Release (CAR) or Insurance for Released Members (IRM), then notwithstanding (i) and (ii) of this subsection, the benefit will be paid provided the combined continuous time the life insurance has been in force under these five coverages is more than two years, measuring from the later of the effective date and the last reinstatement date of each of the SIB, OGTI, RTIP, CAR and IRM coverages.

126. Coverage After Release

a. A member whose entire amount of OGTI coverage is discontinued because he ceases to be a full-time member of the Canadian Forces (Regular) before 1 October 2005 may elect to convert up to the entire amount of their OGTI Member, Spouse or Former Spouse coverage, including Dependent child coverage, and subject to any limitations set out in this policy to the CAR as outlined in Part X. After 1 October 2005, a member may only chose to convert up to the entire amount of such OGTI coverage (s), subject to any limitations set out in this policy, to the IRM plan as outlined in Part XVI of this policy.

b. Upon the death of the member, prior to 1 October 2005, a surviving spouse may convert existing OGTI-Spousal coverage to CAR. On or after 1 October 2005, a surviving spouse may convert existing OGTI-Spousal coverage to IRM.

c. Upon the death of the member, prior to 1 October 2005, a surviving former spouse may convert existing OGTI-Former Spouse coverage to CAR, and on or after 1 October 2005, a surviving former spouse may convert existing OGTI-Former Spouse coverage to IRM, only if the member did not have a surviving spouse.

127. Paid-Up Dependent Life Insurance

See Section 77.

128. Limitation of Coverage

See Section 29.

129. Benefit For Death During Coverage After Release Eligibility Period

See Section 11.

130. Conversion Privileges

See Section 9.

131. Waiver of Premium Benefit

See Section 12.

131A. Accidental Dismemberment

a. The Insurer will pay a benefit as provided in the Schedule of Benefits upon receipt of due proof that an insured member, insured spouse (or former spouse), or dependent child has suffered a dismemberment within 365 days of and as a result of an accident and the insured member, spouse or former spouse was less than 75 years of age on the date of the accident. No benefit will be payable until the expiry of thirteen (13) weeks following the accident date.

b. Schedule of Benefits

Insured	Amount of Insurance
Member	Member coverage, in force, under this plan at the date of accident (to a maximum of $250,000)
Spouse	Spousal coverage, in force, under this plan at the date of accident (to a maximum of $250,000)
Dependent Child	Dependent Child coverage, in force at the date of accident (to a maximum of $10,000)

For Loss of:	Benefit Amount
Both Hands or Both Feet	The Amount of Insurance
One Hand and One Foot	The Amount of Insurance
Sight of Both Eyes	The Amount of Insurance
One Hand and Sight of One Eye	The Amount of Insurance
One Foot and Sight of One Eye	The Amount of Insurance
Hearing (bilateral)	The Amount of Insurance
Speech	The Amount of Insurance
One Hand or One Foot	One Half the Amount of Insurance
Sight of One Eye	One Half the Amount of Insurance
Thumb and Index Finger of the Same Hand	One Quarter the Amount of Insurance
Hearing (unilateral)	One Quarter the Amount of Insurance

c. "Loss" as used above shall also include loss of use.
d. "Loss of sight" shall mean total and irrecoverable loss of sight.
e. "Loss of speech" and "hearing" shall mean entire and irrecoverable loss.
f. In the event more than one of the losses described above results from the same accident, only the largest benefit amount listed in the Schedule of Benefits will be paid.

131B. Exceptions and Limitations - Accidental Dismemberment

No benefit is payable for dismemberment:
a. incurred while participating in a criminal offence; or
b. caused by or related to an intentionally self-inflicted injury or attempted self-destruction, while sane or insane; or
c. resulting from an accident occurring prior to enrolling in or being insured under OGTI, RTIP, CAR, IRM, GOIP or Res GOIP; or
d. incurred through sickness or disease or the medical or surgical treatment thereof except pus-forming infection which occurs through an accidental cut or wound; or
e. if the accident occurred on or after the insured member or spouse's 75th birthday; or

f. for members whose dismemberment(s) is/are attributable to military service. Such dismemberment(s) may be covered under SISIP Policy No. 906906, subject to all of the terms and conditions of that Policy;

g. if death occurs as a result of and within 13 weeks of the accident in which the injury was suffered.

131C. No Duplication of Dismemberment Benefit

a. Where a member has coverage under the GOIP or the Reserve GOIP (Res GOIP) of SISIP Policy No. 901102, then such member must submit his claim for an accidental dismemberment under one of those plans, and is not entitled to apply for or receive any benefit under SISIP Accidental Dismemberment Policy No. 906906 ("Policy No. 906906"), or any of the Long Term Disability (LTD) dismemberment provisions of Policy No. 901102.

b. Where a member suffers an accidental dismemberment that is not Attributable to Military Service, as that term is defined in Policy No. 906906, and where such member is not covered under the GOIP or Res GOIP provisions of Policy No. 901102, then such member must submit his claim for an accidental dismemberment under the applicable LTD dismemberment provisions of Policy No. 901102, and is not entitled to submit an accidental dismemberment claim under Policy No. 906906.

c. Where a member suffers an accidental dismemberment that is Attributable to Military Service, as that term is defined in Policy No. 906906, and such member is not covered under the GOIP or Res GOIP provisions of Policy No. 901102, then such member must submit his claim for an accidental dismemberment under Policy No. 906906, and is not entitled to submit an accidental dismemberment claim under Policy No. 901102.

d. Where a member has more than one accidental dismemberment coverage available to him under two or more of OGTI, RTIP, GOIP or Res GOIP, then the accidental dismemberment benefit payable to such member will be that which is the greater, under all of the coverages the member has in place. The accidental dismemberment benefit is limited in all circumstances to one benefit per dismemberment.

Where a member has both CAR and IRM coverage in force, providing this does not exceed the maximum of $600,000, the accidental dismemberment coverage available to him will be the combined dismemberment coverage under both plans.

PART X - COVERAGE AFTER RELEASE

132. Eligibility

133. Conversion to Individual Life Insurance Policy

134. Effective Date of Coverage

135. Life Insurance Benefit

136. Beneficiary

137. Limitation of Coverage

138. Benefit for Death During Coverage After Release Eligibility Period

139. Conversion Privileges

140. Supplementary Survivor Benefit (SSB)

141. Eligibility - SSB

142. Amount and Duration of Benefit - SSB

143. Paid-Up Dependent Life Insurance

144. Continuation of Coverage on Former Spouse

145. Accidental Dismemberment

146. Exceptions and Limitations – Accidental Dismemberment

147. Waiver of Premium Benefit

148. Assignment

PART X

COVERAGE AFTER RELEASE (CAR)

132. Eligibility

a. Coverage After Release (CAR) is available to the following:

i. On or after 1 April, 1981, members under age 65 (excluding members under the Post Retirement Continuation Plan) who have coverage under Survivor Income Benefit (SIB), Optional Group Term Insurance Plan (OGTI), the Reserve Term Insurance Plan (RTIP), the General Officers' Insurance Plan (GOIP), the Reserve General Officers' Insurance Plan (Res GOIP), or the Military Post-Retirement Life Insurance Plan (MPRLIP) shall be eligible to elect CAR coverage within 60 days of their release date from the Canadian Forces or within 60 days of a decrease in MPRLIP coverage, as applicable;

ii. Eligible members under age 65 who have claimed or received Long Term Disability (LTD) benefits under this policy immediately following their release date shall be eligible to apply for CAR within 60 days of the denial of such a claim, or 60 days of the termination date of any Extension of Coverage of the LTD benefit, whichever comes first;

iii. An eligible spouse with spousal OGTI or RTIP or spousal Dependent Life Insurance under Parts IV, VI, IX and/or XIV of this policy, may elect CAR under the same terms and conditions applicable to a member. If the member did not have a spouse at date of death, a former spouse with any of these coverages may elect CAR under the same terms and conditions applicable to a member.

iv. A former Canadian Forces member (or spouse, if the member is deceased, or former spouse if the member is deceased and the member did not have a spouse at date of death) may apply for CAR on himself, his spouse or his former spouse up to age 55 inclusive, with the provision of evidence of insurability. The age limit is extended by one year for each year or part year the member was a participant in any of the life insurance coverages (excluding CAR) available under this policy. However, under no circumstances will an application for coverage, or for an increase in coverage, be allowed after the proposed life insured has reached 60 years of age. This age limit applies to each of the member, the spouse and the former spouse.

v. The spouse of a former Canadian Forces member is eligible to be insured when the former spouse's coverage is paid up.

b. To convert eligible coverage(s) in force without evidence of insurability, an eligible member (or spouse, if the member is deceased, or former spouse, and the member did not have a spouse at date of death) must satisfy paragraphs a. and b. of Section 4 within 60 days of the member's release date, or within 60 days of a decrease in MPRLIP coverage,as applicable. Evidence of insurability satisfactory to the Insurer and at no expense to the Insurer shall be required in all other circumstances.

133. Conversion To Individual Life Insurance Policy

See Section 8.

134. Effective Date of Coverage

Where an eligible member (or spouse if the member is deceased or a former spouse if the member is deceased and the member did not have a spouse at date of death) has satisfied the conditions of section 132, coverage under CAR shall be effective on the latest of the following dates:

a. 1 April 1981;
b. the 61st day following the member's date of release from the Canadian Forces;
c. the date of approval of coverage by the Insurer;
d. in the case of a conversion associated with MPRLIP coverage, the date following the decrease in coverage or the date the Policyowner or the Insurer receives the application and required premium;
e. the 61st day following the termination date of any "Extension of Coverage" of LTD benefits, if applicable; and
f. the 61st day following a denial of a member's claim for LTD benefits.

135. Life Insurance Benefit

a. Application shall be made in units of $10,000 to a maximum of 40 units or $400,000. In circumstances where amounts transferred or converted are not a multiple of $10,000, the amount shall be rounded to the next higher multiple of $10,000.

b. Subject to subsection d. of this section 135, on the certificate anniversary next following the member's 65th birthday, premiums shall terminate and the CAR coverage shall be automatically reduced to a paid-up certificate providing coverage equal to 10% of the member's coverage in effect. The balance of the CAR coverage may be converted to an individual policy on the terms stated in section 8.

c. Subject to subsection e. of this section 135, on the certificate anniversary next following the spouse's or former spouse's 65th birthday, premiums shall terminate and the CAR coverage shall be automatically reduced to a paid-up certificate providing coverage equal to 10% of the spousal coverage or former spouse coverage in effect. The balance of the CAR coverage may be converted to an individual policy on the terms stated in section 8.

d. On and after 01 January 1999, the coverage of a member may be maintained under the CAR option beyond the certificate anniversary date next following the member's 65th birthday, provided the member's written election to maintain the coverage is received by the Insurer or the Policyholder prior to that certificate anniversary date next following the 65th birthday. Where this election is made, the member will have no subsequent entitlement to a paid-up certificate and no conversion privileges.

e. On and after 01 January 1999, the coverage of a spouse or former spouse may be maintained under the CAR option beyond the certificate anniversary date next following the spouse's or former spouse's 65th birthday, provided the spouse's or former spouse's written election to maintain the coverage is received by the Insurer or the Policyholder prior to that certificate anniversary date next following the spouse's or former spouse's 65th birthday. Where this election is made, the spouse or former spouse will have no subsequent entitlement to a paid-up certificate and no conversion privileges.

f. On receipt of proof satisfactory to the Insurer of the death of the life insured, the Insurer shall pay the benefit to the beneficiary.

g. For any member or any spouse or former spouse who made an election to maintain CAR coverage pursuant to subsection 135 d. or e. respectively, CAR coverage will cease on the day the member, spouse or former spouse, as applicable, reaches the age of 75, and no further premiums will be payable.

136. Beneficiary

An eligible member (or surviving spouse or former spouse) may designate a beneficiary, in writing, at any time. Such a designation shall be entered into the records of the Insurer or the Policyowner. If no beneficiary has been designated or if none be living at the member's death, the Insurer shall pay benefits to the member's estate upon receipt of due proof of the member's death. The member shall be the beneficiary of the spousal or the former spouse's insurance, unless he has indicated otherwise in writing.

137. Limitation of Coverage

a. If a life insured's death results from self-destruction while the life insured is sane or insane:
   (i) no CAR life insurance benefit shall be payable unless the life insurance became effective or was reinstated more than two years prior to the date of death.
   (ii) no increase in CAR shall be payable unless that increase became effective or was reinstated more than two years prior to the date of death.
   (iii) and the life insured obtained coverage under CAR by virtue of coverage transferred from SIB, OGTI or RTIP then notwithstanding (i) and (ii) of this subsection, the benefit will be paid provided the combined continuous time the life insurance has been in force under these four coverages is more than two years, measuring from the later of the effective date and the last reinstatement date of each of the SIB, RTIP, OGTI and CAR coverages.

b. Also see Section 29, Limitation of Coverage.

c. There will be no new entrants to the CAR plan after 1 October 2005. Accordingly, where the date of the member's release is subsequent to 1 October 2005, he is not eligible for the CAR plan. In the case of a spouse and/or former spouse, then they shall not be able to enter the CAR plan where the date of the member's death is subsequent to 1 October 2005.

d. The maximum amount available for conversion to the CAR plan, from the member's combined GOIP and MPRLIP coverages at the time of conversion, shall not exceed 1.75 times the member's salary upon release from the Canadian Forces.

138. Benefit for Death During Coverage After Release Eligibility Period

See Section 11.

139. Conversion Privileges

See Section 8.

140. Supplementary Survivor Benefit (SSB)

The SSB is available on and after 1 January, 1988 and is a monthly annuity payable to the surviving spouse of a deceased member, provided the deceased member:

a. had CAR coverage at age 65 and was issued a paid-up certificate; and
b. was in receipt of the Canadian Forces Superannuation Act annuity at time of death with a surviving spouse as defined by the Canadian Forces Superannuation Act.

The surviving spouse must complete the required application and authority form for release of information for the Canadian Forces Superannuation Act benefit payments.

A surviving member with CAR spousal coverage is entitled to the SSB if the spouse was a former member of the Canadian Forces and meets the eligibility criteria set out in section 141.

141. Eligibility - SSB

Effective 01 January 1999, the SSB is only available to members age 60 and over on 01 January 1999; and the SSB is not available to any member, spouse or former spouse who has elected to extend CAR coverage pursuant to subsection 135 e. or f.

In order to be eligible for the SSB:

a. The member must have had coverage under the SIB, the OGTI, the CAR or GOIP on 01 January 1988; or
b. A minimum of 10 years' participation in the SIB, the OGTI, the RTIP or the GOIP is required if the member became a participant in the relevant life insurance options under this policy after 01 January 1988.

142. Amount and Duration of Benefit - SSB

The monthly Supplementary Survivor Benefit payment will be the lesser of:

a. 75% of the Canadian Forces Superannuation Act spousal survivor monthly payments inclusive of benefits under the Supplementary Retirement Benefits Act;
b. $1/12^{th}$ of Coverage After Release in effect at age 65 to a maximum of $150,000 multiplied by the monthly 'Cash Flow Interest Rate'; and
c. the pro-rata portion of maximum aggregate benefit which the Non-Public Property Board of Directors ("NPP BOD") considers appropriate.

The Policyholder reserves the right to terminate, or reduce the amount of, the Supplementary Survivor Benefit, at any time. Subject to the foregoing, the Supplementary Survivor Benefit shall immediately terminate upon the death of the recipient.

143. Paid-Up Dependent Life Insurance

See Section 77.

144. Continuation of Coverage on Former Spouse

If a member does not have a spouse, the member may elect to maintain CAR coverage on a former spouse as defined in Subsection 1.d.

145. Accidental Dismemberment

a. The Insurer will pay a benefit as provided in the Schedule of Benefits below, upon receipt of due proof that an insured member, spouse or former spouse has suffered a dismemberment within 365 days of and as a result of an accident and the member, spouse or former spouse was less than 65 years of age on the date of the accident. No benefit will be payable until the expiry of thirteen (13) weeks following the accident date.

b. Schedule of Benefits

Insured	Amount of Insurance
Member	Member coverage, in force, under this plan at the date of accident (to a maximum of $250,000)
Spouse	Spousal coverage, in force, under this plan at the date of Accident (to a maximum of $250,000)
Dependent Child	Dependent Child coverage, in force at the date of accident (to a maximum of $10,000)

For Loss of:	Benefit Amount
Both Hands or Both Feet	The Amount of Insurance
One Hand and One Foot	The Amount of Insurance
Sight of Both Eyes	The Amount of Insurance
One Hand and Sight of One Eye	The Amount of Insurance
One Foot and Sight of One Eye	The Amount of Insurance
Loss of Hearing	The Amount of Insurance
Loss of Speech	The Amount of Insurance
One Hand or One Foot	One Half the Amount of Insurance
Sight of One Eye	One Half the Amount of Insurance
Thumb and Index Finger of The Same Hand	One Quarter the Amount of Insurance
Hearing (unilateral)	One Quarter the Amount of Insurance

c. "Loss" as used above shall also include loss of use.

d. "Loss of sight" shall mean total and irrecoverable loss of sight.

e. "Loss of speech" and "hearing" shall mean entire and irrecoverable loss.

f. In the event more than one of the losses described above results from the same accident, only the largest benefit amount listed in the Schedule of Benefits will be paid.

g. where a member claims accidental dismemberment and has more than one accidental dismemberment coverage available to him under two or more of OGTI, RTIP, GOIP or Res GOIP, then the accidental dismemberment benefit payable to such member will be that which is the greater, under all of the coverages the member has in place. The accidental dismemberment benefit is limited in all circumstances to one benefit per dismemberment.

Where a member has both CAR and IRM coverage in force, providing this does not exceed the maximum of $600,000, the accidental dismemberment coverage available to him will be the combined dismemberment coverage under both plans.

146. Exceptions and Limitations – Accidental Dismemberment

a. No benefit is payable for dismemberment:
   (i) incurred while participating in a criminal offence;
   (ii) intentionally self-inflicted injury or attempted self-destruction, while sane or insane;
   (iii) resulting from an accident occurring prior to enrolling in CAR;
   (iv) if death occurs as a result of and within 13 weeks of the accident in which the injury was suffered;
   (v) incurred through sickness or disease or medical or surgical treatment thereof except pus-forming infection which occurs through an accidental cut or wound; or
   (vi) if the accident occurred on or after the insured's 65th birthday.

b. where a member suffers an accidental dismemberment that is Attributable to Military Service, as that term is defined in Policy No. 906906, and such member is not covered under the GOIP or Res GOIP provisions of Policy No. 901102, then such member must submit his claim for accidental dismemberment under Policy No. 906906, and is not entitled to submit an accidental dismemberment claim under Policy No. 901102.

147. Waiver of Premium Benefit

a. If at the date of release from the Canadian Forces the member had LTD coverage in force, the Insurer will waive the payment of the premium for the insurance of a member, insured spouse, or insured former spouse under this coverage and will continue the insurance in force upon receipt at its Head Office of proof satisfactory to the Insurer that while insured under this coverage and prior to the member's 65th birthday:

   i. the member became totally disabled; and
   ii. the member has been totally and continuously disabled for six months previous to filing any claim for benefit under this provision.

b. "Total Disability" shall have the meaning given that term in Subsection 1.h.

c. Premiums will be waived during the continuance of the total disability and until the certificate anniversary date next following the 65th birthday of the member unless the member fails to submit proof of the continuance of total disability or fails to be examined medically, when required. The Insurer may require a medical examination of the member by a medical examiner designated and paid by the Insurer. Any premiums paid after the onset of total disability but prior to the expiry of the six month waiting period will be refunded to the member upon determination of total disability.

d. There is no Waiver of Premium benefit in the event the spouse or former spouse becomes disabled.

e. If an eligible member applied for LTD coverage while serving in the Canadian Forces and the coverage was denied, there will be no Waiver of Premium benefit for any total disability which results from a medical condition that was material to the decline of the LTD coverage.

f. If an eligible member never submitted an application for LTD coverage while serving in the Canadian Forces then there will be no Waiver of Premium benefit included with the member's CAR.

g. There is no entitlement to Waiver of Premium under this Part if a member is in receipt of LTD benefits under Part III(B) of this policy.

148. Assignment

A member shall not assign any rights or benefits under this coverage.

PART XII - RESERVE TERM INSURANCE PLAN (RTIP)

157. Eligibility

158. How Eligible Member or Spouse Becomes Insured

159. Life Insurance Benefit

160. Limitation of Coverage

161. Benefit for Death During Coverage After Release Eligibility Period

162. Conversion Privileges

163. Beneficiary

164. Assignment

165. Limitations and Exclusions

166. Coverage After Release

167. Paid-Up Life Insurance

168. Continuation of Coverage on Former Spouse

169. Waiver of Premium

169A. Accidental Dismemberment

169B. Exceptions and Accidental Dismemberment Limitations

169C. No Duplication of Dismemberment Benefit

PART XII

RESERVE TERM INSURANCE PLAN (RTIP)

157. Eligibility

Reserve Term Insurance (RTIP) is available to the following:

a. members of the Canadian Forces (Reserve) on Class "A" or "B" reserve service; and
b. spouses and former spouses of these members; and
c. members of the Canadian Forces (Reserve), with RTIP coverage, who transfer to Class “C” reserve service.

158. How Eligible Members, Spouses or Former Spouses Become Insured

a. An eligible member may apply for RTIP coverage by complying with the terms stated in Section 4.

b. A member who applies for RTIP or a member who applies to increase the amount of such life insurance shall provide evidence of insurability and at no expense to the Insurer or the Policyowner satisfactory to the Insurer or the Policyowner.

c. A member may apply for RTIP coverage or an increase in coverage on his life or the life of his spouse or if the member does not currently have a spouse, on the life of a former spouse. Evidence of insurability satisfactory to the Insurer or the Policyowner and at no expense to the Insurer or the Policyowner shall be required in all cases.

159. Life Insurance Benefit

a. An eligible member may request RTIP for himself, his spouse or his former spouse in units of $10,000 to a maximum of sixty units or $600,000 per person.

b. See Part IV for Dependent Life coverage on a dependent child.

c. If the member should die while this coverage is in force, the Insurer shall pay the benefit to the beneficiary after receipt of due proof of the member's death. If a member's spouse or former spouse should die while this coverage is in force, the Insurer shall pay the benefit to the beneficiary after receipt of due proof of the spouse's or former spouse's death.

160. Limitation of Coverage

See Section 29.

161. Benefit for Death During Coverage After Release Eligibility Period

See Section 11.

162. Conversion Privileges

See Section 9.

163. Beneficiary

A member may designate a beneficiary, in writing, at any time. Such designation shall be entered in the records of the Insurer or the Policyowner. If no beneficiary has been designated or if none be living at the member's death, the Insurer shall pay benefits to the member's estate upon receipt of due proof of the member's death. The member shall be the primary beneficiary of the spousal or former spouse's life insurance, unless he has indicated otherwise, in writing.

164. Assignment

A member shall not assign any rights or benefits under this coverage.

165. Limitations and Exclusions

a. If a life insured's death results from self-destruction while the life insured is sane or insane:
   i. no RTIP life insurance benefit shall be payable unless the life insurance became effective or was reinstated more than two years prior to the date of death; and
   ii. no increase in RTIP coverage shall be payable unless that increase in coverage became effective or was reinstated more than two years prior to the date of death.
   iii. and the life insured obtained coverage under RTIP by virtue of coverage transferred from Survivor Income Benefit (SIB), Optional Group Term Insurance (OGTI), Coverage After Release (CAR) or Insurance for Released Members (IRM), then notwithstanding (i) and (ii) of this subsection, the benefit will be paid provided the combined continuous time the life insurance has been in force under these five coverages is more than two years, measuring from the later of the effective date and the last reinstatement date of each of the SIB, OGTI , RTIP, CAR and IRM coverages.

166. Coverage After Release

a. A member whose RTIP coverage is discontinued because he ceases to be a member of the Reserve Force and is released from the Canadian Forces before 1 October 2005 may elect to continue member, spousal coverage or former spouse coverage under CAR as outlined in Part X. If released after 1 October 2005, the member may elect to continue member, spousal or former spouse coverage under IRM as outlined in Part XVI of this policy.

b. Upon the death of the member, prior to 1 October 2005, a surviving spouse may convert existing RTIP-Spousal coverage to CAR. On or after 1 October 2005, a surviving spouse may convert existing RTIP-Spousal coverage to IRM.

c. Upon the death of the member, prior to 1 October 2005, a surviving former spouse may convert existing RTIP-Former Spouse coverage to CAR , only if the member did not have a surviving spouse. On or after 1 October 2005, a surviving former spouse may convert existing RTIP-Former Spouse coverage to IRM, only if the member did not have a surviving spouse.

167. Paid-Up Dependent Life Insurance

See Section 77.

168. Continuation of Coverage on Former Spouse

Members may elect to maintain RTIP coverage on a spouse who becomes a former spouse as defined in Subsection 1.d., subject to the limitation set out in Subsection 7.e.(ii).

169. Waiver of Premium

There is no Waiver of Premium benefit under this coverage.

169A. Accidental Dismemberment

g. The Insurer will pay a benefit as provided in the Schedule of Benefits upon receipt of due proof that an insured Member, insured Spouse (or former Spouse), or Dependent Child has suffered a dismemberment within 365 days of and as a result of an accident and the insured member, spouse or former spouse was less than 75 years of age on the date of the accident. No benefit will be payable until the expiry of thirteen (13) weeks following the accident date.

h. Schedule of Benefits

Insured	Amount of Insurance
Member	Member coverage, in force, under this plan at the date of accident (to a maximum of $250,000)
Spouse	Spousal coverage, in force, under this plan at the date of accident (to a maximum of $250,000)
Dependent Child	Dependent Child coverage, in force at the date of accident (to a maximum of $10,000)

For Loss of:	Benefit Amount
Both Hands or Both Feet	The Amount of Insurance
One Hand and One Foot	The Amount of Insurance
Sight of Both Eyes	The Amount of Insurance
One Hand and Sight of One Eye	The Amount of Insurance
One Foot and Sight of One Eye	The Amount of Insurance
Hearing (bilateral)	The Amount of Insurance
Speech	The Amount of Insurance
One Hand or One Foot	One Half the Amount of Insurance
Sight of One Eye	One Half the Amount of Insurance
Thumb and Index Finger of the Same Hand	One Quarter the Amount of Insurance
Hearing (unilateral)	One Quarter the Amount of Insurance

i. "Loss" as used above shall also include loss of use.
j. "Loss of sight" shall mean total and irrecoverable loss of sight.
k. "Loss of speech" and "hearing" shall mean entire and irrecoverable loss.
l. In the event more than one of the losses described above results from the same accident, only the largest benefit amount listed in the Schedule of Benefits will be paid.
m. where a member claims accidental dismemberment and has more than one accidental dismemberment coverage available to him under two or more of OGTI, RTIP, CAR, IRM, GOIP or Res GOIP, then the accidental dismemberment benefit payable to such member will be that which is the greater, under all of the coverages the member has in place. The accidental dismemberment benefit is limited in all circumstances to one benefit per dismemberment.

169B. Exceptions and Accidental Dismemberment Limitations

No benefit is payable for dismemberment:
a. incurred while participating in a criminal offence; or
b. caused by or related to an intentionally self-inflicted injury or attempted self-destruction, whilesane or insane; or
c. resulting from an accident occurring prior to enrolling in or being insured under OGTI, RTIP, CAR, IRM, GOIP or Res GOIP; or
d. incurred through sickness or disease or the medical or surgical treatment thereof except pus-forming infection which occurs through an accidental cut or wound; or
e. if the accident occurred on or after the insured member or spouse's 75th birthday; or
f. for Members whose dismemberment(s) is/are attributable to military service. Such dismemberment(s) may be covered under SISIP Policy No. 906906, subject to all of the terms and conditions of that Policy; or
g. if death occurs as a result of and within 13 weeks of the accident in which the injury was suffered.

169C. No Duplication of Dismemberment Benefit

a. Where a member has coverage under the GOIP or the Res GOIP of SISIP Policy No. 901102, then such member must submit his claim for an accidental dismemberment under one of those plans, and is not entitled to apply for or receive any benefit under SISIP Accidental Dismemberment Policy No. 906906, or any of the LTD dismemberment provisions of Policy No. 901102.

b. Where a member suffers an accidental dismemberment that is not Attributable to Military Service, as that term is defined in Policy No. 906906, and where such member is not covered under the GOIP or Res GOIP provisions of Policy No. 901102, then such member must submit his claim for an accidental dismemberment under the applicable LTD dismemberment provisions of Policy No. 901102, and is not entitled to submit an accidental dismemberment claim under Policy No. 906906.

c. Where a member suffers an accidental dismemberment that is Attributable to Military Service, as that term is defined in Policy No. 906906, and such member is not covered under the GOIP or Res GOIP provisions of Policy No. 901102, then such member must submit his claim for an accidental dismemberment under Policy No. 906906, and is not entitled to submit an accidental dismemberment claim under Policy No. 901102.

d. Where a member has more than one accidental dismemberment coverage available to him under two or more of OGTI, RTIP, GOIP or Res GOIP, then the accidental dismemberment benefit payable to such member will be that which is the greater, under all of the coverages the member has in place. The accidental dismemberment benefit is limited in all circumstances to one benefit per dismemberment.

   Where a member has both CAR and IRM coverage in force, providing this does not exceed the maximum of $600,000, the accidental dismemberment coverage available to him will be the combined dismemberment coverage under both plans.

PART XIV - RESERVE GENERAL OFFICERS' INSURANCE PLAN (Res GOIP)

PART XIV

RESERVE GENERAL OFFICERS' INSURANCE PLAN (Res GOIP)

192. Eligibility

Primary Reserve Force officers on Class "A" or short term Class "B" reserve service, or Primary Reserve Force officers on long term Class "B" reserve service who hold the substantive rank of Colonel and above in all classifications, and Lieutenant Colonel in the Legal Classification are eligible for coverage under the Reserve General Officers' Insurance Plan (Res GOIP) on the latest of the following dates:

a. 01 July, 1994; or
b. the date of promotion to the first eligible rank; or,
c. the date the officer begins employment in the eligible reserve service.

193. How Eligible Member Becomes Insured

An eligible member may become insured under Res GOIP for Basic Life Insurance, Accidental Death and Dismemberment Insurance, Dependent Life Insurance and Dependent Accidental Death and Dismemberment Insurance by completing and submitting the enrollment cards not more than 60 days after he becomes eligible for Res GOIP coverage or by submitting a written application for insurance to the Insurer or the Policyowner. Coverage will be effective on the latest of the following dates:

a. 01 July 1994;
b. the date the enrollment cards are received by the Insurer or the Policyowner and the applicant's eligibility is confirmed;
c. if evidence of insurability is required, the date coverage is approved by the Insurer at its Head Office; or,
d. if, on the date of eligibility, the member is absent from normal duties by reason of illness or injury, the member shall become insured under the Res GOIP on the later of:
    (i) the first day of the calendar month coincidental with, or next following, completion of 31 consecutive days of return to normal duties; or,
    (ii) the date evidence of insurability is approved by the Insurer at its Head Office.

An eligible member may apply for Optional Life Insurance by completing and submitting the enrollment cards not more than 60 days after he becomes eligible or by submitting a written application for insurance to the Insurer or the Policyowner, submitting the required premium payment, and providing evidence of insurability satisfactory to the Insurer or the Policyowner where required and without expense to the Insurer or the Policyowner. The Insurer only requires evidence of insurability if the member applies for the Optional Life Insurance more than 60 days after he becomes eligible for such coverage.

194. Life Insurance Benefit

Upon receipt of due proof at its Head Office that the member died while insured under this coverage, the Insurer will pay to a member's beneficiary the amount of life insurance in force on the member's life at the time of his death as determined in accordance with the Schedule of Benefits which follows.

Schedule of Benefits

For the purposes of life insurance coverage under this Part XIV, the "deemed annual salary" of a member equals the Primary Reserve Force daily rate of pay for the member times 30 days per month for 12 months.

Basic Life Insurance

a. A member on Class "A" or short term Class "B" reserve service is insured for one (1) time the member's deemed annual salary at time of death, rounded to the nearest $1,000;

b. A member on long term Class "B" reserve service is insured for two (2) times the member's deemed annual salary at the time of death, rounded to the nearest $1,000.

Optional Life Insurance

c. There is no optional life insurance for a member on Class "A" or short term Class "B" reserve service.

d. A member on long term Class "B" reserve service who has purchased Optional Life Insurance is insured for an amount equal to one (1) time the member's deemed annual salary at time of death, rounded to the nearest $1,000.

195. Conversion Privilege Prior to Release

See Section 9.

196. Conversion Privilege at Release

See Section 8.

197. Benefit for Death During Coverage After Release Eligibility Period

See Section 11.

198. Waiver of Premium Benefit

There is no waiver of premium benefit under the Res GOIP coverage.

MEMBER ACCIDENTAL DEATH AND DISMEMBERMENT INDEMNITY

199. Payment of Benefit

Subject to the "Exceptions and Limitations" section below, if a member suffers any of the losses specified below as a result of an injury suffered by accidental, external, and violent means, the Insurer will pay the amount of insurance specified in the Schedule of Benefits below in an amount and for the loss specified in the Schedule of Indemnities below, upon receipt of proof that satisfies the Insurer that:

a. the injury occurred while the member was insured under this coverage;
b. the loss occurred within 90 days of the injury; and,
c. the loss resulted directly and solely from the injury and independently of all other causes.

Schedule of Benefits

Amount of Insurance for Class "A" and short term Class "B" members
$100,000

Amount of Insurance for long term Class "B members
$250,000

Schedule of Indemnities

Full amount of insurance for loss of:

Life
Both Hands
Both Feet
One Hand and One Foot
Sight of Both Eyes
One Hand and Sight of One Eye
One Foot and Sight of One Eye
Hearing (bilateral)
Speech

One half of the full amount of insurance for loss of:

Sight of One Eye
One Hand
One Foot

One-quarter of the full amount of insurance for the loss of:

Thumb and Index Finger of the Same Hand
Hearing (unilateral)

"Loss" as used above shall also mean loss of use.

"Loss of sight" shall mean total and irrecoverable loss of sight.

The total amount payable for all losses resulting from any one accident shall not exceed the dependent's full amount of insurance.

200. Beneficiary - Member AD&D

In the case of accidental death, the benefit will be paid to the member's named beneficiary. If no beneficiary is named or if the beneficiary predeceases the member, the amount of benefit payable will be paid to the member's estate.

In the case of dismemberment, the benefit will be paid to the member.

201. Exceptions and Limitations

a. No accidental death and dismemberment benefit will be payable for any loss caused wholly or partly, directly or indirectly, by:

(i) disease, or bodily or mental infirmity, or medical or surgical treatment thereof; or,
(ii) ptomaines, or bacterial infections, except infection introduced through a visible wound accidentally sustained; or,
(iii) self-destruction or self-inflicted injury, whether the member be sane or insane.

b. Where a member suffers an accidental dismemberment that is Attributable to Military Service, as that term is defined in Policy No. 906906, and such member is not covered under the GOIP or Res GOIP provisions of Policy No. 901102, then such member must submit his claim for an accidental dismemberment under Policy No. 906906, and is not entitled to submit an accidental dismemberment claim under Policy No. 901102.

c. Accidental deaths Attributable to Military Service, occurring subsequent to 31 March 2006, and which are eligible for the lump sum death benefit under the New Veteran’s Charter (“NVC”), will not be paid under the Accidental Death and Dismemberment portion of this policy.

201A. No Duplication of Dismemberment Benefit

a. Where a Member has coverage under the General Officers' Insurance Plan ("GOIP") or the Reserve General Officers' Insurance Plan ("Res GOIP") of SISIP Policy No. 901102 ("Policy No. 901102"), then such Member must submit his claim for an accidental dismemberment under one of those plans, and is not entitled to apply for or receive any benefit under SISIP Accidental Dismemberment Policy No. 906906 ("Policy No. 906906"), or any of the Long Term Disability dismemberment provisions of Policy No. 901102.

b. Where a Member suffers an accidental dismemberment that is not Attributable to Military Service, as that term is defined in Policy No. 906906, and where such Member is not covered under the GOIP or Res GOIP provisions of Policy No. 901102, then such Member must submit his claim for an accidental dismemberment under the applicable Long Term Disability dismemberment provisions of Policy No. 901102, and is not entitled to submit an accidental dismemberment claim under Policy No. 906906.

c. Where a Member suffers an accidental dismemberment that is Attributable to Military Service, as that term is defined in Policy No. 906906, and such Member is not covered under the GOIP or Res GOIP provisions of Policy No. 901102, then such Member must submit his claim for an accidental dismemberment under Policy No. 906906, and is not entitled to submit an accidental dismemberment claim under Policy No. 901102.

DEPENDENT LIFE INSURANCE

202. Payment of Benefit

Upon receipt of proof that satisfies the Insurer that a dependent has died while the member was insured under this Part, a member with the Res GOIP coverage will be paid the following life insurance benefit by the Insurer:

Schedule of Insurance	
Spouse	$5,000
Each Child	$2,500

203. Coverage After Release - Dependents

The Dependent Life Insurance provided by this Part shall remain in force while the member is insured under Res GOIP. Termination of Res GOIP coverage shall terminate the Dependent Life Insurance coverage. If the dependent's insurance terminates because the member is released from the Canadian Forces, before October 1, 2005, then a dependent may continue to be insured as outlined under CAR, Part X. If the dependent's insurance terminates because the member is released from the Canadian Forces on or after October 1, 2005, then a dependent may continue to be insured as outlined under the IRM, Part XVI.

DEPENDENT ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

204. Payment of Benefit

Subject to the "Exceptions and Limitations" section below, if a dependent suffers any of the losses listed below, the Insurer will pay to the member the amount of insurance specified in the Schedule of Benefits below. The loss must result from an injury suffered by accidental, external, and violent means. The Insurer requires satisfactory proof that:

a. the injury occurred while the dependent was insured under this coverage;
b. the loss occurred within 90 days of the injury; and,
c. the loss resulted directly and solely from the injury and independently of all other causes.

Schedule of Benefits

Amount of Insurance

Spouse	$5,000
Each Child	$2,500

Full amount of insurance for loss of:

Life
Both Hands
Both Feet
One Hand and One Foot
One Hand and Sight of One Eye
Sight of Both Eyes
One Foot and Sight of One Eye
Hearing (bilateral)
Speech

One half of the full amount of insurance for loss of:

Sight of One Eye
One Hand
One Foot

One-quarter of the full amount of insurance for the loss of:

Thumb and Index Finger of the Same Hand
Hearing (unilateral)

"Loss" as used above shall also mean loss of use.

"Loss of sight" shall mean total and irrecoverable loss of sight.

The total amount payable for all losses resulting from any one accident shall not exceed the dependent's full amount of insurance.

205. Exceptions and Limitations - Dependent AD&D

No accidental death and dismemberment benefit will be payable for any loss caused wholly or partly, directly or indirectly, by:

a. disease, or bodily or mental infirmity, or medical or surgical treatment thereof; or,
b. ptomaines, or bacterial infections, except infection introduced through a visible wound accidentally sustained; or,
c. self-destruction or self-inflicted injury, whether the dependent be sane or insane.

206. Discontinuance of Insurance

Under Res GOIP, the relevant insurance shall cease on the earliest of the following dates:

a. 60 days after the member ceases to be a member of the Canadian Forces. If the date of release is prior to October 1, 2005, the member may convert the coverage to the CAR option within the allowable grace period. If the date of release is on or after October 1, 2005, the member may convert the coverage to the IRM option within the allowable grace period; or,
b. 60 days after the member is transferred to an ineligible type of reserve service. The member may convert the coverage to the Reserve Term Insurance Plan within the allowable grace period; or,
c. the date the Insurer or the Policyowner receives notification that the member has withdrawn authorization for the required premium contribution; or
d. the date of termination of the policy; or,
e. for dependents, the earlier of:
    (1) any of the above dates; or,
    (2) for spouses, the date such person ceases to be a spouse; or,
    (3) for a child, the date such person ceases to be a dependent child.
f. In the event the insurance coverage is cancelled or terminated, there shall be no refund of the premium paid.

PART XVI – INSURANCE FOR RELEASED MEMBERS

PART XVI

INSURANCE FOR RELEASED MEMBERS (IRM)

The effective date of this Part XVI is 1 October 2005.

215. Eligibility

a. Insurance for Released Members (IRM) is available to the following on or after 01 October 2005:

i. members under age 65 (excluding members under the Post Retirement Continuation Plan) who have coverage under Survivor Income Benefit (SIB), Optional Group Term Insurance (OGTI), the Reserve Term Insurance Plan (RTIP), the General Officers' Insurance Plan (GOIP), the Reserve General Officers' Insurance Plan (Res GOIP), or the Military Post-Retirement Life Insurance Plan (MRPLIP) shall be eligible to elect IRM coverage within 60 days of their release date, providing their release date is on or after 01 October 2005, from the Canadian Forces or within 60 days of a decrease in MPRLIP coverage, as applicable;

ii. an eligible spouse with spousal OGTI or RTIP or spousal Dependent Life Insurance under Parts IX, XII and/or IV of this policy, may elect IRM under the same terms and conditions applicable to a member. If the member did not have a spouse at date of death, a former spouse with any of these coverages may elect IRM under the same terms and conditions applicable to a member;

iii. a former Canadian Forces member (or spouse, if the member is deceased, or former spouse if the member is deceased and the member did not have a spouse at date of death) may apply for IRM on himself, his spouse or his former spouse up to age 65 inclusive, with the provision of evidence of insurability;

iv. the spouse of a former Canadian Forces member is eligible to be insured when the former spouse's coverage is paid up under the CAR plan;

v. members and/or spouses insured under the CAR plan who have chosen to convert all or part of their coverage under CAR to the IRM plan.

b. To convert eligible coverage(s) in force, without evidence of insurability, an eligible member, spouse or former spouse must satisfy paragraphs (a) and (b) of Section 4 within 60 days of the member's release date, or within 60 days of a decrease in MPRLIP, as applicable. Evidence of insurability satisfactory to the Insurer and at no expense to the Insurer shall be required in all other circumstances.

216. Effective Date of Coverage

Where an eligible member (or spouse if the member is deceased or a former spouse if the member is deceased and the member did not have a spouse at date of death) has satisfied the conditions of section 215, coverage under IRM shall be effective on the latest of the following dates:

a. 01 October 2005;

b. the 61st day following the member's date of release from the Canadian Forces;

c. the date of approval of coverage by the Insurer;

d. in the case of a conversion associated with MPRLIP coverage, the date following the decrease in coverage or the date the Policyowner or the Insurer receives the application and required premium;

e. the 61st day following the termination date of any "Extension of Coverage" of LTD benefits, if applicable; and

f. in the case of a conversion associated with CAR, the earlier of 01 October 2005, if the member elected to transfer the coverage within the 60 day conversion period, or the date the conversion form was received by the Insurer.

217. Life Insurance Benefit

a. Application shall be made in units of $10,000 to a maximum of 60 units or $600,000. In circumstances where amounts transferred or converted are not a multiple of $10,000, the amount shall be rounded to the next higher multiple of $10,000.

b. Dependent Life coverage under IRM is $10,000.

c. On receipt of proof satisfactory to the Insurer of the death of the life insured, the Insurer shall pay the benefit to the Beneficiary.

d. The IRM coverage will cease on the member's, spouse's or former spouse's 75th birthday, and no further premiums will be payable.

e. There is no paid up certificate under the IRM.

218. Beneficiary

An eligible member (or surviving spouse or former spouse) may designate a Beneficiary, in writing, at any time. Such a designation shall be entered into the records of the Insurer or the Policyowner. If no Beneficiary has been designated or if none be living at the member's death, the Insurer shall pay benefits to the member's estate upon receipt of due proof of the member's death. The member shall be the Beneficiary of the spousal or the former spouse's insurance, unless he has indicated otherwise in writing.

219. Exclusions and Limitations

a. If a life insured's death results from self-destruction while the life insured is sane or insane:

(i) no IRM life insurance benefit shall be payable unless the life insurance became effective or was reinstated more than two years prior to the date of death.

(ii) no increase in IRM shall be payable unless that increase became effective or was reinstated more than two years prior to the date of death.

(iii) and the life insured obtained coverage under IRM by virtue of coverage transferred from SIB, OGTI, MPRLIP, GOIP, RTIP, Res GOIP or CAR then notwithstanding (i) and (ii) of this subsection, the benefit will be paid provided the combined continuous time the life insurance has been in force under these coverages is more than two years, measuring from the later of the effective date and the last reinstatement date of each of the SIB, OGTI, MPRLIP, GOIP, RTIP, Res GOIP, CAR and IRM coverages.

b. Also see Section 29, Limitation of Coverage.

c. The maximum amount available for conversion to the IRM plan, from the member's combined GOIP and MPRLIP coverages at the time of the conversion, shall not exceed 1.75 times the member's salary upon release from the Canadian Forces.

220. Benefit for Death During IRM Eligibility Period

If the member dies within the 60 day period during which the member could have made application for IRM, the Insurer shall pay the applicable amount under SIB, OGTI, RTIP, GOIP and/or Res GOIP. If an IRM certificate of insurance has already been issued, no payment shall be made under this provision unless the certificate of insurance for IRM is surrendered without payment of claim. Upon surrender, the Insurer shall refund premiums paid on the IRM insurance. A Beneficiary designated in any conversion application form shall be the Beneficiary under this provision.

221. Continuation of Coverage on Former Spouse

If a member does not have a spouse, the member may elect to maintain IRM coverage on a former spouse as defined in Subsection 1(d).

222. Assignment

A member shall not assign any rights or benefits under this coverage.

ACCIDENTAL DISMEMBERMENT INSURANCE

223. Accidental Dismemberment

a. The Insurer will pay a benefit as provided in the Schedule of Benefits upon receipt of due proof that an insured member, insured spouse (or former spouse), or dependent child has suffered a dismemberment within 365 days of and as a result of an accident and the insured member, spouse or former spouse was less than 75 years of age on the date of the accident. No benefit will be payable until the expiry of thirteen (13) weeks following the accident date.

b. Schedule of Benefits

Insured	Amount of Insurance
Member	Member coverage, in force, under this plan at the date of accident (to a maximum of $250,000)
Spouse	Spousal coverage, in force, under this plan at the date of accident (to a maximum of $250,000)
Dependent child	Dependent child coverage, in force at the date of accident (to a maximum of $10,000)

For Loss of:	Benefit Amount
Both Hands or Both Feet	The Amount of Insurance
One Hand and One Foot	The Amount of Insurance
Sight of Both Eyes	The Amount of Insurance
One Hand and the Sight of One Eye	The Amount of Insurance
One Foot and the Sight of One Eye	The Amount of Insurance
Hearing (bilateral)	The Amount of Insurance
Loss of Speech	The Amount of Insurance
One Hand or One Foot	One Half the Amount of Insurance
Sight of One Eye	One Half the Amount of Insurance
Thumb And Index Finger of the Same Hand	One Quarter the Amount of Insurance
Hearing (unilateral)	One Quarter the Amount of Insurance

c. "Loss" as used above shall also include loss of use.

d. "Loss of sight" shall mean total and irrecoverable loss of sight.

e. "Loss of speech" and "hearing" shall mean entire and irrecoverable loss.

f. Paraplegia, Hemiplegia or Quadriplegia shall mean the complete and irreversible paralysis of such limbs and must be continuous for twelve consecutive months from the date of the accident causing the loss. Benefits may be paid earlier if certification is received by competent medical authority that the injury is irrecoverable.

g. In the event more than one of the losses described above results from the same accident, only the largest benefit amount listed in the Schedule of Benefits will be paid.

224. Exceptions and Limitations - Dismemberment

No benefit is payable for dismemberment:

a. incurred while participating in a criminal offence; or

b. caused by or related to an intentionally self-inflicted injury or attempted self-destruction, while sane or insane; or

c. resulting from an accident occurring prior to enrolling in or being insured under OGTI, RTIP, CAR, IRM, GOIP and/or Res GOIP; or

d. incurred through sickness or disease or the medical or surgical treatment thereof except pus-forming infection which occurs through an accidental cut or wound: or

e. if the accident occurred on or after the insured member or spouse's 75th birthday; or

f. for members whose dismemberment(s) is/are attributable to military service. Such dismemberment(s) may be covered under SISIP Policy No. 906906, subject to all of the terms and conditions of that Policy;

g. where a member has more than one accidental dismemberment coverage available to him under two or more of OGTI, RTIP, GOIP or Res GOIP, then the accidental dismemberment benefit payable to such member will be that which is the greater, under all of the coverages the member has in place. The accidental dismemberment benefit is limited in all circumstances to one benefit per dismemberment.

   Where a member has both CAR and IRM coverage in force, providing this does not exceed the maximum of $600,000, the accidental dismemberment coverage available to him will be the combined dismemberment coverage under both plans; or

h. if death occurs as a result of and within 13 weeks of the accident in which the injury was suffered.

PREVIOUS POLICIES

PART III (A) PRE-DECEMBER 1, 1999

LONG TERM DISABILITY INSURANCE (LTD) PLAN

LONG TERM DISABILITY - DISABILITY BENEFIT

NOTE: Part III (A) applies to insured members of the Canadian Forces who were released from the Canadian Forces before December 1, 1999.

PART III(A)

LONG TERM DISABILITY INSURANCE (LTD)

DISABILITY BENEFIT

51. Eligibility

Long Term Disability insurance coverage under this Part III is available only to the following Canadian Forces members:

a. members of the Canadian Forces (Regular).

b. members of the Canadian Forces (Reserve) on Class "C" reserve service.

c. members who were not in receipt of benefits under policy numbers 911104 or 911105 as of November 1, 1989.

52. How Eligible Member Becomes Insured

An eligible member becomes insured under this Part:

a. In the case of a Class C Member, for 30 days starting on the first day of paid service and subject to satisfactory completion of the medical examination required for continuation in the Canadian Forces. Submission of an application form within this 30 day period is required to continue the LTD coverage past the 30 days.

b. In the case of a Regular Force member enrolment is automatic on or after 1 April 1982 and coverage continues until the member is released from the Canadian Forces. No application form is required.

c. In circumstances other than outlined above, when the member applies for LTD coverage in accordance with Section 4. Evidence of insurability, satisfactory to the Insurer and at no expense to the Insurer, shall be required in all cases.

53. Benefit in Event of Total Disability

An insured member will be eligible to receive a monthly income benefit if he has become totally disabled, as defined in Subsection 1(h), for 13 consecutive weeks or more and is released from the Canadian Forces while still totally disabled. Upon receipt of proof of the foregoing satisfactory to the Insurer, the Insurer will commence payment.

54. Amount of Monthly Income Benefit

a. The monthly income benefit shall be 75% of the member's monthly pay in effect on the date of release from the Canadian Forces less any applicable reductions stated in Section 55. Effective January 1, 1999, the base for calculating the LTD benefit shall be the member's monthly pay in effect on the date of release, including all retroactive pay increases with an effective date prior to the day after the member's date of release from the Canadian Forces.

b. Benefits for partial months shall be based pro rata on a 30 day month.

c. Benefits shall be increased annually on January 1st. Increases will be proportionate to the Consumer Price Index increases from the date the disability benefit payment commenced. Long Term Disability benefit increases shall be rounded to the next higher 1/4 of 1%, if not already a multiple thereof, and limited to a maximum of 2% per year.

55. Reductions

a. The monthly benefit payable shall be reduced by the sum of:
   (i) the monthly income benefits payable to the member under the Canadian Forces Superannuation Act and the primary Canada or Quebec Pension Plans (including retroactive payments);
   (ii) the earned income of the member including retroactive payments, unless the member is participating in a rehabilitation program approved by the Insurer; and
   (iii) the total monthly income benefits payable to the member under the Pension Act (including dependents benefits and retroactive payments).

b. If the sum of all monthly income benefits for any month or partial month under all sources, including the following:
   (i) The Canadian Forces Superannuation Act;
   (ii) The Canada Pension Plan or Quebec Pension Plan;
   (iii) The Defence Services Pension Continuation Act; and,
   (iv) The Pension Act

   exceeds 100% of the member's monthly pay in effect on the day disability benefits commenced, then the monthly income benefit otherwise payable for that month or partial month under this coverage will be reduced by the amount of such excess, except as provided in Subsection 55(c).

c. For disabilities occurring on or after 01 December 1973, any increase in monthly income benefits from the sources specified in subsection 55(b) shall not be included in determining the monthly income benefit under this contract, unless those increases during a given calendar year exceed cost of living adjustment plus 10% of the benefit level applicable to any such source on 31 December of the previous calendar year.

56. Duration of Benefits

Where an insured member has been totally disabled for 13 consecutive weeks, he becomes entitled to benefits on the day after the date of release from the Canadian Forces. The benefit will be payable for each succeeding month, or partial month, that such total disability continues. In the event of death of the member, the monthly benefit shall be payable for the entire month in which death occurs. The Insurer reserves the right to require evidence of continuing total disability satisfactory to the Insurer and at no expense to the Insurer.

57. Subrogation

Where the total disability of the insured member giving rise to benefits under this Part III is caused by any actionable wrong of a third party, the insured member subrogates his right of action against such third party to the Insurer and agrees to execute any documents required to perfect the subrogation.

58. Limitations and Exceptions

a. No benefits are payable for that portion of any period of disability during which the member is not under the care and treatment of a legally qualified physician or specialist other than himself. The member shall be required to be under the care of an appropriate specialist if the disabling condition necessitates such treatment. The member bears the onus of proving that he is under the care and treatment of a legally qualified physician or specialist, or alternatively that the disabling condition does not require the ongoing care and treatment of a legally qualified physician or specialist.

b. Where the disabling condition does not necessitate periodic examination of the member by the legally qualified physician who treats him, the Insurer may require the member to be examined by such physician or a physician of its choice, at such intervals as the Insurer may deem necessary for optimal treatment and/or assessment of the member's disability. If the member fails to be examined as required by the Insurer, the Insurer shall have the right to suspend payment of all benefits until such examination of the member is completed. Nothing in this section prevents the Insurer from discontinuing the payment of disability benefits upon completion of the required examination if such examination demonstrates that the member is no longer totally disabled, as defined by Section 1(h) of this policy.

c. No coverage is provided if total disability results from any of the following:
   (i) injury sustained as a result of participation in the commission of a criminal offence;
   (ii) intentionally self-inflicted injury or attempted self destruction, while sane or insane; or
   (iii) total disability commencing during the first 12 months of coverage from injuries or illness for which the member consulted a physician during the six month period immediately preceding the date he became insured under this policy.

d. Effective January 1, 1995, no benefits are payable to an insured member after he reaches the age of 65. This limitation applies only to an insured member whose claim for benefits is approved on or after January 1, 1995.

59. Rehabilitation Program Reductions

Totally disabled members in receipt of monthly benefits shall be encouraged to enter an approved rehabilitation program. If a totally disabled member receives income from a program of rehabilitation approved by the Insurer, the member's monthly benefit will be reduced by an amount equal to 50% of rehabilitative income, provided however that there shall be no reduction in monthly benefits until the member's total income from all sources, including rehabilitative income, exceeds 75% of his Equivalent Salary. When total income from all sources, including rehabilitative income, exceeds 100% of Equivalent Salary, the monthly benefit shall be reduced on a dollar for dollar basis by the amount in excess of 100%.

60. Equivalent Salary

Equivalent Salary is that salary a totally disabled member would have received if he had remained a member of the Canadian Forces at the same rank and classification as when he became disabled. The equivalent salary is determined on the date rehabilitative employment begins and remains constant during any period of approved rehabilitation.

LONG TERM DISABILITY - DISMEMBERMENT BENEFIT

61. Payment of Benefit

Upon receipt of due proof that an insured member has suffered a dismemberment or loss of sight within 365 days of and as a result of an accident, and has been released from the Canadian Forces, the Insurer will pay a monthly income benefit to the former member for a fixed benefit period as provided in Section 63 or until death, whichever occurs first. The member must be released within three years of the accident date. No benefit is payable for the first 13 weeks following the accident date.

62. Amount of Benefit - Dismemberment

The amount of monthly income benefit shall be 75% of the member's monthly pay on the date of release less any reductions described below. Benefits shall be increased annually on January 1st. Increases shall be proportionate to the Consumer Price Index increases from the date the dismemberment benefit commenced. Dismemberment benefit increases shall be rounded to the next higher 1/4 of 1%, if not already a multiple thereof, and limited to a maximum of 2% per year. Benefits for partial months shall be based pro rata on a 30 day month.

63. Schedule of Benefits - Dismemberment

a. The income benefit payable will be:

Loss	Fixed Benefit Period
Loss of both hands or feet	36 months
Loss of one hand and one foot	36 months
Loss of sight of both eyes	36 months
Loss of one hand or one foot and sight of one eye	36 months
Loss of hearing or speech	36 months
Loss of one hand or one foot	24 months
Loss of sight of one eye	12 months
Loss of thumb and index finger of the same hand	12 months

b. "Loss" as used above shall also include loss of use.

c. "Loss of sight" shall mean total and irrecoverable loss of sight.

d. In the event more than one of the losses described above results from the same accident, only one benefit period shall apply and that will be the longest period.

e. If total disability resulting from any of the above losses continues beyond the fixed benefit period for that loss, benefits hereunder shall continue to be provided in accordance with the terms and conditions of the Long Term Disability provisions of this Part III.

64. Reductions - Dismemberment

a. The monthly dismemberment benefit shall be reduced by any monthly benefits payable pursuant to the following:
   (i) The Pension Act (including dependents' benefits and retroactive payments);
   (ii) The Canadian Forces Superannuation Act; and,
   (iii) The Canada or Quebec Pension Plans (primary benefits only).

b. No dismemberment benefits shall be reduced for any rehabilitative earnings received during a fixed benefit period.

65. Exceptions and Limitations - Dismemberment

No monthly income benefits are payable for dismemberment or losses for injuries:

a. sustained while participating in the commission of a criminal offence;

b. intentionally self-inflicted or attempted self destruction, whether sane or insane;

c. resulting from an accident occurring prior to coverage under this policy; or

d. of a member who left the Canadian Forces voluntarily or retired from the Canadian Forces, at compulsory retirement age.

PROVISIONS APPLICABLE TO BOTH DISABILITY AND DISMEMBERMENT BENEFITS

66. Extension of Coverage

a. For all members receiving LTD benefits on or before December 31, 1994, Extended Coverage for sixty months duration shall be provided by the Insurer after final payment of monthly income benefits. For all members approved for and in receipt of LTD benefits on or after January 1, 1995, Extended Coverage for thirty-six months duration shall be provided by the Insurer after final payment of monthly income benefits. This extension shall commence on the earlier of the following dates:

(i) the date upon which the operation of the reduction formula for rehabilitative earnings reduces the monthly income benefit to zero; or,

(ii) The date the member ceases to be totally disabled.

b. This extended coverage shall be applicable to all forms of insurance coverage and benefits under this policy for which the member was eligible at the commencement and through the duration of the original disability, provided the member furnishes the Insurer with the results of an annual medical examination in a form satisfactory to and at no expense to the Insurer. If the member becomes totally disabled as a result of the cause for which benefits were originally paid, then benefits will be payable in accordance with the claimant's benefit level. The benefits will be subject to all applicable adjustments and reductions.

c. No Long Term Disability or Dismemberment benefits will be payable under this extension as a result of a cause separate and unrelated to that of the original disability.

67. Assignment

No member has the right to assign, alienate, encumber, or commute any payments of monthly disability income or dismemberment benefits.

68. Reimbursement of Insurer

If a member's claim for benefits under the Canadian Forces Superannuation Act, the Canada Pension Plan, the Quebec Pension Plan, the Defence Services Pension Continuation Act, or the Pension Act, on account of total disability or dismemberment is denied, the benefits under this coverage shall become payable in accordance with these terms and conditions, provided the member agrees in writing that if benefits are subsequently awarded, including retroactive benefits, to the member under any of the said Acts, the member will reimburse the Insurer to the extent that the benefits paid under this coverage exceed the benefits that would otherwise be payable.

69. Proof of Claim

a. Written proof of claim in a form satisfactory to the Insurer, covering the occurrence, character and extent of loss for which a claim for benefits is made, must be furnished to the Insurer within 120 days after the member's date of release from the Canadian Forces.

b. Written proof of the continuance of such disability must be furnished to the Insurer at such intervals as it may reasonably require and at no cost to the Insurer.

c. The Insurer shall have the right to require, as part of the proof of claim, satisfactory evidence
   (i) that the member either is not eligible or has made application for all benefits referred to in Section 68,
   (ii) that he has furnished all required proofs for such benefits, and
   (iii) of the amount of such benefits payable.

70. Payment of Claim

a. Benefits payable under this coverage shall be paid on the last day of each month during the period for which the Insurer is liable.

b. If any benefit under this Part III becomes payable to the estate of the member, the Insurer, at its option, may pay such benefit, not exceeding one month's benefit, to any relative by blood or marriage. Any payment made by the Insurer in good faith pursuant to this section shall fully discharge the Insurer to the extent of such payment.

71. Major Medical Insurance

See Part IIIB, Division 4.

PART VII - POST RETIREMENT CONTINUATION PLAN (PRCP)

103. Life Insurance Benefit

104. Optional Plans

105. Eligibility

106. Insurability

107. Premiums

108. Effective Date

109. Waiver of Premium

110. Conversion Privilege

111. Death During Eligibility Period

PART VII
POST RETIREMENT CONTINUATION PLAN (PRCP)

103. Life Insurance Benefit

a. The Insurer will pay the beneficiary of a retired member, spouse or former spouse the amount of life insurance in force on the life of the retired member, spouse or former spouse. The amount payable shall be determined in accordance with the Schedule of Insurance shown below, and shall be paid upon receipt at the Insurer's Head Office of due proof that the retired member, spouse or former spouse died while insured under this coverage.

b. Schedule of Insurance - Retired Members

Retired Member's Attained Age	Amount of Life Insurance		
	PLAN 1	PLAN 2	PLAN 3
35 or under	$50,000	$75,000	$100,000
36	49,000	73,500	98,000
37	48,000	72,000	96,000
38	47,000	70,500	94,000
39	46,000	69,000	92,000
40	45,000	67,500	90,000
41	44,000	66,000	88,000
42	43,000	64,500	86,000
43	42,000	63,000	84,000
44	41,000	61,500	82,000
45	40,000	60,000	80,000
46	39,000	58,500	78,000
47	38,000	57,000	76,000
48	37,000	55,500	74,000
49	36,000	54,000	72,000
50	35,000	52,500	70,000
51	33,000	49,500	66,000
52	31,000	46,500	62,000
53	29,000	43,500	58,000
54	27,000	40,500	54,000
55	25,000	37,500	50,000
56	23,000	34,500	46,000
57	21,000	31,500	42,000
58	19,000	28,500	38,000
59	17,000	25,500	34,000
60	15,000	22,500	30,000
61	12,000	18,000	24,000
62	9,000	13,500	18,000
63	6,000	9,000	12,000
64	5,000	7,500	10,000
65 or over	3,500	5,250	7,000

c. Schedule of Insurance - Spouse or Former Spouse

Spouse's/ Former Spouse's Attained Age	Amount of Life Insurance		
	PLAN 1	PLAN 2	PLAN 3
Under 61	$10,000	$10,000	$10,000
61 - 64 inclusive	5,000	5,000	5,000
65 and over	NIL	NIL	NIL

104. Optional Plans

a. This life insurance is offered as three optional plans, with the following premium rates:

Plan 1 - $240.00 annually
Plan 2 - $360.00 annually
Plan 3 - $480.00 annually

b. The plans shall provide the amounts of decreasing life insurance for retired members, according to the Schedule of Insurance above and the plan selected, to age 65 and whole life insurance thereafter as long as the annual premium is paid. The coverage further provides for a fixed amount of level term life insurance on spouses, as specified in the Schedule of Insurance above.

105. Eligibility

a. To be eligible for PRCP coverage a retired member must:
   i. have completed two years of continuous coverage under the Survivor Income Benefit, General Officers' Insurance Plan or Optional Term Life Insurance provisions of this policy; and
   ii. have served at least fifteen years in the Canadian Forces (Regular) immediately prior to his release date; and
   iii. either:
      1. elect to be covered by PRCP within 31 days of release from the Canadian Forces (Regular), or
      2. elect to be covered by PRCP within 31 days of the termination date of any Extension of Coverage under the Long Term Disability coverage of this policy.

b. Notwithstanding the foregoing, the PRCP is closed to new retirees as of 31 March 1981. Existing insured’s as at 31 March 1981 shall be allowed to continue this coverage or transfer to Coverage After Release in accordance with the conditions outlined in Part X of this policy.

106. Insurability

No evidence of insurability shall be required of retired members selecting Plan 1. The Insurer may require satisfactory evidence of insurability at no expense to the Insurer from those retired members selecting Plans 2 or 3.

107. Premiums

All premiums are payable annually.

108. Effective Date

The PRCP coverage of an eligible retired member shall be effective on the latest of the following dates:

a. 01 June 1974; or
b. 31 days following release from the Canadian Forces (Regular); or
c. 31 days following the termination date of any Extension of Coverage of the Long Term Disability coverage of this policy.

109. Waiver of Premium

a. The Insurer will waive the payment of premiums for the insurance of a retired member and spouse or former spouse under PRCP and will continue the insurance in force upon receipt at its Head Office of proof satisfactory to the Insurer that while insured under this coverage and prior to the retired member's sixty-fifth birthday:
   i. the retired member became totally disabled; and
   ii. the retired member has been totally and continuously disabled for six months prior to filing any claim for benefit under this provision.

b. "Total Disability" shall have the meaning given that term in Subsection 1(h).

c. Premiums will be waived during the continuance of the total disability during the lifetime of the retired member unless the retired member fails to submit proof of the continuance of total disability or fails to be examined medically, when required. The Insurer may require a medical examination of the retired member by a medical examiner designated and paid by the Insurer. Any premiums paid after the onset of total disability but prior to the expiry of the six month waiting period will be refunded to the retired member upon determination of total disability.

110. Conversion Privilege

a. A retired member, spouse or former spouse shall have the right to convert the life insurance provided by this PRCP to an individual policy to be issued by the Insurer. A retired member may exercise this privilege at any time. A spouse or former spouse must exercise this privilege within 31 days of the discontinuance of this coverage on the retired member.

b. The amount of the individual policy shall be selected by the retired member, spouse or former spouse at the time of conversion, but shall not be less than the minimum amount for which the selected Insurer issues such individual policies, and shall not exceed the amount of life insurance in force on the retired member,

spouse or former spouse at their respective attained ages in accordance with the above Schedule of Insurance and Plan selected. No evidence of insurability shall be required.

111. Death During Eligibility Period

a. If a member, spouse or former spouse dies during the 31-day eligibility period, then benefits will be paid in accordance with the provisions of the 31-day extended death benefit of the Survivor Income Benefit, General Officers' Insurance Plan, and Dependent Life Insurance sections of this contract.

b. No benefits will be paid under this PRCP even if an application and evidence of insurability have been received and approved at the Head Office of the Insurer during the 31 day period. If a Certificate of Insurance had been issued, no payment shall be made under the extended death benefit provisions listed in Subsection 111(a) unless the Certificate of Insurance is surrendered without the payment of any claim thereon.

PART VIII - MAJOR MEDICAL INSURANCE PRE-95 (MM1)

112. Eligibility

113. Deductible

114. Maximum Lifetime Benefits

115. Definitions

116. Hospital Benefits

117. Health Care Benefits

118. Exclusions

PART VIII

MAJOR MEDICAL INSURANCE (MM1)

112. Eligibility

a. The Insurer shall pay a benefit for covered expenses incurred as a result of injury or disease during a calendar year by eligible Long Term Disability claimants, Reserve Long Term Disability claimants, or eligible dependents of any of them, provided that:
   (i) none are eligible for major medical benefits from any other source, or any plan or program of any government or the Crown or of any subdivision or agency of the government or the Crown, including any plan or program established pursuant to provincial automobile insurance legislation, and
   (ii) the insured person's eligibility under this Part was established prior to 01 January, 1995. A dependent acquired after 31 December, 1994, is deemed to be an insured person under this Part if any or all members of the immediate family are insured under this Part.

b. Benefits shall be classified as either Hospital Benefits or Health Care Benefits.

113. Deductible

There shall be an annual deductible amount of $25 per family to be satisfied first as covered expenses are incurred for Health Care. If all or part of the deductible expenses are incurred during the last 3 months of the calendar year, then those expenses may be carried over as a credit toward the deductible for the next year.

114. Maximum Lifetime Benefits

The maximum lifetime benefit will be $200,000 for each insured person, representing the gross amount of benefit each insured person can receive during his lifetime, including all single, broken, and extended periods of claims. When an insured person in a family unit reaches the $200,000 lifetime limit, then all insured persons in that family unit and the total of the benefits to date shall be transferred to Part XI.

115. Definitions

The following expenses shall be covered:

a. "hospital charges" shall mean the following expenses:
   (i) charges made by a hospital for room and board; and charges of the hospital for other hospital services and supplies furnished to the claimant, beneficiary, or dependent, as the case may be, for use while confined therein (but not including charges for special nursing services or for services of physicians or surgeons);
   (ii) charges for anaesthetics and the administration thereof when incurred during hospital confinement; and
   (iii) charges for local use of an ambulance when incurred in connection with hospital confinement.

b. "convalescent care charges" shall mean the following expenses:
   (i) charges made by a convalescent care facility for room and board or services and supplies shall be considered covered expenses (i) up to a reasonable and customary standard ward accommodation charge, and (ii) for not more than a total of 180 days of confinement in a Convalescent Care Facility, per disability.
   (ii) charges for local use of an ambulance when incurred in connection with confinement in a convalescent care facility.

c. "surgical charges" shall mean the expenses incurred for a surgical procedure and for necessary post-operative treatment in connection with the surgical procedure.

d. "medical charges" shall mean expenses incurred for radioactive isotope therapy and for any other radiotherapy which does not qualify as a surgical procedure, including those other covered expenses which are not hospital charges, convalescent care charges or surgical charges as defined above.

e. charges of a "convalescent care facility" defined in this part as an institution (or a distinct part of an institution) which:
   (i) is primarily engaged in providing for inpatients (i) skilled nursing care and related services for patients who require medical or nursing care, or (ii) rehabilitation service for the rehabilitation of injured or sick persons;
   (ii) has policies, which are developed with the advice of (and with provision of review of such policies from time to time by) a group of professional personnel, including one or more physicians and one or more registered professional nurses, to govern the skilled nursing care and related medical or other services it provides;
   (iii) has a physician, a registered professional nurse, or a medical staff responsible for the execution of such policies;
   (iv) (i) has a requirement that the health care of every patient must be under the supervision of a physician, and (ii) provides for having a physician available to furnish necessary medical care in case of emergency;
   (v) maintains clinical records on all patients;
   (vi) provides nursing needs twenty-four hours a day in accordance with the policies developed as provided in sub-paragraph e(ii) above, and has at least one registered professional nurse employed full-time;
   (vii) provides appropriate methods and procedures for the dispensing and administration of drugs and biologicals;
   (viii) has in effect a utilization review plan which provides for the review, on a sample or other basis, of admissions to the institution, the duration of stays therein, and the professional services (including drugs and biologicals) furnished (i) with respect to the medical necessity of the services, and (ii) for the purpose of promoting the most efficient use of available health facilities and services, and with such review to be made by either:

(a) a staff committee of the institution composed of two or more physicians, with or without participation of other professional personnel, or,

(b) a group similarly composed which is established by the local medical society and some or all of the hospitals and convalescent care facilities in the locality; and which review provides for prompt notification to the facility, the individual, and his attending physician of any finding by the physician members of such committee or group that any further stay in the facility is not medically necessary;

(ix) is licensed pursuant to applicable provincial or local law or is approved by the appropriate provincial or local agency as meeting the standards established for such licensing; except that such term shall not include any institution which is primarily for custodial care.

116. Hospital Benefits

The Insurer shall pay claims from insured persons for charges made for any of the following items, which shall be considered covered hospital expenses, but subject to the condition that the charges are reasonable, customary and not covered by any provincial government medical insurance allowances; and such further limitations of coverage as provided in this section:

a. charges made by hospital located in Canada for room and board for each day shall be considered to the extent of the usual rate for semi-private accommodation;

b. charges made by a hospital located outside Canada for room, board, and ancillary in-patient services shall be considered covered expenses up to the reasonable and customary charge per day over any provincial government allowance, if such services are non-elective and rendered on account of emergency reasons for injury or disease occurring outside Canada, or occurring outside Canada when the required hospital facilities are unavailable within Canada; otherwise, such charges shall be considered covered expenses only up to the prevailing level of charges for such services corresponding to the province of residence of the member or dependent, as the case may be; and

c. charges made by a convalescent care facility for room and board or services and supplies shall be considered covered expenses (i) up to a reasonable and customary standard ward accommodation charge, and (ii) for not more than a total of 180 days of confinement in a Convalescent Care Facility, per illness.

117. Health Care Benefits

The Insurer shall pay claims from insured persons for all reasonable and customary charges for medical services and supplies prescribed by a licensed physician or licensed dentist to the extent that such charges are not covered by a provincial government medical insurance allowance and subject to the limitations of coverage provided in this section, including the following:

a. Drugs and medicines obtainable only on a dentist's or physician's prescription, including oral contraceptives.

b. (i) Private duty nursing service furnished in a hospital or elsewhere by the following:
   (1) a registered graduate nurse who is entitled to use the suffix "R.N." after his or her name;
   (2) a Certified Nursing Assistant who is entitled to use the suffix "C.N.A." after his or her name;
   (3) a nurse who is a member of the Victorian Order of Nurses and is entitled to use the suffix "V.O.N.," after his or her name, provided that such nurse does not ordinarily reside in the home of the insured person and is not related to the insured person by blood or marriage.

   (ii) Attendant care in the home for quadriplegics, provided that such attendant does not ordinarily reside in the home of the insured person and is not related to the insured person by blood or marriage.

c. Dental Services:
   (i) When necessitated by damage to sound, natural teeth or surrounding tissue as a result of an injury which occurs while the claimant, beneficiary or dependent, as the case may be, is insured under this coverage, or
   (ii) for the excision of impacted unerupted teeth or of a tumour or cyst, or incision and drainage of an abscess or cyst, or
   (iii) for any other oral surgical procedure not involving any tooth structure, alveolar process or gingival tissues.

d. Local use of an ambulance, other than by airline or railroad.

e. The following services and supplies:
   (i) Anaesthetics and oxygen and the administration thereof;
   (ii) Rental (or, at the Insurer's option, purchase) of iron lung, oxygen tent, hospital bed, wheel chair and similar durable medical equipment designed primarily for use in a hospital for therapeutic purposes;
   (iii) Blood and blood plasma, and the administration thereof, to the extent the charges therefor are not reduced by blood donations;
   (iv) Braces, crutches and prostheses when necessitated by an injury which occurs, or by a disease which commences, while the claimant, beneficiary, or dependent, as the case may be, is insured under this coverage, including charges for replacement when required because of pathological change, but not including charges for repair or maintenance;
   (v) X-ray examinations and laboratory tests;
   (vi) Physiotherapy;
   (vii) Emergency transportation by airline or railroad to the nearest hospital qualified to provide the necessary treatment, subject to a maximum expense of $200.00 in any period of 12 consecutive month period;
   (viii) For the fitting or cost of eye glasses or hearing aid when necessitated by damage to the natural eye or ear as a result of an injury which occurs while the claimant, beneficiary or dependent, as the case may be, is insured under this coverage;

(ix) Repairs and maintenance to wheelchairs and other technical aids subject to a maximum expenditure of $500 per annum, upon written recommendation by the Rehabilitation Coordinator.

f. Medical treatment or surgical procedure by a physician.

g. Charges made for the services of physicians and surgeons, rendered outside Canada,

(i) in the case of such services which are non-elective and rendered for emergency reasons for injury or disease occurring outside Canada, only to the extent that the charges are reasonable and customary, according to the area in which the services are rendered; and

(ii) in the case of such services which are non-elective and rendered for emergency reasons for injury or disease occurring in Canada but where required services are not available in Canada, only to the extent that the charges are reasonable and customary, according to the area in which the services are rendered; otherwise, such charges shall be considered covered expenses only up to the prevailing fee for the same services as indicated in the Provincial Medical Association Schedule of Fees corresponding to the province of residence of the claimant, beneficiary or dependent, as the case may be.

h. Charges made by a licensed speech therapist, clinical psychologist, osteopath, chiropractor or podiatrist shall be considered covered expenses only up to a maximum of 20 treatments in any calendar year, for all treatments received by any one individual from any one category of said practitioners.

i. Charges made for the services of a licensed physiotherapist or professional masseur as prescribed by a legally qualified physician.

j. Charges made for the services of an ophthalmologist or optometrist, but limited to one eye refraction per person every 24 consecutive months.

118. Exclusions

No Health Care Benefits shall be payable for the following services or supplies or expenses:

a. For general health examinations including those for insurance or employment purposes;

b. Dental treatment, except as indicated above;

c. Services not approved or prescribed by a physician;

d. Treatment or prescriptions resulting from declared or undeclared war, riot or insurrection;

e. Expenses not normally incurred when a person is not insured;

f. Hospital or surgical expenses primarily for cosmetic purposes; and,

g. Treatments resulting from an intentionally self-inflicted injury or illness.

PART XI - MAJOR MEDICAL INSURANCE POST-94 (MM2)

149. Eligibility

150. Deductible

151. Maximum Lifetime Benefits

152. Payment of Benefits

153. Definitions

154. Hospital Benefits

155. Extended Health Care Benefits

156. Exclusions

PART XI

MAJOR MEDICAL INSURANCE (MM2)

149. Eligibility

a. The Insurer shall pay a benefit for covered expenses incurred as a result of injury or disease during a calendar year by eligible Long Term Disability claimants, Reserve Long Term Disability claimants, or eligible dependents, provided that:
   (i) none are eligible for major medical benefits from any other source, or any plan or program of any government or the Crown or of any subdivision or agency of the government or the Crown, including any plan or program established pursuant to provincial automobile insurance legislation, and
   (ii) the insured person's eligibility under this Part was established subsequent to 31 December, 1994 or,
   (iii) the insured person's eligibility under this Part is as a result of being transferred from Part VIII.

b. Benefits shall be classified as either Hospital Benefits or Extended Health Care Benefits.

c. There will be no new entrants to the Major Medical Plan subsequent to 31 March 2006.

150. Deductible

There shall be an annual deductible amount of $60 per insured person and $100 per family unit to be satisfied first as covered expenses are incurred for Extended Health Care. If all or part of the deductible expenses are incurred during the last three months of the calendar year, then those expenses may be carried over as a credit toward the deductible for the next year.

151. Maximum Lifetime Benefit

The maximum lifetime benefit will be $1,000,000, for each insured person, representing the gross amount of benefit each insured person can receive during his lifetime, including all single, broken, and extended periods of claims, and including amounts transferred from Part VIII, if applicable.

152. Payment of Benefits

a. The Insurer will reimburse:
   (i) 100% of the eligible expenses under Section 154;
   (ii) 80% of the eligible expenses under Subsections 155 a. to d.;
   (iii) 100% of the eligible expenses under Paragraph 155 e.(i);
   (iv) 80% of the eligible expenses under Paragraph 155 e.(ii);
   when proof satisfactory to the Insurer has been received that the insured person has incurred any of the eligible expenses defined in these provisions for medically necessary services.

153. Definitions

a. "hospital charges" shall mean the following expenses:
   (i) charges made by a hospital for room and board; and charges of the hospital for other hospital services and supplies furnished to the claimant, beneficiary, or dependent, as the case may be, for use while confined therein (but not including charges for special nursing services or for the services of physicians or surgeons and excluding hospital charges referred to as co-insurance charges or user fees);
   (ii) charges for anaesthetics and the administration thereof when incurred during hospital confinement; and
   (iii) charges for local use of an ambulance when incurred in connection with hospital confinement.

b. "surgical charges" shall mean the expenses incurred for a surgical procedure and for necessary post-operative treatment in connection with the surgical procedure.

c. "medical charges" shall mean expenses incurred for radioactive isotope therapy and for any other radiotherapy which does not qualify as a surgical procedure, including those other covered expenses which are not hospital charges, or surgical charges as defined above.

d. "Insurer" means The Manufacturers Life Insurance Company.

e. "calendar year" means January 1 to December 31.

f. "family unit" means a member and his covered dependants.

g. 'Hospital" means a legally licensed hospital which provides facilities for diagnosis, major surgery and the care and treatment of a person suffering from disease or injury on an in-patient basis, with 24 hour services by registered nurses and physicians. This includes legally licensed hospitals providing specialized treatment for mental illness, drug and alcohol addiction, cancer, arthritis and convalescing or chronically ill persons. This does not include nursing homes, homes for the aged, rest homes or other places providing similar care.

h. "physician" means a doctor of medicine (M.D.) legally licensed to practise medicine.

i. "reasonable and customary charges" mean those which are usually made to a person without coverage for the items of expense listed which do not exceed the general level of charges in the area where the expense is incurred, as determined by the Insurer.

j. "nurse" means a registered nurse, registered nursing assistant, licensed practical nurse, and certified nursing assistant who is listed on the appropriate provincial registry and in the absence of such registry, a nurse with comparable qualifications as determined by the Insurer.

k. "dentist" means a person licensed to practise dentistry by the provincial licensing authority, or in the absence of such authority, a person with comparable qualifications as determined by the Insurer.

l. "chiropodist/podiatrist" means a person licensed by the appropriate provincial licensing authority or in those provinces where there is no licensing authority, members of the Canadian Association of Foot Professionals, or in the absence of such association, a person with comparable qualifications as determined by the Insurer.

m. "chiropractor" means a member of the Canadian Chiropractic Association or of a provincial association affiliated with it, or in the absence of such association, a person with comparable qualifications as determined by the Insurer.

n. "electrologist" means a person who, as determined by the Insurer, qualifies as a certified electrologist.

o. "naturopath" means a member of the Canadian Naturopathic Association or any provincial association affiliated with it, or in the absence of such association, a person with comparable qualifications as determined by the Insurer.

p. "osteopath" means a person who holds the degree of doctor of osteopathic medicine from a college of osteopathic medicine approved by the Canadian Osteopathic Association, or in the absence of such association, a person with comparable qualifications as determined by the Insurer.

q. "physiotherapist" means a member of the Canadian Physiotherapy Association or of a provincial association affiliated with it, or in the absence of such association, a person with comparable qualifications as determined by the Insurer.

r. "psychologist" means a permanently certified psychologist who is listed on the appropriate provincial registry in the province where the service is rendered, or in the absence of such registry, a person with comparable qualifications as determined by the Insurer.

s. "registered massage therapist" means a person licensed by the appropriate provincial licensing body or in the absence of a provincial licensing body, a person whose qualifications the Insurer determines to be comparable with those required by a licensing body.

t. "speech language pathologist" means a person who holds a master's degree in speech language pathology and is a member or is qualified to be a member of the Canadian Speech and Hearing Association or any provincial association affiliated with it, or in the absence of such registry, a person with comparable qualifications as determined by the Insurer.

u. "ophthalmologist" means a person licensed to practice ophthalmology.

v. "optometrist" means a member of the Canadian Association of Optometrists or of a provincial association associated with it, or in the absence of such association, a person with comparable qualifications as determined by the Insurer.

154. Hospital Benefits

The Insurer shall pay claims from insured persons for charges made for any of the following items, which shall be considered covered hospital expenses, but subject to the condition that the charges are reasonable, customary and not covered by any provincial government medical insurance allowances; and such further limitations of coverage as provided in this section:

(i) hospital charges for an insured person residing outside Canada mean the reasonable and customary charges for hospital room and board other than standard ward charges (ie: semi-private accommodation) up to the maximum of $100 per day of hospitalization excluding hospital charges referred to as coinsurance charges or user fees.

(ii) hospital charges for all other insured persons mean the reasonable and customary charges for semi-private hospital room and board charges in excess of the charges for public ward up to the maximum of $100 per day of hospitalization, excluding hospital charges referred to as coinsurance charges or user fees.

155. Extended Health Care Benefits

The Insurer shall pay claims from insured persons for all reasonable and customary charges for medical services and supplies to the extent that such charges are not covered by provincial government medical insurance allowance, and subject to the limitations of coverage provided in this section, including the following:

a. Drug Benefit: Drugs and medicines obtainable only on a dentist's or physician's prescription, including, but not limited to:

(i) oral contraceptives;

(ii) injectable drugs, including allergy serums administered by injection;

(iii) needles, syringes and chemical diagnostic aids for the treatment of diabetes;

(iv) drug delivery devices to deliver asthma medication, which are integral to the product, and approved by the Insurer.

b. Vision Care Benefit: The reasonable and customary charges for the following items of vision care expense:

(i) eye examinations by an optometrist limited to one examination in a 24 month period; and

(ii) eye glasses and contact lenses that are necessary for the correction of the vision and are prescribed by an opthomologist or

optometrist, and repairs to them, limited to a maximum of $200.00 every 24 month period.

c. Paramedical Practitioner's Benefit: To be eligible, the expenses must be medically necessary for the treatment of disease or injury. Services of those practitioners designated require a prescription. Eligible expenses for the services of a practitioner include only those services which are within his area of expertise and require the skills and qualifications of such a practitioner. Eligible expenses are the reasonable and customary charges for the services of the following practitioners limited to the maximum eligible expense specified for each practitioner:

(i) a physiotherapist on the prescription of a physician;

(ii) a registered massage therapist to a maximum of $300.00 in a calendar year;

(iii) a speech language pathologist on the prescription of a physician to a maximum of $500.00 in a calendar year;

(iv) a psychologist on the prescription of a physician to a maximum of $1000.00 in a calendar year;

(v) a chiropractor to a maximum of $500.00 in a calendar year;

(vi) an osteopath to a maximum of $300.00 in a calendar year;

(vii) a naturopath to a maximum of $300.00 in a calendar year;

(viii) a podiatrist or chiropodist to a maximum of $300.00 in a calendar year; and

(ix) an electrologist on the prescription of a psychiatrist or psychologist and limited to treatment for removal of excessive hair from exposed areas of the face and neck when the patient suffers from severe emotional trauma as a result of this condition and limited to a maximum of $20.00 per visit. This also includes treatment when performed by a physician.

d. Miscellaneous Expense Benefits: To be eligible, the expenses must be medically necessary for the treatment of disease or injury and prescribed by a physician, unless otherwise specified. Eligible expenses are the reasonable and customary charges for the items of expense listed below:

(i) private duty nursing services where such services are rendered in the patient’s private residence or elsewhere by a nurse or attendant care in the home for quadriplegics, provided that such nurse or attendant does not ordinarily reside in the home of the insured person and is not related to the insured person by blood or marriage, and subject to a maximum of $15,000.00 in a calendar year;

(ii) dental services:

(a) the services of a dental surgeon and charges for dental prosthesis required for the treatment of a fractured jaw or for the treatment of accidental injuries to natural teeth if the fracture or injury was caused by external, violent and accidental injury or blow other than an accident associated with normal acts such as cleaning, chewing and eating, provided the treatment occurred within 12 months following the accident.

(b) for the excision of impacted unerupted teeth or of a tumour or cyst, or incision and drainage of an abscess or cyst.

(c) for any other oral surgical procedure not involving any tooth structure, alveolar process or gingival tissues.

(iii) the initial purchase of eye glasses, contact lenses or hearing aids if required as a direct result of surgery or an accident when the purchase is made within six months of such surgery or accident. This time limit may be extended if, as determined by the Insurer, the purchase could not have been made within the time frame specified.

(iv) licensed ground ambulance service to the nearest hospital equipped to provide the required treatment when the physical condition of the patient prevents the use of another means of transportation.

(v) emergency air ambulance service to the nearest hospital equipped to provide the required treatment when the physical condition of the patient prevents the use of another means of transportation.

(vi) orthopedic shoes which are an integral part of a brace or specifically constructed for the patient including modifications to such shoes, provided the shoes or modifications is prescribed in writing by a physician or a podiatrist, subject to a maximum total eligible expense in any one calendar year of the lesser of:

(a) the total charges less the average cost of regular footwear as determined by the Insurer, or

(b) $150.00 in a calendar year.

(vii) hearing aids and repairs to them, excluding batteries, limited to a maximum of $500.00 every 60 month period.

(viii) trusses, crutches, splints, casts and cervical collars.

(ix) braces which contain either metal or hard plastic excluding dental braces and braces used primarily for athletic use.

(x) orthopedic brassieres limited to a maximum of $100.00 per calendar year.

(xi) breast prosthesis following mastectomy and a replacement limited to once every 24 month period.

(xii) wigs, when the patient is suffering from total hair loss as a result of an illness or disease limited to a maximum expense of $500.00 per lifetime.

(xiii) colostomy, ileostomy, and tracheostomy supplies and catheters and drainage bags for incontinent, paraplegic or quadriplegic patients.

(xiv) temporary artificial limbs.

(xv) artificial eyes and permanent artificial limbs to replace temporary artificial limbs and replacements thereof but not within

(a) 60 months of the last purchase in the case of a member or dependent over 21 years of age, or

(b) 12 months of the last purchase in the case of a dependent 21 years of age or less, unless medically proven that growth or shrinkage of surrounding tissue requires replacement of the existing prosthesis.

(xvi) oxygen and its administration.

(xvii) insulin pumps and associated equipment for insulin dependent diabetes, when prescribed for a patient by a physician associated with a recognized centre for the treatment of diabetes at a university teaching centre in Canada, excluding repair or

replacement during the 60 month period following the date of purchase of such equipment.

(xviii) blood glucose monitors for insulin dependent diabetes and for non-insulin dependent diabetes if legally blind or colour blind, excluding repair or replacement during the 60 month period following the date of purchase of such equipment.

(xix) rental, or purchase at the Insurer's option, of durable equipment manufactured specifically for medical use and which is required for temporary and therapeutic use in the patient's private residence. Eligible equipment must be approved by the Insurer and includes, but is not limited to, items such as

(a) walkers,
(b) hospital beds,
(c) apnea monitors,
(d) alarms systems for eneuritic patients.

Reimbursement will be limited to the cost of non-motorized equipment unless specifically proven that the patient requires motorized equipment.

(xx) rental, or purchase at the Insurer's option, of a wheelchair required for therapeutic use in the patient's private residence. Reimbursement will be limited to the cost of non-motorized equipment unless specifically proven that the patient requires motorized equipment. Repairs and maintenance of a purchased wheelchair are eligible expenses but limited to a maximum expenditure of $500 per calendar year for a manual wheelchair and $1000 per calendar year for a power wheelchair.

(xxi) physician services where such services are not eligible for reimbursement under the participant's provincial health insurance plan, but where such services would be eligible for reimbursement under one or more other provincial health insurance plans.

(xxii) bandages and surgical dressings required for the treatment of an open wound or ulcer.

(xxiii) elasticized support stockings and elasticized apparel for burn victims manufactured to individual patient specifications or having a minimum compression of 30mm.

(xxiv) orthotics, limited to one pair in a calendar year.

(xxv) acupuncture treatments performed by a physician.

(xxvi) electrolysis treatments performed by a physician limited to (i) treatment for removal of excessive hair from exposed areas of the face and neck when the patient suffers from severe emotional trauma as a result of this condition, and (ii), a maximum of $20.00 per visit.

e. Out-of-Province Benefit

(i) Emergency Benefit While Travelling: The Insurer shall pay claims from insured persons for the reasonable and customary charges in excess of the amount payable by a provincial health insurance plan, for the following items of expense if they are required for emergency treatment of an injury or disease which occurs while travelling on vacation or business outside the province of residence for a period not exceeding 40 days from the date of departure from

the province of residence limited to the maximum eligible expense of $100,000 per period of travel:

(a) public ward accommodation and auxiliary hospital services in a general hospital;

(b) services of a physician;

(c) one way economy air fare for the patient's return to his province of residence. One way economy air fare for a professional attendant accompanying the participant is also included where medically required;

(d) medical evacuation, which may include ambulance services, when suitable care, as determined by the Insurer, is not available in the area where the emergency occurred;

(e) family assistance benefits, including reimbursement for the cost of:

(i) return transportation for covered dependent children under age 16 who are left unattended because the participant or the participant's covered spouse is hospitalized. If necessary an escort will be provided to accompany the dependent children. The maximum payable is the cost of economy air fare;

(ii) return transportation if a family member is hospitalized and as a result the family members are unable to return home on the originally scheduled flight, and must purchase new return tickets. The extra cost of the return air fare is payable, to a maximum of the cost of economy air fare;

(iii) a visit of a relative if the family member is hospitalized for more than seven days while travelling alone. This includes economy air fare, meals and accommodations to a maximum of $150 per day, for a spouse, parent, child, brother or sister. This benefit also covers expenses incurred if it is necessary to identify a deceased family member prior to release of the body;

(iv) meals and accommodations if the participant or a covered dependent's trip is extended due to hospitalization of a family member. The additional expenses incurred by accompanying family members for accommodations and meals are provided to a maximum of $150 per day;

The combined maximum payable for family assistance benefits is $2,500 for any one travel emergency;

f. return of the deceased in the event of death of a family member. The necessary authorizations will be obtained and arrangements made for the return of the deceased to the province of residence. The maximum payable for the preparation and return of the deceased is $3,000.

(i) Referral Benefit: The Insurer shall pay claims from insured persons for the reasonable and customary

charges in excess of the amount payable by a provincial health insurance plan, for the following items of expense provided they are performed following written referral by the attending physician in the patient's province of residence and are not offered in the province of residence, subject to the annual deductible and limited to the maximum eligible expense of $25,000 per illness:

(a) public ward accommodation and auxiliary hospital services in a general hospital;

(b) services of a physician or surgeon.

156. Exclusions

No benefit shall be payable for:

a. Medical examinations including those for insurance, school, camp, association, employment, passport or similar purposes;

b. Dental treatment, except as indicated above;

c. Services not approved or prescribed by a physician where required;

d. Treatment or prescriptions resulting from declared or undeclared war, riot or insurrection;

e. Expenses not normally incurred when a person is not insured or for services or products normally rendered without charge;

f. Services or products for cosmetic purposes only, or for conditions not detrimental to health, except those required as a result of accidental injury;

g. Treatments resulting from an intentionally self-inflicted injury or illness;

h. Items purchased primarily for athletic use;

i. Expenses for services and supplies rendered or prescribed by a person who is ordinarily a resident in the patient's home, or who is related to the patient by blood or marriage;

j. Experimental products or treatments for which substantial evidence provided through objective clinical testing of the product's or treatment's safety and effectiveness for the purpose and under the conditions of the use recommended does not exist to the Insurer's satisfaction;

k. Benefits which are legally prohibited by the government from coverage;

l. Any single purchase of drugs which would not reasonably be used within 90 days from date of purchase;

m. Vitamins (except injectables), vitamin supplements, minerals, protein supplements, dietary supplements or diet foods, except as specifically included above;

n. Infant foods;

o. Sugar or salt substitutes;

p. Lozenges, mouth washes, non-medicated shampoos, contact lens care products and skin cleansers, protectives, or emollients;

q. Transport or travel, other than as specifically provided;

r. Services provided by a physician licensed and practicing in Canada where the insured person is eligible to be insured under a provincial health insurance plan, except for such services which are specifically included above;

s. The portion of charges which are payable under a provincial health insurance plan or a provincially sponsored program;

t. The portion of charges for services rendered or supplies provided in a hospital outside of Canada, that would normally be payable under a provincial health or hospital plan if the services or products had been rendered in a hospital in Canada. This limitation does not apply to the "Out-of-Province Benefit";

u. The portion of charges which is the legal liability of any other party;

v. Contraceptives, other than oral;

w. Expenses incurred outside the insured person's province of residence if they are required for the emergency treatment of an injury or disease which occurred more than 40 days after the date of departure from the province of residence;

x. "Emergency Benefit While Travelling" incurred by an insured person who is temporarily or permanently residing outside Canada; and,

y. Expenses for the regular treatment of an injury or disease which existed prior to the insured person's departure from his province of residence.

PART XIII - PRE-DECEMBER 1, 1999

RESERVE LONG TERM DISABILITY INSURANCE (Res LTD)

RESERVE MEMBER DISABILITY BENEFIT

RESERVE LONG TERM DISABILITY - DISMEMBERMENT BENEFIT

PROVISIONS APPLICABLE TO BOTH DISABILITY AND DISMEMBERMENT BENEFITS

PART XIII

RESERVE LONG TERM DISABILITY INSURANCE (Res LTD)

RESERVE MEMBER DISABILITY BENEFIT

170. Eligibility

Reserve Long Term Disability insurance under this Part XIII is available to:

a. members of the Canadian Forces Primary Reserve on Class "A" or short term Class "B" reserve service; and

b. members of the Canadian Forces (Primary Reserve) on Class "B" reserve service of more than 180 days.

171. How Eligible Members Become Insured

a. An eligible member may apply for Reserve Long Term Disability coverage by complying with the terms stated in Section 4."

b. Evidence of insurability satisfactory to the Insurer and at no expense to the Insurer shall be required in all circumstances.

172. Coverage Available

a. Eligible members on Class "A" or short-term Class "B" reserve service may apply for:

i. basic coverage which is based on a deemed monthly salary of $2000 and effective October 3, 2011 $2,700; or

ii. optional coverage which is based on a deemed monthly salary of $3000 or $4000 and effective October 3, 2011 $3,700 or $4,700. If the member selects the optional coverage he shall provide to the Insurer or the Policyowner arms-length written substantiation of employment income, other than income earned through reserve service (which income combined with the income earned through reserve service, merits a deemed monthly salary nearest to $3,000 or $4,000 and effective October 3, 2011 $3,700 or $4,700, satisfactory to the Insurer or the Policyowner and without expense to the Insurer or the Policyowner.

b. Eligible members on Class "B" reserve service of more than 180 days may apply for coverage equal to 75% of the member's monthly salary in effect on the date of release from the Canadian Forces less any reductions as described in Section 177.

173. Definition of "On Duty"

a. A member will be considered "on duty" during the performance of reserve service for which the member is authorized and entitled to pay, including:

i. Reserve Force training or duty at a local headquarters including parades, local demonstrations or local exercises, including the necessary travelling time to proceed directly to and return directly from the place where the activities are to be performed. The travel time will be deemed to take place immediately prior to and immediately after the required duty times;

ii. Reserve Force training/duty at other than a designated local area. The member is deemed to be "on duty" for reserve service while proceeding directly to the duty location, during the performance of authorized activities at the duty location, and returning directly from the duty location; and

iii. periods of continuous reserve service. In these instances, "on duty" coverage will equate to 24 hour, full time coverage provided the member is authorized for such service and is receiving the entitled pay for such continuous service.

b. The Reserve Force member on Class "B" reserve service of more than 180 days will be considered "on duty" twenty-four hours, seven days a week.

174. Benefit in Event of Total Disability

An insured member will be eligible to receive a monthly income benefit if he has become totally disabled, as defined in Subsection 1.h. for 13 consecutive weeks or more and is released from the Canadian Forces while still totally disabled. Upon receipt of proof of the foregoing satisfactory to the Insurer, the Insurer will commence payment.

175. Amount of Monthly Income Benefit

a. The amount of monthly income benefit to which a totally disabled insured member is entitled shall be determined according to the following schedule, and shall be subject to Section 177.

b. Schedule of Benefits

Each member on Class "A" or short term Class "B" reserve service.	The monthly income benefit shall be equal to 75% of the Member's deemed monthly salary of $2,000 and effective October 3, 2011 $2,700 or optional amounts of $3,000 or $4,000 and effective October 3, 2011 $3,700 or $4,700 in effect on the date of release from the Canadian Forces.
Each member on long term Class "B" reserve service.	The monthly income benefit shall be equal to 75% of the member's monthly salary in effect on the date of release from the Canadian Forces.

Effective 01 January 1999, the base for calculating the LTD benefit shall be the member's monthly pay in effect on the date of release, including all retroactive pay increases with an effective date prior to the day after the member's date of release from the Canadian Forces.

c. Benefits shall be increased annually on 1 January in conjunction with increases in the Consumer Price Index for Canada. Increases will be proportionate to the Consumer Price Index increases from the date the disability benefit payments commenced and shall be rounded to the next higher 1/4 of 1%, if not already a multiple thereof, and limited to a maximum of 2% per year. Benefits for partial months shall be based pro rata on a 30 day month.

176. Duration of Benefits

The disability income benefit becomes payable the day after the date of release from the Canadian Forces, provided the member has been totally disabled for thirteen consecutive weeks. The benefit will be payable for each succeeding month or partial month that such total disability continues, until the member's 65th birthday. The Insurer reserves the right to require evidence of continuing total disability, at no expense to the Insurer. In the event of death of the member, the monthly benefit shall be payable for the entire month in which death occurs.

177. Reductions

a. The amount of monthly benefit payable shall be reduced by the sum of:
   i. the monthly income benefits payable to the member under the Canadian Forces Superannuation Act and the Canada or Quebec Pension Plans (including retroactive payments);
   ii. the earned income of the member including retroactive payments, unless the member is participating in a rehabilitation program approved by the Insurer;
   iii. the total monthly income benefits payable to the member under the Pension Act (including dependents' benefits and retroactive payments); and
   iv. the monthly income benefits payable under similar coverage provided through another employer or as a result of different employment, workers' compensation benefits, benefits receivable under any regulation concerning automobile insurance, and employer pension plan benefits.

b. If the sum of all monthly income benefits for any month or partial month from all sources indicated above exceeds 100% of the member's monthly salary for long term Class "B" members or the deemed monthly salary for other members in effect on the day disability benefits commence, then the disability benefit otherwise payable for that month or partial month will be reduced by the amount of such excess, except as provided in Subsection 177.c.

c. Any increase in monthly income benefits from the sources indicated above shall not be included in determining the monthly income benefit payable under this contract, unless those increases during a given calendar year exceed cost of living adjustments plus 10% of the benefit level applicable to any such source on 31 December of the previous calendar year.

178. Rehabilitation Program Reductions

Totally disabled members in receipt of monthly benefits shall be encouraged to enter an approved rehabilitation program. If a totally disabled member receives income from a program of rehabilitation approved by the Insurer, the member's monthly benefit will be reduced by an amount equal to 50% of rehabilitative income, provided however that there shall be no reduction in monthly benefits until the member's total income from all sources, including rehabilitative income, exceeds 75% of his Equivalent Salary. When total income from all sources, including rehabilitative income, exceeds 100% of Equivalent Salary, the monthly benefit shall be reduced on a dollar for dollar basis by the amount in excess of 100%.

179. Equivalent Salary

For long term Class "B" members, equivalent salary is that salary a totally disabled member received at release from the Canadian Forces. For Class "A" members and short term Class "B" members, equivalent salary is equal to the applicable deemed salary levels. The equivalent salary is determined on the date rehabilitative employment begins and remains constant during any period of approved rehabilitation.

180. Subrogation

Where the total disability of the insured member giving rise to benefits under this policy is caused by any actionable wrong of a third party, the insured member subrogates his right of action against such third party to the Insurer and undertakes to execute any document required to perfect the subrogation.

181. Limitations and Exceptions

a. No benefits shall be payable for any period of disability during which the member is not under the care and treatment of a legally qualified physician or specialist other than himself. A member shall be required to be under the care of an appropriate specialist if the disabling condition necessitates such specialized treatment. The member bears the onus of proving that he is under the care and treatment of a legally qualified physician or specialist, or alternatively that the disabling condition does not require the ongoing care and treatment of a legally qualified physician or specialist.

b. Where the disabling condition does not necessitate periodic examination of the member by the legally qualified physician who treats him, the Insurer may require the member to be examined by such physician or a physician of its choice, at such intervals as the Insurer may deem necessary for optimal treatment and/or assessment of the member's disability. If the member fails to be examined as required by the Insurer, the Insurer shall have the right to suspend payment of all benefits until such examination of the member is completed. Nothing in this section prevents the Insurer from discontinuing the payment of disability benefits upon completion of the required examination if such examination demonstrates that the member is no longer totally disabled, as defined by Section 1.h. of this policy.

c. No coverage is provided if total disability results from any of the following:
   i. injury sustained as a result of participation in the commission of a criminal offence;
   ii. intentionally self-inflicted injury or attempted self destruction, while sane or insane; or
   iii. total disability commencing during the first 12 months of coverage from injuries or sickness for which the member consulted a physician during the 6 month period immediately preceding the date he became insured under this policy.

RESERVE LONG TERM DISABILITY - DISMEMBERMENT BENEFIT

182. Reserve Long Term Disability - Dismemberment Benefit

Upon receipt of due proof that an insured member has suffered a dismemberment within 365 days of and as a result of an accident and has been released from the Canadian Forces, the Insurer will pay a monthly income benefit to the former member for a fixed benefit period, as provided in Subsection 183.b., or until death, whichever occurs first. The member must be released within three years of the accident date and no benefit is payable for the first 13 weeks following the accident date.

183. Amount of Benefit - Dismemberment

a. The amount of monthly income benefit shall be 75% of the member's monthly pay (or deemed monthly pay if on Class "A" or short term Class "B" reserve service) on the date of release less any reductions described below. Benefits shall be increased annually on 1 January in conjunction with increases in the Consumer Price Index for Canada. Increases shall be proportionate to the Consumer Price Index increases from the date the dismemberment benefit commenced. Dismemberment benefit increases shall be rounded to the next higher 1/4 of 1%, if not already a multiple thereof, and limited to a maximum of 2% per year. Benefits for partial months shall be based pro rata on a 30 day month.

b. Schedule of Benefits - Dismemberment

The income benefit payable will be:

Loss	Benefit Period
Loss of both hands or feet	36 months
Loss of one hand and one foot	36 months
Loss of sight of both eyes	36 months
Loss of one hand or one foot and sight of one eye	36 months
Loss of hearing or speech	36 months
Loss of one hand or one foot	24 months
Loss of sight of one eye	12 months
Loss of thumb and index finger of the same hand	12 months

c. "Loss" as used above shall also mean loss of use.

d. "Loss of sight" shall mean total and irrecoverable loss of sight.

e. In the event more than one of the losses described above results from the same accident, only one benefit period shall apply and that will be the longest period.

f. If total disability resulting from any of the above losses continues beyond the fixed benefit period for that loss, benefits hereunder shall continue to be provided in accordance with the terms and conditions of the Reserve Long Term Disability provisions of this Part XIII.

184. Reductions - Dismemberment

a. The amount of any monthly dismemberment benefit shall be reduced by the sum of any monthly benefits payable pursuant to the following:
   i. The Pension Act (including dependents' benefits and retroactive payments);
   ii. The Canadian Forces Superannuation Act;
   iii. The Canada or Quebec Pension Plans; and
   iv. Monthly income benefits payable under similar coverage provided through another employer or as a result of different employment, workers compensation benefits, benefits receivable under any regulation concerning automobile insurance and employer pension plan benefits.

b. No dismemberment benefits shall be reduced for any rehabilitative earnings received during a fixed benefit period.

185. Exceptions and Limitations - Dismemberment

No benefits are payable for dismemberment or losses for injuries:
   a. sustained while participating in the commission of a criminal offence;
   b. intentionally self-inflicted or attempted self destruction, whether sane or insane;
   c. resulting from an accident occurring prior to coverage under this policy;
   d. of a member who left the Canadian Forces voluntarily or retired from the Canadian Forces at compulsory retirement age.

PROVISIONS APPLICABLE TO BOTH DISABILITY AND DISMEMBERMENT BENEFITS

186. Extension of Coverage

a. Extended coverage of up to twelve months duration shall be provided by the Insurer after final payment of monthly income benefits. This extension shall commence on the earlier of the following dates:

   i. the date upon which the operation of the reduction formula for rehabilitative earnings reduces the monthly income benefit to zero; or

   ii. the date the member ceases to be totally disabled.

b. This extended coverage shall be applicable to all forms of insurance coverage and benefits under this policy for which the member was eligible at the commencement and throughout the duration of the original disability, provided the member furnishes the Insurer with the results of an annual medical examination, in form satisfactory and at no expense to the Insurer. If the member becomes totally disabled during this 12 month period, as a result of the cause for which benefits were originally paid, then benefits will be payable in accordance with the claimant's pre-employment benefit level. The benefit would be subject to any and all applicable adjustments and reductions.

c. No Long Term Disability or Dismemberment benefits will be payable under this extension as a result of a cause separate and unrelated to that of the original disability.

187. Assignment

No member has the right to assign, alienate, encumber, or commute any payment of monthly disability
income or dismemberment benefits.

188. Reimbursement of Insurer

If a member's claim for benefits under the Canadian Forces Superannuation Act, the Canada Pension Plan, the Quebec Pension Plan, Defence Services Pension Continuation Act, the Pension Act, other employer insurance, workers' compensation, any regulation concerning automobile insurance or employer pension plan, on account of total disability or dismemberment is denied, the benefits under this coverage shall become payable in accordance with its terms and conditions, provided the member agrees in writing that if benefits are subsequently awarded, under any of said Acts and programs (including retroactive benefits), the member will reimburse the Insurer to the extent the benefits paid under this coverage exceed the benefits that would otherwise be payable.

189. Proof of Claim

a. Written proof of claim in a form satisfactory to the Insurer, covering the occurrence, character and extent of loss for which a claim for benefits is made, must be furnished to the Insurer within 120 days after the member's date of release from the Canadian Forces.

b. Written proof of the continuance of such disability must be furnished to the Insurer at such intervals as it may reasonably require at no cost to the Insurer.

c. The Insurer shall have the right to require satisfactory evidence
   (i) that the member either is not eligible, or has made application, for all benefits referred to in Section 188; and
   (ii) that he has furnished all required proofs for such benefits; and
   (iii) of the amount of such benefits payable.

190. Payment of Claim

a. Benefits payable under this coverage shall be paid on the last day of each month during the period for which the Insurer is liable.

b. If any benefit under this Part XIII becomes payable to the estate of the member, the Insurer, at its option, may pay such benefit, not exceeding one month's benefit, to any relative by blood or marriage. Any payment made by the Insurer in good faith pursuant to this section shall fully discharge the Insurer to the extent of such payment.

191. Major Medical Insurance

See Parts VIII and XI.

PART XV - MAJOR MEDICAL INSURANCE (MM)

PART XV

MAJOR MEDICAL INSURANCE (MM)

207. Eligibility

a. The Insurer shall pay a benefit for covered expenses incurred as a result of injury or disease during a calendar year by eligible Survivor Income beneficiaries, or eligible dependents of these beneficiaries, provided that none are eligible for major medical benefits from any other source, or any plan or program of any government or the Crown or of any subdivision or agency of the government or the Crown, including any plan or program established pursuant to provincial automobile insurance legislation. Eligible dependents are as defined in Subsection 1(b).

b. Benefits shall be classified as either Hospital Benefits or Extended Health Care Benefits.

208. Deductible

There shall be an annual deductible amount of $25 per family to be satisfied first as covered expenses are incurred for Extended Health Care. If all or part of the deductible expenses are incurred during the last 3 months of the calendar year, then those expenses may be carried over as a credit toward the deductible for the next year. The deductible applies per calendar year to the combined eligible expenses.

209. Maximum Lifetime Benefit

The maximum lifetime benefit will be $100,000, for each insured person, representing the gross amount of benefit each insured person can receive during his lifetime, including all single, broken, and extended periods of claims.

210. Payment of Benefits

a. The Insurer will reimburse:
   (i) 100% of the eligible expenses under Section 212
   (ii) 100% of the eligible expenses under Subsections 213 (a) to (d);
   (iii) 100% of the eligible expenses under Paragraph 213 (e) (i);
   (iv) 100% of the eligible expenses under Paragraph 213 (e) (ii);
   when proof, satisfactory to the Insurer, has been received that the insured person has incurred any of the eligible expenses defined in these provisions for medically necessary services.

211. Definitions

a. "hospital charges" shall mean the following expenses:
   (i) charges made by a hospital for room and board; and charges of the hospital for other hospital services and supplies furnished to the claimant, beneficiary, or dependent, as the case may be, for use while confined therein (but not including charges for special nursing services or for services of physicians or surgeons);
   (ii) charges for anaesthetics and the administration thereof when incurred during hospital confinement; and
   (iii) charges for local use of an ambulance when incurred in connection with hospital confinement.

b. "surgical charges" shall mean the expenses incurred for a surgical procedure and for necessary post-operative treatment in connection with the surgical procedure.

c. "medical charges" shall mean expenses incurred for radioactive isotope therapy and for any other radiotherapy which does not qualify as a surgical procedure, including those other covered expenses which are not hospital charges, or surgical charges as defined above.

d. "Insurer" means The Manufacturers Life Insurance Company.

e. "calendar year" means January 1 to December 31.

f. "family unit" means a member and his covered dependants.

g. 'Hospital" means a legally licensed hospital which provides facilities for diagnosis, major surgery and the care and treatment of a person suffering from disease or injury on an in-patient basis, with 24 hour services by registered nurses and physicians. This includes legally licensed hospitals providing specialized treatment for mental illness, drug and alcohol addiction, cancer, arthritis and convalescing or chronically ill persons. This does not include nursing homes, homes for the aged, rest homes or other places providing similar care.

h. "physician" means a doctor of medicine (M.D.) legally licensed to practice medicine.

i. "reasonable and customary charges" mean those which are usually made to a person without coverage for the items of expense listed which do not exceed the general level of charges in the area where the expense is incurred, as determined by the Insurer.

j. "nurse" means a registered nurse, registered nursing assistant, licensed practical nurse, and certified nursing assistant who is listed on the appropriate provincial registry and in the absence of such registry, a nurse with comparable qualifications as determined by the Insurer.

k. "dentist" means a person licensed to practise dentistry by the provincial licensing authority, or in the absence of such authority, a person with comparable qualifications as determined by the Insurer.

l. "chiropodist/podiatrist" means a person licensed by the appropriate provincial licensing authority or in those provinces where there is no licensing authority, members of the Canadian Association of Foot Professionals, or in the absence of such association, a person with comparable qualifications as determined by the Insurer.

m. "chiropractor" means a member of the Canadian Chiropractic Association or of a provincial association affiliated with it, or in the absence of such association, a person with comparable qualifications as determined by the Insurer.

n. "electrologist" means a person who, as determined by the Insurer, qualifies as a certified electrologist.

o. "naturopath" means a member of the Canadian Naturopathic Association or any provincial association affiliated with it, or in the absence of such association, a person with comparable qualifications as determined by the Insurer.

p. "osteopath" means a person who holds the degree of doctor of osteopathic medicine from a college of osteopathic medicine approved by the Canadian Osteopathic Association, or in the absence of such association, a person with comparable qualifications as determined by the Insurer.

q. "physiotherapist" means a member of the Canadian Physiotherapy Association or of a provincial association affiliated with it, or in the absence of such association, a person with comparable qualifications as determined by the Insurer.

r. "psychologist" means a permanently certified psychologist who is listed on the appropriate provincial registry in the province where the service is rendered, or in the absence of such registry, a person with comparable qualifications as determined by the Insurer.

s. "registered massage therapist" means a person licensed by the appropriate provincial licensing body or in the absence of a provincial licensing body, a person whose qualifications the Insurer determines to be comparable with those required by a licensing body.

t. "speech language pathologist" means a person who holds a master's degree in speech language pathology and is a member or is qualified to be a member of the Canadian Speech and Hearing Association or any provincial association affiliated with it, or in the absence of such registry, a person with comparable qualifications as determined by the Insurer.

u. "ophthalmologist" means a person licensed to practise ophthalmology.

v. "optometrist" means a member of the Canadian Association of Optometrists or of a provincial association associated with it, or in the absence of such association, a person with comparable qualifications as determined by the Insurer.

212. Hospital Benefits

The Insurer shall pay claims from insured persons for charges made for any of the following items, which shall be considered covered hospital expenses, but subject to the condition that the charges are reasonable, customary and not covered by any provincial government medical insurance allowances; and such further limitations of coverage as provided in this section:

(i) hospital charges for an insured person residing outside Canada mean the reasonable and customary charges for hospital room and board other than standard ward charges (ie: semi-private accommodation) up to the maximum of $100 per day of hospitalization excluding hospital charges referred to as coinsurance charges or user fees.

(ii) hospital charges for all other insured persons mean the reasonable and customary charges for semi-private hospital room and board charges in excess of the charges for public ward up to the maximum of $100 per day of hospitalization, excluding hospital charges referred to as coinsurance charges or user fees.

213. Extended Health Care Benefits

The Insurer shall pay claims from insured persons for all reasonable and customary charges for medical services and supplies to the extent that such charges are not covered by provincial government medical insurance allowance, and subject to the limitations of coverage provided in this section, including the following:

a. Drug Benefit: Drugs and medicines obtainable only on a dentist's or physician's prescription, including, but not limited to:
   (i) oral contraceptives;
   (ii) injectable drugs, including allergy serums administered by injection;
   (iii) needles, syringes and chemical diagnostic aids for the treatment of diabetes;
   (iv) drug delivery devices to deliver asthma medication, which are integral to the product, and approved by the Insurer.

b. Vision Care Benefit: The reasonable and customary charges for the following items of vision care expense:
   (i) eye examinations by an optometrist limited to one examination in a 24 month period; and
   (ii) eye glasses and contact lenses that are necessary for the correction of the vision and are prescribed by an opthomologist or optometrist, and repairs to them, limited to a maximum of $200.00 every 24 month period.

c. Paramedical Practitioner's Benefit: To be eligible, the expenses must be medically necessary for the treatment of disease or injury. Services of those practitioners designated require a prescription. Eligible expenses for the services of a practitioner include only those services which are within his area of expertise and require the skills and qualifications of such a practitioner. Eligible expenses are the reasonable and customary charges for the services of the following practitioners limited to the maximum eligible expense specified for each practitioner:
   (i) a physiotherapist on the prescription of a physician;

(ii) a registered massage therapist to a maximum of $300.00 in a calendar year;
(iii) a speech language pathologist on the prescription of a physician to a maximum of $500.00 in a calendar year;
(iv) a psychologist on the prescription of a physician to a maximum of $1000.00 in a calendar year;
(v) a chiropractor to a maximum of $500.00 in a calendar year;
(vi) an osteopath to a maximum of $300.00 in a calendar year;
(vii) a naturopath to a maximum of $300.00 in a calendar year;
(viii) a podiatrist or chiropodist to a maximum of $300.00 in a calendar year; and
(ix) an electrologist on the prescription of a psychiatrist or psychologist and limited to treatment for removal of excessive hair from exposed areas of the face and neck when the patient suffers from severe emotional trauma as a result of this condition and limited to a maximum of $20.00 per visit. This also includes treatment when performed by a physician.

d. Miscellaneous Expense Benefits: To be eligible, the expenses must be medically necessary for the treatment of disease or injury and prescribed by a physician, unless otherwise specified. Eligible expenses are the reasonable and customary charges for the items of expense listed below:
(i) private duty nursing service furnished in a hospital or elsewhere by a nurse or attendant care in the home for quadriplegics, provided that such nurse or attendant does not ordinarily reside in the home of the insured person and is not related to the insured person by blood or marriage, and
(ii) dental services:
(a) the services of a dental surgeon and charges for dental prosthesis required for the treatment of a fractured jaw or for the treatment of accidental injuries to natural teeth if the fracture or injury was caused by external, violent and accidental injury or blow other than an accident associated with normal acts such as cleaning, chewing and eating, provided the treatment occurred within 12 months following the accident.
(b) for the excision of impacted unerupted teeth or of a tumour or cyst, or incision and drainage of an abscess or cyst.
(c) for any other oral surgical procedure not involving any tooth structure, alveolar process or gingival tissues.
(iii) the initial purchase of eye glasses, contact lenses or hearing aids if required as a direct result of surgery or an accident when the purchase is made within six months of such surgery or accident. This time limit may be extended if, as determined by the Insurer, the purchase could not have been made within the time frame specified.
(iv) licensed ground ambulance service to the nearest hospital equipped to provide the required treatment when the physical condition of the patient prevents the use of another means of transportation.
(v) emergency air ambulance service to the nearest hospital equipped to provide the required treatment when the physical condition of the patient prevents the use of another means of transportation.

(vi) orthopaedic shoes which are an integral part of a brace or specifically constructed for the patient including modifications to such shoes, provided the shoes or modifications is prescribed in writing by a physician or a podiatrist, subject to a maximum total eligible expense in any one calendar year of the lesser of:
    (a) the total charges less the average cost of regular footwear as determined by the Insurer, or
    (b) $150.00 in a calendar year.

(vii) hearing aids and repairs to them, excluding batteries, limited to a maximum of $500.00 every 60 month period.

(viii) trusses, crutches, splints, casts and cervical collars.

(ix) braces which contain either metal or hard plastic excluding dental braces and braces used primarily for athletic use.

(x) orthopaedic brassieres limited to a maximum of $100.00 per calendar year.

(xi) breast prosthesis following mastectomy and a replacement limited to once every 24 month period.

(xii) wigs, when the patient is suffering from total hair loss as a result of an illness or disease limited to a maximum expense of $500.00 per lifetime.

(xiii) colostomy, ileostomy, and tracheostomy supplies and catheters and drainage bags for incontinent, paraplegic or quadriplegic patients.

(xiv) temporary artificial limbs.

(xv) artificial eyes and permanent artificial limbs to replace temporary artificial limbs and replacements thereof but not within
    (a) 60 months of the last purchase in the case of a member or dependent over 21 years of age, or
    (b) 12 months of the last purchase in the case of a dependent 21 years of age or less, unless medically proven that growth or shrinkage of surrounding tissue requires replacement of the existing prosthesis.

(xvi) oxygen and its administration.

(xvii) insulin pumps and associated equipment for insulin dependent diabetes, when prescribed for a patient by a physician associated with a recognized centre for the treatment of diabetes at a university teaching centre in Canada, excluding repair or replacement during the 60 month period following the date of purchase of such equipment.

(xviii) blood glucose monitors for insulin dependent diabetes and for non-insulin dependent diabetes if legally blind or colour blind, excluding repair or replacement during the 60 month period following the date of purchase of such equipment.

(xix) rental, or purchase at the Insurer's option, of durable equipment manufactured specifically for medical use and which is required for temporary and therapeutic use in the patient's private residence. Eligible equipment must be approved by the Insurer and includes, but is not limited to, items such as
    (a) walkers,
    (b) hospital beds,
    (c) apnea monitors,
    (d) alarms systems for eneuritic patients.

Reimbursement will be limited to the cost of non-motorized equipment unless specifically proven that the patient requires motorized equipment.

(xx) rental, or purchase at the Insurer's option, of a wheelchair required for therapeutic use in the patient's private residence. Reimbursement will be limited to the cost of non-motorized equipment unless specifically proven that the patient requires motorized equipment.

Repairs and maintenance of a purchased wheelchair are eligible expenses but limited to a maximum of $500 per calendar year for a manual wheelchair and $1000 per calendar year for a power wheelchair.

(xxi) physician services where such services are not eligible for reimbursement under the participant's provincial health insurance plan, but where such services would be eligible for reimbursement under one or more other provincial health insurance plans.

(xxii) bandages and surgical dressings required for the treatment of an open wound or ulcer.

(xxiii) elasticized support stockings and elasticized apparel for burn victims manufactured to individual patient specifications or having a minimum compression of 30mm.

(xxiv) orthotics, limited to one pair in a calendar year.

(xxv) acupuncture treatments performed by a physician.

(xxvi) electrolysis treatments performed by a physician limited to (i) treatment for removal of excessive hair from exposed areas of the face and neck when the patient suffers from severe emotional trauma as a result of this condition, and (ii), a maximum of $20.00 per visit.

e. Out-of-Province Benefit

(i) Emergency Benefit While Travelling: The Insurer shall pay claims from insured persons for the reasonable and customary charges in excess of the amount payable by a provincial health insurance plan, for the following items of expense if they are required for emergency treatment of an injury or disease which occurs while travelling on vacation or business outside the province of residence for a period not exceeding 40 days from the date of departure from the province of residence limited to the maximum eligible expense of $100,000 per period of travel:

(a) public ward accommodation and auxiliary hospital services in a general hospital;

(b) services of a physician;

(c) one way economy air fare for the patient's return to his province of residence. One way economy air fare for a professional attendant accompanying the participant is also included where medically required;

(d) medical evacuation, which may include ambulance services, when suitable care, as determined by the Insurer, is not available in the area where the emergency occurred;

(e) family assistance benefits, including reimbursement for the cost of:

(ii) return transportation for covered dependent children under age 16 who are left unattended because the participant or the participant's covered spouse is hospitalized. If necessary an escort will be provided to accompany the dependent children. The maximum payable is the cost of economy air fare;

(iii) return transportation if a family member is hospitalized and as a result the family members are unable to return home on the originally scheduled flight, and must purchase new return tickets. The extra cost of the return air fare is payable, to a maximum of the cost of economy air fare;

(iv) a visit of a relative if the family member is hospitalized for more than seven days while travelling alone. This includes economy air fare, meals and accommodations to a maximum of $150 per day, for a spouse, parent, child, brother or sister. This benefit also covers expenses incurred if it is necessary to identify a deceased family member prior to release of the body;

(v) meals and accommodations if the participant or a covered dependant's trip is extended due to hospitalization of a family member. The additional expenses incurred by accompanying family members for accommodations and meals are provided to a maximum of $150 per day;

The combined maximum payable for family assistance benefits is $2,500 for any one travel emergency;

(f) return of the deceased in the event of death of a family member. The necessary authorizations will be obtained and arrangements made for the return of the deceased to the province of residence. The maximum payable for the preparation and return of the deceased is $3,000.

(ii) Referral Benefit: The Insurer shall pay claims from insured persons for the reasonable and customary charges in excess of the amount payable by a provincial health insurance plan, for the following items of expense provided they are performed following written referral by the attending physician in the patient's province of residence and are not offered in the province of residence, subject to the annual deductible and limited to the maximum eligible expense of $25,000 per illness:

(a) public ward accommodation and auxiliary hospital services in a general hospital;

(b) services of a physician or surgeon.

214. Exclusions

No benefit shall be payable for:

a. Medical examinations including those for insurance, school, camp, association, employment, passport or similar purposes;

b. Dental treatment, except as indicated above;

c. Services not approved or prescribed by a physician where required;

d. Treatment or prescriptions resulting from declared or undeclared war, riot or insurrection;

e. Expenses not normally incurred when a person is not insured or for services or products normally rendered without charge;

f. Services or products for cosmetic purposes only, or for conditions not detrimental to health, except those required as a result of accidental injury;
g. Treatments resulting from an intentionally self-inflicted injury or illness;
h. Items purchased primarily for athletic use;
i. Expenses for services and supplies rendered or prescribed by a person who is ordinarily a resident in the patient's home, or who is related to the patient by blood or marriage;
j. Experimental products or treatments for which substantial evidence provided through objective clinical testing of the product's or treatment's safety and effectiveness for the purpose and under the conditions of the use recommended does not exist to the Insurer's satisfaction;
k. Benefits which are legally prohibited by the government from coverage;
l. Any single purchase of drugs which would not reasonably be used within 90 days from date of purchase;
m. Vitamins (except injectables), vitamin supplements, minerals, protein supplements, dietary supplements or diet foods, except as specifically included above;
n. Infant foods;
o. Sugar or salt substitutes;
p. Lozenges, mouth washes, non-medicated shampoos, contact lens care products and skin cleansers, protectives, or emollients;
q. Transport or travel, other than as specifically provided;
r. Services provided by a physician licensed and practicing in Canada where the insured person is eligible to be insured under a provincial health insurance plan, except for such services which are specifically included above;
s. The portion of charges which are payable under a provincial health insurance plan or a provincially sponsored program;
t. The portion of charges for services rendered or supplies provided in a hospital outside of Canada, that would normally be payable under a provincial health or hospital plan if the services or products had been rendered in a hospital in Canada. This limitation does not apply to the "Out-of-Province Benefit";
u. The portion of charges which is the legal liability of any other party;
v. Contraceptives, other than oral;
w. Expenses incurred outside the insured person's province of residence if they are required for the emergency treatment of an injury or disease which occurred more than 40 days after the date of departure from the province of residence;
x. "Emergency Benefit While Travelling" incurred by an insured person who is temporarily or permanently residing outside Canada; and,
y. Expenses for the regular treatment of an injury or disease which existed prior to the insured person's departure from his province of residence.