CANADIAN BAPTIST

GROUP BENEFIT FLEX PLAN

for active employees of

CBM Office staff, CBOQ and FBU

BENEFIT DETAILS

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

Great-West Life Online

Information and details on Great-West Life's corporate profile, our products and services, investor information, news releases and contact information can all be found at our website **www.greatwestlife.com**.

Great-West Life Online Services for Plan Members

As a Great-West Life plan member, you can also register for GroupNet™ for Plan Members at **www.greatwestlife.com**.

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

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

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

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

Great-West Life's Toll-Free Number

Contact a customer service representative at Great-West Life:

- For assistance with your medical and dental coverage, please call 1-800-957-9777.
- For assistance with your Health Care Spending Account, please call 1-877-883-7072.

Choices

This booklet describes the principal features of the group benefit plan sponsored by your employer, but **Group Policy Nos. 156241 and 156243** issued by Great-West Life and **Group Policy Nos. 37223** and **34297** issued by Manulife Financial are the governing documents. If there are variations between the information in the booklet and the provisions of any of the policies, the policies will prevail.

This booklet in either its paper or electronic form is provided for information purposes only and does not create or confer any contractual rights or obligations.

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

The Plan is underwritten by

THE Great-West Life ASSURANCE COMPANY

and

Manulife Financial
For your future™

04-13

Access to Documents

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

Legal Actions

Every action or proceeding against an insurer for the recovery of insurance money payable under the contract is absolutely barred unless commenced within the time set out in the Insurance Act or other applicable legislation (e.g. *Limitations Act, 2002* in Ontario, Quebec Civil Code).

Appeals

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

Benefit Limitation for Overpayment

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

PROTECTING YOUR PERSONAL INFORMATION

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

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

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

We may exchange personal information with your health care providers, your plan administrator, any insurance or reinsurance companies, administrators of government benefits or other benefit programs, other organizations, or service providers working with us or the above when relevant and necessary to administer the plan.

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

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

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

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YOU SHOULD KNOW

Effective Date of Plan –	July 1, 2012
Covered Classes –	Active employees of CBM, CBOQ and FBU

IMPORTANT

The coverages described in this group benefits plan are insured under Group Policy Nos. 156241 and 156243 issued to the Contractholder by Great-West Life. They are available to you if you are included in the covered classes shown above. Only those coverages for which you become covered will apply to you.

The basic and optional Accidental Death and Dismemberment Insurance and the optional Critical Illness Insurance is insured under Group Policy Nos. 37223 and 34297 issued by Manulife Financial.

Preferred Vision Services (PVS) described in this group benefit plan is a service provided by Great-West Life to its customers through Preferred Vision Services. It does not form part of the contract issued to the Contractholder by Great-West Life.

This booklet is a description of the group benefits at the date shown on the front cover.

CONFORMATION WITH LAW

If any provision of this group plan conflicts with any law which applies to individuals shown in the covered classes, the plan will be amended to conform to that law.

COST

You will be advised of the amount of your contribution, if any, when you enroll for the coverage.

WAITING PERIOD

You will become eligible for coverage as follows:

- All employees of CBM and FBU, and CBOQ Executive Staff and pastors: on the date of your employment.
- Non-executive staff of CBOQ: on the first day of the month following your completion of 90 days of employment.

The coverages are described in the Benefit Summary and the coverage description pages. Be sure to read these pages carefully. They show when benefits are or are not payable, and outline the conditions, limitations and exclusions that apply to the coverages.

RETIREMENT

Certain coverages are continued through your retirement. You may contact your plan administrator for full details.

BENEFIT SUMMARY

COVERAGES FOR YOU AND YOUR ELIGIBLE DEPENDENTS

This summary must be read together with the benefits described in this booklet.

	GREEN LEAF OPTION	ORANGE LEAF OPTION	BLUE LEAF OPTION
Member Basic Life Insurance			
Amount	$25,000	$40,000	2x your annual earnings to a maximum of $500,000
Reduction	Coverage reduces to $5,000 at age 65 and reduces to $2,500 at age 70.		
Dependent Basic Life Insurance			
Spouse	$5,000	$10,000	$20,000
Child	$2,000	$4,000	$6,000
Reduction at Member's Age 65			
Spouse	$2,500	$5,000	$5,000
Child	$1,000	$2,000	$3,000
Termination	Coverage terminates when you reach age 70.		
Optional Life Insurance			
Member and Spouse	Available in $10,000 units to a maximum of $500,000, for you or your spouse, subject to approval of evidence of insurability. If you are covered under this plan as both a member and a spouse, you are limited to the $500,000 maximum.		
Child	Available in $2,000 units to a maximum of $20,000.		

Long Term Disability Income Benefits			
Waiting Period	119 days		
Amount	67% of your monthly earnings to a maximum monthly benefit of $5,000.		
Tax Status	Taxable		
Termination	Age 65		

	GREEN LEAF OPTION	ORANGE LEAF OPTION	BLUE LEAF OPTION
Healthcare			
Deductible	Nil		
Reimbursement Levels			
Global Medical Assistance Expenses	100%		
Visioncare Expenses	Not covered	100% to limits specified below	
In-Canada Prescription Drug Expenses			
- Dispensing Fee	100% up to a maximum $5		
Drug Charge: - "Formulary" Drug Plan Expenses - "Non-Formulary Drug Plan Expenses	70% 50%	80% 60%	90% 70%
Out-of-Pocket Maximum	If out-of-pocket drug expenses exceed the applicable limit (per person, described below) in a calendar year, eligible drug expenses will be reimbursed at 100% for the remainder of that calendar year.		
Out-of-Pocket Limit	$2,000	$1,000	$500
	Out-of-Pocket Maximum for Quebec Residents: An out-of-pocket maximum is applied to in-province expenses for drugs listed in the *Liste de médicaments* published by the *Régie del'assurance-maladie du Québec* if you live in Quebec (provincial formulary drug expenses). If the sum of the non-reimbursable amounts you are required to pay for provincial formulary drug expenses incurred for you and your dependent children or for your spouse in a calendar year reaches the maximum out-of-pocket level established by law, the amount payable for provincial formulary drug expenses incurred for the same individuals for the rest of the calendar year will be adjusted as follows: 1. Reimbursement will be made at 100%. 2. No further out-of-pocket amounts will apply. The out-of-pocket maximum does not apply to drug expenses incurred outside Quebec.		
All Other Expenses	70%	80%	100%

	GREEN LEAF OPTION	ORANGE LEAF OPTION	BLUE LEAF OPTION
Basic Expense Maximums			
Home Nursing Care	$5,000 every 3 calendar years		$10,000 each calendar year
Home Nursing Care Limit	Beginning on your 65th birthday, the maximum is limited to a lifetime maximum of $5,000, reduced by the amount paid during the previous 3 calendar years.		Not Applicable
Drugs Used To Treat Erectile Dysfunction	Not covered	$1,200 each calendar year	
Hearing Aids	Not covered	$300 every 4 years	$600 every 5 years
Custom-fitted Orthopedic Shoes and Custom-made Foot Orthotics	Not covered	$300 every calendar year	
Myoelectric Arms	$10,000 per prosthesis		
External Breast Prosthesis	1 initial prosthesis and 1 replacement every 2 calendar years		
Surgical Brassieres	2 each calendar year		
Mechanical or Hydraulic Patient Lifters	$2,000 per lifter once every 5 years		
Outdoor Wheelchair Ramps	$2,000 lifetime		
Blood-glucose Monitoring Machines	1 every 4 years		
Insulin Infusion Pumps	$5,000 per pump once every 5 years		
Insulin Jet Injectors	Not covered	$1,000 lifetime	
Transcutaneous Nerve Stimulators	$700 lifetime		
Extremity Pumps for Lymphedema	$1,500 lifetime		
Custom-made Compression Hose	2 pair each calendar year		
Wigs			
- For Cancer Patients	$100 lifetime		
- For Alopecia Totalis	$250 lifetime		
Accidental Dental Injury	Included	Not covered (covered under Dentalcare)	
Ambulance (Including Air Ambulance)	Included		
Diagnostic Supplies	Included		

	GREEN LEAF OPTION	ORANGE LEAF OPTION	BLUE LEAF OPTION
Paramedical Expense Maximums			
Acupuncturists	Not covered	$500 each calendar year	$750 each calendar year
Chiropractors	$200 each calendar year	$500 each calendar year	$750 each calendar year
Physiotherapists	$1,000 each calendar year	Unlimited	Unlimited
Massage Therapists	$200 each calendar year	$500 each calendar year	$750 each calendar year
Naturopaths	$200 each calendar year	$500 each calendar year	$750 each calendar year
Osteopaths	$200 each calendar year	$500 each calendar year	$750 each calendar year
Homeopaths	Not covered	Not covered	$750 each calendar year
Podiatrists	Not covered	$500 each calendar year	$750 each calendar year
Psychologists/Social Workers	$200 each calendar year	$500 each calendar year	$750 each calendar year
Speech Therapists	$200 each calendar year	$500 each calendar year	$750 each calendar year
Occupational Therapists	Not covered	Not covered	$750 each calendar year
Visioncare Expense Maximums			
Eye Examinations	Not covered	$50 every 24 months	$90 every 24 months
Glasses, Contact Lenses and Laser Eye Surgery			
- Dependent Children Under Age 18	Not covered	$150 every 12 months	$200 every 12 months
- All Others	Not covered	$150 every 24 months	$200 every 24 months
Out-of-Country Emergency Care Expense Maximum	$1,000,000 per emergency		
Global Medical Assistance Expenses	Included		
Lifetime Healthcare Maximum	Unlimited		

	GREEN LEAF OPTION	ORANGE LEAF OPTION	BLUE LEAF OPTION
Dentalcare			
Payment Basis	Not covered	The dental fee guide in effect in your province of residence on the date treatment is rendered.	
Deductible	Not covered	Nil	
Reimbursement Levels			
Basic Coverage	Not covered	80%	90%
Major Coverage	Not covered	Not covered	60%
Orthodontic Coverage	Not covered	Not covered	50%
Accidental Dental Injury Coverage	Not covered	100%	
Plan Maximums			
Basic Treatment	Not covered	$2,000 each calendar year	$2,000 each calendar year combined with Major Treatment
Major Treatment	Not covered	Not covered	$2,000 each calendar year combined with Basic Treatment
Orthodontic Treatment	Not covered	Not covered	$2,000 lifetime
Accidental Dental Injury Treatment	Not covered	Unlimited	
Recall Examinations	Not covered	Once every 12 months for adults, once every 6 months for eligible children.	
Health Care Spending Account			
You Only	$500	$250	Not included
You + 1 Dependent	$1,000	$500	Not included
You + 2 or More Dependents	$1,600	$700	Not included

DEFINITIONS

The following definitions apply throughout this group benefit plan unless a term is defined differently within a specific coverage for the purposes of that coverage.

ACTIVELY AT WORK means you are not disabled according to the definition of disability under this policy's long term disability income benefit, and be either (a) actually working at the employer's place of business or a place where the employer's business requires you to work, or (b) absent due to vacation, weekends, statutory holidays, or shift variances.

ACTIVE EMPLOYEES means those who are permanently employed and work a minimum of 20 hours per week.

BENEFITS means any amounts which become payable under a coverage.

CALENDAR YEAR means January 1 through December 31.

CONTRACT means Group Insurance Policy No. 156241 or No. 156243.

CONTRACTHOLDER means Canadian Baptist Ministries in its capacity as the Policyholder of Group Insurance Policy Nos. 156241 and 156243.

DEDUCTIBLE is the amount of eligible charges shown in the Benefit Summary which must be paid by or on behalf of a covered person in any calendar year before reimbursement will be made under a coverage. There is no deductible under this plan.

DEPENDENT CHILD means your unmarried children under age 22 or under age 25 if they are full-time students. For Quebec residents, full-time students are covered for prescription drug benefits until age 26.

- Children under age 22 are not covered if they are working more than 30 hours a week, unless they are full-time students.

- Children who are incapable of supporting themselves because of physical or mental disorder are covered without age limit if the disorder begins before they turn 22 or while they are students under 25, and the disorder has been continuous since that time.

ELIGIBLE DEPENDENT means your spouse and dependent children.

EMPLOYER means the Contractholder and any of its affiliated or associated employers and churches as defined by the Contractholder which have been approved by Great-West Life for inclusion under the contract.

GREAT-WEST LIFE means The Great-West Life Assurance Company.

MEMBER/PLAN MEMBER is an employee participating in this group insurance plan.

PHYSICIAN means a person, other than an insured or a member of the insured's family, who is a licensed medical doctor in the province where the medical care is received and who gives medical care within the scope of that license.

PROVINCE or PROVINCIAL refers to any province or territory of Canada.

REIMBURSEMENT LEVEL is the percentage of eligible charges shown in the Benefit Summary, which will be reimbursed under a coverage after satisfaction of the deductible.

SICKNESS means disease or illness.

SPOUSE means your legal, common-law or former spouse.

- A common-law spouse is a person who has been living with you in a conjugal relation for at least 36 months, or if you are a Quebec resident, until the earlier birth or adoption of a child of the relationship.

- A former spouse means your divorced or ex-common-law spouse for whom insurance protection for some of the benefits available under the employer's benefit program is mandated by court order.

YOU refers to the employee of the employer as shown in the covered classes on the You Should Know page.

INFORMATION ABOUT YOUR FLEX PLAN

- Option changes and changes in amounts of optional life insurance take effect on the enrolment date coinciding with or next following the date the application for the change is made, unless the change results from a change in family status. If it does, the option change will take effect on the date the application for the change is made, as long as it is made within 31 days of the status change. Otherwise, the change will not take effect until the following re-enrolment date.

  The first re-enrolment date is January 1, 2014. Subsequent re-enrolment occurs every 2 years after that.

  For all increases in optional life insurance (whether as a result of a family status change or otherwise), you must provide proof of insurability and your application for the increase must be approved by Great-West Life.

- You can move up or down to any option on any re-enrolment date. This restriction is waived if the change is due to a family status change.

- If you experience a change in family status during a plan year that affects your coverage needs, you may make changes to your benefit options that directly relate to your status change without waiting for the next re-enrolment period. Any of the following is considered a change in family status:

  - acquiring your first dependent (spouse or child);
  - acquiring a spouse if you have child coverage only;
  - acquiring your first child (birth, adoption or step-child) if you have spouse coverage only;
  - involuntary loss of similar coverage through your spouse's group benefit program (for example, because of a change in your spouse's employment status);
  - death of your spouse or only child;
  - your spouse or only child ceasing to qualify for coverage (for example, through divorce or your child's attainment of a limiting age – see Dependent Coverage in this booklet).

Note: See your plan administrator for details no later than 31 days after a change in family status occurs. Certain conditions apply.

COMMENCEMENT AND TERMINATION OF COVERAGE

You are eligible to participate in the plan when you have completed your Waiting Period as outlined on the page headed “You Should Know.”

- You must be actively at work when coverage takes effect, otherwise the coverage will not be effective until you return to work.

  Increases in your benefits while you are covered by this plan will not become effective unless you are actively at work.

- Temporary and seasonal employees may not join the plan.

Your coverage terminates when your employment ends, you are no longer eligible, you stop paying the required premiums, or the policy terminates, whichever is earliest.

- Your dependents' coverage terminates when your insurance terminates or your dependent no longer qualifies, whichever is earlier.

- When your coverage terminates, you may be entitled to an extension of benefits under the plan. Your plan administrator will provide you with details.

SURVIVOR BENEFITS

If you die while your coverage is still in force, the health and dental benefits for your dependents will be continued until the earliest of:

- the date your dependents no longer qualify;
- if you are a CBM or an FBU employee, 24 months after your death;
- if you are a CBOQ employee, the date your surviving spouse attains the age of 65; or
- the due date of the first premium to which a premium payment has not been made.

WHEN YOU HAVE A CLAIM

MEMBER BASIC OR OPTIONAL LIFE INSURANCE

To submit a Member Basic or Optional Life Insurance claim, your beneficiary must complete the Life Claim form which is available from your plan administrator. Documents necessary to submit with the form are listed on the form.

To submit a claim for the Waiver of Premium benefit, you must complete a Waiver of Premium claim form which is available from your plan administrator. Your attending physician must also complete a portion of this form. A completed claim form must be submitted within 6 months from the end of the qualifying period.

LONG TERM DISABILITY

Obtain an Employee Claim Submission Guide (form M4307B) from your employer and follow the guide's instructions. Return the completed form to your employer as soon as possible, but no later than 6 months after proof of your claim has been requested.

TO MAKE A HEALTH CLAIM

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

Claims must be submitted to Great-West Life as soon as possible, but no later than 15 months after you incur the expense.

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

For all other Healthcare claims, access GroupNet for Plan Members to obtain a personalized claim form or obtain form M635D from your employer. Complete this form making sure it shows all required information.

Attach your receipts to the claim form and return it to the Great-West Life Benefit Payment Office as soon as possible, but no later than 15 months after you incur the expense.

For drug claims, your employer will provide you with a prescription drug identification card. Present your card to the pharmacist with your prescription.

Before your prescription is filled, an Assure Claims check will be done. Assure Claims is a series of seven checks that are electronically done on your drug claim history for increased safety and compliance monitoring. This has been designed to improve the health and quality of life for you and your dependents. Checks done include drug interaction, therapeutic duplication and duration of therapy, allowing the pharmacist to assess and take action if needed prior to the drug being dispensed. Depending on the outcome of the checks, the pharmacist may refuse to dispense the prescribed drug.

When your coverage ends, return your direct pay drug identification card to your employer.

Claims for out-of-country expenses (other than those for Global Medical Assistance expenses) should be submitted to Great-West Life as soon as possible after the expense is incurred. It is very important that you send your claims to the Great-West Life Out-of-Country Claims Department immediately as your Provincial Medical Plan has very strict time limitations.

Access GroupNet for Plan Members to obtain a personalized claim form or obtain form M5432 (Statement of Claim Out-of-Country Expenses form) from your employer. Unless you are a resident of the Territories you must also obtain the Government Assignment form, and residents of British Columbia, Quebec and Newfoundland & Labrador must also obtain the Special Government Claim form. The Great-West Life Out-of-Country Claims Department will forward the appropriate government forms to your attention when required.

If you are a resident of the Territories, you must submit your out-of-country claims to your territorial government for processing before submitting the claim to Great-West Life. When you receive your Explanation of Benefits back from the territory, please send the following to the Great-West Life Out-of-Country Claims Department (be sure to keep copies for your own records):

- a copy of the payment from your territory,
- a completed Statement of Claim Out-of-Country Expenses form (form M5432),
- all required information,
- copies of all original receipts.

Residents of the provinces should complete all applicable forms, making sure all required information is included. Attach all original receipts and forward the claim to the Great-West Life Out-of-Country Claims Department. Be sure to keep a copy for your own records. The plan will pay all eligible claims including your Provincial Medical Plan portion. Your Provincial Medical Plan will then reimburse the plan for the government's share of the expenses.

Out-of-country claims must be submitted within a certain time period that varies by province. For the claims submission period applicable in your province or territory or for any other questions or for assistance in completing any of the forms, please contact Great-West Life's Out-of-Country Claims Department at 1-800-957-9777.

TO MAKE A DENTAL CLAIM

Claims for expenses incurred in Canada may be submitted online. Access GroupNet for Plan Members to obtain a personalized claim form or obtain form M445D from your employer and have your dental service provider complete the form. The completed claim form will contain the information necessary to enter the claim online. To use the online service you will need to be registered for GroupNet for Plan Members and signed up for direct deposit of claim payments with eDetails. For online claim submissions, your Explanation of Benefits will only be available online.

Claims must be submitted to Great-West Life as soon as possible, but no later than 15 months after the dental treatment. You must retain your receipt for 12 months from the date you submit your claim to Great-West Life as a record of the transaction, and you must submit it to Great-West Life on request.

For all other Dentalcare claims, access GroupNet for Plan Members to obtain a personalized claim form or obtain form M445D from your employer. Have your dental service provider complete the form and return it to the Great-West Life Benefit Payment Office as soon as possible, but no later than 15 months after the dental treatment.

TO MAKE A HEALTH CARE SPENDING ACCOUNT CLAIM

The HCSA will reimburse you for the balance of the expense remaining after all other insurance plans have paid out. You must first submit all claims to any government and private insurance plans under which you or any eligible dependents are covered. Once you have received reimbursement for the expense from all other plans, you may submit a claim against the HCSA.

Any claim against the HCSA must be submitted on a claim form. For dental claims, use form M5429A or form M445D (HCSA), and for all other claims, use form M5431A or form M635D (HCSA).

Claims against the HCSA must be submitted to the Great-West Life Benefit Payment Office before the earliest of the following:

- 31 days after the end of the year in which the expenses are incurred;
- the date the HCSA contract terminates, if it terminates because your employer fails to make a required payment;
- 31 days after the date the HCSA contract terminates, if it terminates for any other reason.

GENERAL INFORMATION

CLAIM RULES

PROOF OF LOSS

The time limits for submitting proof of loss under a coverage are described in the applicable coverage description page.

Failure to furnish any such proof within the time required will not invalidate or reduce any such claim if it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible.

PHYSICAL EXAMINATION

Great-West Life, at its own expense, will have the right and opportunity to have any covered person, whose injury, sickness or treatment is the basis of a claim , examined by a physician or dentist designated by Great-West Life when and as often as it may reasonably be required during the period of a claim under the contract.

LEGAL ACTION

No action at law or in equity will be brought to recover under the contract prior to the expiration of 60 days after written proof of loss has been furnished in accordance with requirements of the contract.

OVERPAYMENT OF BENEFITS

Nothing in this group benefit plan will prevent Great-West Life from recovering any overpayment of benefits from the person or organization to whom such payment has been made, irrespective of the cause of such overpayment.

COORDINATING COVERAGE GUIDELINES FOR OUT-OF-COUNTRY/PROVINCE HEALTHCARE EXPENSES

If a person who is covered under the contract for global medical assistance coverage or for expenses resulting from emergency healthcare provided outside Canada or outside the province of residence under the extended healthcare covered is also covered under another plan or plans* which provides similar coverage, any claim will be coordinated with the other plan(s) in accordance with the coordinating coverage guidelines for out-of-country/province healthcare expenses as outlined by the Canadian Life and Health Insurance Association Inc.

*The “other plans” may include employment-related group contracts, individual or group travel or health policies, credit card coverages or any other private insurance source.

COORDINATION OF BENEFITS

Healthcare and Dentalcare benefits are coordinated when other similar coverage is available.

Government Plans

When reimbursement is available under a government plan, each covered expense is reduced by the amount payable under that plan. The reduced covered expense is then considered to be the covered

expense under all other coordination provisions. It is subject to any applicable deductible, reimbursement level, and maximum under this plan.

Government plans are plans that are legislated, funded, or administered by a government. Group plans for government employees are not included.

Group Plans

The amount payable is reduced when this plan is secondary to another group plan. The reduction is the amount by which total payments under all group plans would exceed eligible expenses. An eligible expense is that portion of a customary charge for reasonable treatment for which overage is provided under this plan.

When payments are reduced, each benefit is reduced proportionately. Only the reduced benefit amount is applied to any payment maximum.

Group plans are plans that are available only to members of particular groups and not to the general public. Student accident plans are not considered group plans.

A secondary plan is one that determines its benefits under another plan.

Employee Coverage

A plan determines its benefits first if it covers the person as an employee. If you are covered as an employee under more than one plan, the plans are prioritized in the following order:

1. the plan covering you as an active, full-time employee;
2. the plan covering you as an active, part-time employee;
3. the plan covering you as a retiree.

Dependent Coverage

A plan is secondary if it covers the person as a dependent. If the person is covered as a dependent of more than one person, the plans are prioritized in the following order:

1. the plan covering the person as a dependent spouse;
2. the plan covering the person as a dependent child of the parent with the earlier birthday in the calendar year;
3. the plan covering the person as a dependent child of the parent whose first name begins with the earlier letter in the alphabet, if both parents have the same birthday.

If the parents are separated or divorced, the plans under which benefits for the child are determined are prioritized in the following order:

1. the plan of the parent with custody of the child;
2. the plan of the spouse of the parent with custody of the child;
3. the plan of the parent without custody of the child;
4. the plan of the spouse of the parent without custody of the child.

Dental Accidents

In the case of dental accidents, dental plans are secondary to health plans with dental accident coverage.

Benefits Paid Under Another Plan

If benefits have already been paid under another group plan, this plan is automatically secondary.

Prorated Benefits

If these rules do not establish an order of benefit determination or another plan has different rules, benefits will be prorated between plans in proportion to the amounts available before coordination.

Coordination With This Plan

Coordination of benefits will also take place within this plan if:

1. a person is covered as both an employee and a dependent under this plan, or
2. a person is covered as a dependent of two employees under this plan.

BENEFICIARY DESIGNATION

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

MEMBER BASIC LIFE INSURANCE

On your death, Great-West Life will pay your life insurance benefits to your named beneficiary. If you have not named a beneficiary or there is no surviving beneficiary at the time of your death, payment will be made to your estate. Your employer will explain the claim requirements to your beneficiary.

WAIVER OF PREMIUM

You are entitled to waiver of premium benefits until you reach age 70 as long as you satisfy the disability definition under the Long Term Disability plan.

TERMINATION OF WAIVER OF PREMIUM

Your Waiver of Premium will cease on the earliest of:

- the date you no longer are receiving LTD benefits,
- the date of your 70th birthday, or
- the date of your death.

RECURRENT DISABILITY

After the waiting period, separate periods of disability arising from the same disease or injury are considered to be one period of disability unless they are separated by at least 6 months.

CONVERSION PRIVILEGE

If any or all of your insurance terminates on or before your 70th birthday, you may be eligible to apply for an individual conversion policy without providing proof of your insurability. You must apply and pay the first premium no later than 31 days after your group insurance terminates. See your plan administrator for details. If you die during the 31-day period, the amount of member life insurance available for conversion will be paid to your beneficiary or estate, even if you didn't apply for conversion.

DEPENDENT BASIC LIFE INSURANCE

If one of your dependents dies, Great-West Life will pay you the dependent life insurance benefit according to the plan you select as described in the **Benefit Summary**. Your employer will explain the claim requirements.

- Your dependent life insurance terminates when you reach age 70 or when you no longer have eligible dependents, whichever comes first.

WAIVER OF PREMIUM

If you are disabled and the premiums for your Member basic life insurance are waived, your dependent life insurance will also continue without premium payment until your own coverage terminates or your dependents no longer qualify.

CONVERSION PRIVILEGE

If your spouse's insurance terminates on or before his or her 70th birthday, he or she may be eligible for an individual conversion policy without providing proof of insurability. You or your spouse must apply and pay the first premium no later than 31 days after the group insurance terminates. See your plan administrator for details.

OPTIONAL LIFE INSURANCE

Optional Life Insurance allows you to choose additional coverage for yourself, your spouse and your eligible child(ren). Check the **Benefit Summary** for the amount of Optional Life Insurance available. When you apply for Optional Life Insurance, you must provide proof of your insurability, and your application must be approved by Great-West Life.

To cover your child, you must apply for coverage within 31 days of becoming eligible or from the date of adoption. Within the first 31 days, evidence of insurability is not required for your child. If you apply for Child Optional Life coverage after 31 days of the child's birth or date of adoption, medical evidence satisfactory to Great-West Life on behalf of your child will be required before coverage takes effect.

On your death, Great-West Life will pay your life insurance to your named beneficiary. If you have not named a beneficiary or if there is no surviving beneficiary at the time of your death, payment will be made to your estate. Your employer will explain the claim requirements. If your spouse dies you will be paid the amount for which he or she was insured.

Your optional life insurance terminates when you reach age 65. Your spouse's coverage terminates at the same time, or when he or she reaches age 65 or is no longer your spouse, whichever comes first. Your child's coverage terminates when your coverage terminates or when he or she is no longer an eligible dependent, whichever comes first.

WAIVER OF PREMIUM

If you are approved for waiver of premium on your member basic life insurance, any optional life insurance for yourself, your spouse or your child will also continue without premium payment as long as your basic life insurance continues but not beyond the date your optional insurance would otherwise terminate.

TERMINATION OF WAIVER OF PREMIUM

Your Waiver of Premium will cease on the earliest of:

- the date you no longer are receiving life waiver of premium benefits,
- the date of your 70th birthday, or
- the date of your death.

RECURRENT DISABILITY

After the waiting period, separate periods of disability arising from the same disease or injury are considered to be one period of disability unless they are separated by at least 6 months.

CONVERSION PRIVILEGE

If your or your spouse's optional life insurance terminates, you or your spouse may be eligible to apply for an individual conversion policy without providing proof of insurability. You must apply and pay the first premium no later than 31 days after your group insurance terminates. See your plan administrator for details. If you die during this 31-day period, the amount of optional life insurance available for conversion will be paid to you or your beneficiary or estate, even if you didn't apply for conversion.

LIMITATIONS

- If you or your spouse die within two years after applying for Optional Life Insurance, Great-West Life has the right to verify any medical information you or your spouse provided. If any inconsistencies are discovered, the claim will be denied and any premiums paid will be refunded.

- No benefit is paid for suicide within the first two years of initial or increased optional life coverage. In such a situation, Great-West Life refunds the premiums that have been received. This limitation does not apply to coverage for a dependent child.

LONG TERM DISABILITY (LTD) INCOME BENEFITS

The plan provides you with regular income to replace income lost because of a lengthy disability due to disease or injury. Benefits begin after the waiting period is over and continue until you are no longer disabled **as defined by the policy** or you reach age 65, whichever comes first. Check the **Benefit Summary** for the benefit amount and waiting period.

Coverage terminates at age 65 less the Waiting Period, or retirement, whichever is earlier.

WAITING PERIOD

If disability is not continuous, the days you are disabled can be accumulated to satisfy the waiting period as long as no interruption is longer than 2 weeks and the disabilities arise from the same disease or injury. If your employer provides short term disability or sick leave benefits that are still being paid when the waiting period ends, the waiting period will be extended until the end of the short term disability or sick leave benefit period, but not later than one year after your disability started.

DEFINITION OF TOTALLY DISABLED

LTD benefits are payable for the first 24 months following the waiting period if disease or injury prevents you from doing your own job. You are **not** considered disabled if you can perform a combination of duties that regularly took at least 60% of your time to complete.

After 24 months, LTD benefits will continue only if your disability prevents you from being gainfully employed in any job. Gainful employment is work you are medically able to perform, for which you have at least the minimum qualifications, and provides you with an income of at least 75% of your indexed monthly earnings before you became disabled.

RECURRENT DISABILITY

After the waiting period, separate periods of disability arising from the same disease or injury are considered to be one period of disability unless they are separated by at least 6 months.

TAX STATUS OF BENEFITS

Because your employer pays the cost of LTD coverage, benefits are taxable.

AMOUNT OF DISABILITY BENEFIT PAYABLE

Your LTD benefit is reduced by other income you are entitled to receive while you are disabled. Your benefit is first reduced by:

- disability or retirement benefits you are entitled to on your own behalf under the Canada or Quebec Pension Plan, except for increases that take effect after the benefit period starts;
- benefits under any Workers' Compensation Act or similar law.

There is a further reduction of your LTD benefit if the total of the income listed below exceeds 80% of your monthly earnings before you became disabled. If it does, your benefit is reduced by the excess amount:

- your income under this plan;
- benefits another member of your family is entitled to on the basis of your disability under the Canada or Quebec Pension Plan that are paid directly to you, except for increases that take effect after the benefit period starts;
- loss of income benefits available through legislation, except for Employment Insurance benefits, which you and any other member of your family are entitled to on the basis of your disability, including automobile insurance benefits where permitted by law;
- disability benefits under a plan of insurance available through membership in an association;
- employment income, disability benefits, or retirement benefits related to any employment except an approved rehabilitation plan or program (termination pay and severance benefits are included as employment income under this provision).

Earnings received from an approved rehabilitation plan or program are not used to reduce your LTD benefit unless those earnings, together with your income from this plan and the other income listed above, including any increases in Canada or Quebec Pension Plan benefits that take effect after the benefit period starts, would exceed your indexed monthly earnings before you became disabled. If it does, your benefit is reduced by the excess amount.

VOCATIONAL REHABILITATION BENEFITS

Vocational rehabilitation involves a work related activity or training strategy that is designed to help you return to gainful employment. A plan or program will be approved if it is appropriate for the expected duration of your disability and it facilitates your earliest possible return to work.

MEDICAL COORDINATION BENEFITS

Medical coordination is a process of early involvement to ensure that you are diagnosed quickly and receive appropriate treatment on a timely basis. The goal is to enable you to return to work as early as possible and to prevent the disability from becoming long term or permanent.

LIMITATIONS

No benefits are paid for:

- any period in which you do not participate or cooperate in a prescribed plan of medical treatment appropriate for your condition. Depending on the severity of the condition, you may be required to be under the care of a specialist. If substance abuse contributes to your disability, the treatment program must include participation in a recognized substance withdrawal program;
- the scheduled duration of a lay-off or leave of absence. This does not apply to any portion of a period of maternity leave during which you are disabled due to pregnancy;
- any period after you fail to participate or cooperate in an approved rehabilitation plan or program;
- any period after you fail to participate or cooperate in a recommended medical coordination program;
- any 12-month period in which you do not live in Canada for at least 6 months;
- any period of confinement in a prison or similar institution;
- disability arising from war, insurrection, or voluntary participation in a riot.

CONVERSION PRIVILEGE

If you change jobs, you may apply for an individual LTD conversion policy without medical evidence. You must apply and pay the first premium no later than 31 days after you start your new job, and you must start your new job no later than 6 months after you leave your present one. Your application must be acceptable according to Great-West Life's underwriting rules in effect for individual disability insurance conversion policies at the time of application. See your plan administrator for details.

HEALTHCARE

DEFINITIONS

Where used in this coverage, the following words or phrases have the meanings set forth below:

(1) "Convalescent hospital" or "chronic care facility" means an extended care facility such as a sanatorium or skilled nursing home or a special wing or ward of a hospital, which has a transfer agreement with the hospital.

(2) "Hospital" means an institution that is legally termed a hospital, is open at all times, offers in-patient accommodation, has a staff of one or more physicians available at all times, and provides continuous 24-hour nursing by graduate registered nurses.

(3) "Medical emergency" is a sudden, unexpected injury or an acute episode of disease.

(4) "Physician" means a person, other than an insured or a member of the insured's family, who is a licensed medical doctor in the province where the medical care is received and who gives medical care within the scope of that license.

(5) "Customary charges" are the lowest of:

(a) representative prices in the area where the treatment was provided,
(b) prices shown in any applicable professional association fee guide, and
(c) maximum prices established by law.

All expenses will be reimbursed at the level shown in the **Benefit Summary**. Benefits may be subject to plan maximums and frequency limits. Check the **Benefit Summary** for this information.

The plan covers customary charges for the following services and supplies. All covered services and supplies must represent reasonable treatment. Treatment is considered reasonable if it is accepted by the Canadian medical profession, it is proven to be effective, and it is of a form, intensity, frequency and duration essential to diagnosis or management of the disease or injury.

You are only covered for Healthcare benefits that apply to the option that you choose as shown in the **Benefit Summary**.

COVERED EXPENSES

- Ambulance transportation, including air ambulance, to the nearest centre where adequate treatment is available.

- Home nursing services of a registered nurse, licensed practical nurse or registered nursing assistant who is not a member of your family, when services are provided in Canada, but only if the patient requires the specific skills of a trained nurse.

  You should apply for a pre-care assessment before home nursing begins.

- Drugs and drug supplies described below when prescribed by a physician or other person entitled by law to prescribe them, and provided in Canada. Benefits for drug expenses outside Canada are payable only as provided under the out-of-country emergency care provision.

- Drugs which require a written prescription according to the Food and Drugs Act, Canada or provincial legislation in effect where the drug is dispensed, including oral contraceptives.

- Injectable drugs including vitamins, insulins and allergy extracts. Syringes for self-administered injections are also covered.

- Disposable needles for use with non-disposable insulin injection devices, lancets and test strips.

- Extemporaneous preparations or compounds if one of the ingredients is a covered drug.

- Certain other drugs that do not require a prescription by law may be covered. If you have any questions, contact your plan administrator before incurring the expense.

Covered drugs consists of:

- those drugs listed in the National Formulary or Special Authorization (SA) drug list established by the pharmacy benefits manager in effect on the date of purchase,
- diabetic supplies, and
- all other eligible “non-formulary” drugs.

Unless medical evidence is provided to Great-West Life that indicates why a drug is not to be substituted, Great-West Life can limit the covered expense to the cost of the lowest priced interchangeable drug.

For drugs eligible under a provincial drug plan, coverage is limited to the deductible amount and coinsurance you are required to pay under that plan.

- Rental or, at Great-West Life's discretion, purchase of certain medical supplies, appliances and prosthetic devices prescribed by a physician.

- Custom-made foot orthotics and custom-fitted orthopedic shoes, including modifications to orthopedic footwear, when prescribed by a physician.

- Hearing aids, including batteries, tubing and ear molds provided at the time of purchase, when prescribed by a physician.

- Diabetic supplies prescribed by a physician: Novolin-pens or similar insulin injection devices using a needle, blood-letting devices including platforms but not lancets. Lancets are covered under prescription drugs.

- Blood-glucose monitoring machines prescribed by a physician.

- External insulin infusion pumps prescribed by a physician.

- Needleless insulin jet injectors prescribed by a physician.

- Diagnostic x-rays and lab tests, when coverage is not available under your provincial government plan.

- Treatment of injury to sound natural teeth. Treatment must start within 60 days after the accident unless delayed by a medical condition.

A sound tooth is any tooth that did not require restorative treatment immediately before the accident. A natural tooth is any tooth that has not been artificially replaced.

No benefits are paid for:

- accidental damage to dentures,
- dental treatment completed more than 12 months after the accident,
- orthodontic diagnostic services or treatment.

- Out-of-hospital services of a qualified acupuncturist.
- Out-of-hospital treatment of muscle and bone disorders, including diagnostic x-rays, by a licensed chiropractor.
- Out-of-hospital treatment of movement disorders by a licensed physiotherapist.
- Out-of-hospital services of a qualified massage therapist.
- Out-of-hospital services of a licensed naturopath.
- Out-of-hospital services of a qualified homeopath.
- Out-of-hospital services of a licensed osteopath, including diagnostic x-rays.
- Out-of-hospital treatment of foot disorders, including diagnostic x-rays, by a licensed podiatrist.
- Out-of-hospital treatment by a registered psychologist or qualified social worker.
- Out-of-hospital treatment of speech impairments by a qualified speech therapist.
- Out-of-hospital services of a qualified occupational therapist.

VISIONCARE

- Eye examinations, including refractions, when they are performed by a licensed ophthalmologist or optometrist, and coverage is not available under your provincial government plan.
- Glasses and contact lenses required to correct vision when provided by a licensed ophthalmologist, optometrist or optician.
- Laser eye surgery required to correct vision when performed by a licensed ophthalmologist.

For information on available discounts on eyewear and vision care services, refer to the Preferred Vision Services section of this booklet following the Healthcare benefit.

GLOBAL MEDICAL ASSISTANCE PROGRAM

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

home province to be eligible for global medical assistance benefits. The following services are covered, subject to Great-West Life's prior approval:

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

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

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

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

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

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

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

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

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

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

OUT-OF-COUNTRY EMERGENCY CARE

The plan covers medical expenses incurred as a result of a medical emergency arising while you or your dependent is outside Canada for vacation, business or education purposes. To qualify for benefits, you must be covered by the government health plan in your home province.

A medical emergency is a sudden, unexpected injury or an acute episode of disease.

The following services and supplies are covered when related to the initial medical treatment:

- treatment by a physician;
- diagnostic x-ray and laboratory services;

- hospital accommodation in a standard or semi-private ward or intensive care unit, if the confinement begins while you or your dependent is covered;
- medical supplies provided during a covered hospital confinement;
- paramedical services provided during a covered hospital confinement;
- hospital out-patient services and supplies;
- medical supplies provided out-of-hospital if they would have been covered in Canada;
- drugs;
- out-of-hospital services of a professional nurse;
- ambulance services by a licensed ambulance company to the nearest centre where essential treatment is available;
- dental accident treatment if it would have been covered in Canada (if you elect the Green Leaf plan). Dental accident treatment is covered under Dentalcare if you elect either the Orange or Blue Leaf Plan.

If your medical condition permits you to return to Canada, benefits will be limited to the amount payable under this plan for continued treatment outside Canada or the amount payable under this plan for comparable treatment in Canada, plus return transportation, whichever is less.

LIMITATIONS

Except to the extent otherwise required by law, no benefits are paid for:

- expenses private insurers are not permitted to cover by law;
- services or supplies for which a charge is made only because you have insurance coverage;
- the portion of the expense for services or supplies that is payable by the government health plan in your home province, whether or not you are actually covered under the government health plan;
- any portion of services or supplies which you are entitled to receive, or for which you are entitled to a benefit or reimbursement, by law or under a plan that is legislated, funded, or administered in whole or in part by a government ("government plan"), without regard to whether coverage would have otherwise been available under this plan. In this limitation, government plan does not include a group plan for government employees;
- services or supplies that do not represent reasonable treatment;
- services or supplies associated with:
  - treatment performed only for cosmetic purposes;
  - recreation or sports rather than with other daily living activities;
  - the diagnosis or treatment of infertility;
  - contraception, other than oral contraceptives.
- services or supplies not listed as covered expenses;
- extra medical supplies that are spares or alternates;
- services or supplies received outside Canada except as listed under Out-of-Country Emergency Care and Global Medical Assistance;
- services or supplies received out-of-province in Canada unless you are covered by the government health plan in your home province and Great-West Life would have paid benefits for the same services or supplies if they had been received in your home province. This limitation does not apply to Global Medical Assistance;
- expenses arising from war, insurrection, or voluntary participation in a riot;
- chronic care;
- podiatric treatments for which a portion of the cost is payable under the Ontario Health Insurance Plan (OHIP). Benefits for these services are payable only after the maximum annual OHIP benefit has been paid;
- visioncare services and supplies required by an employer as a condition of employment.

In addition under the prescription drug coverage, no benefits are paid for:

- atomizers, appliances, prosthetic devices, colostomy supplies, first aid supplies, diagnostic supplies or testing equipment;
- non-disposable insulin delivery devices or spring loaded devices used to hold blood letting devices;
- delivery or extension devices for inhaled medications;
- oral vitamins, minerals, dietary supplements, homeopathic preparations, infant formulas or injectable total parenteral nutrition solutions;
- diaphragms, condoms, contraceptive jellies, foams, sponges, suppositories, contraceptive implants or appliances;
- smoking cessation products, except to the extent otherwise required by law;
- fertility drugs, except to the extent otherwise required by law;
- any drug that does not have a drug identification number as defined by the Food and Drugs Act, Canada;
- any single purchase of drugs which would not reasonably be used within 100 days;
- drugs dispensed by a dentist or clinic or by a non-accredited hospital pharmacy;
- drugs administered during treatment in an emergency room of a hospital, or as an in-patient in a hospital;
- preventative immunization vaccines and toxoids;
- non-injectable allergy extracts;
- drugs that are considered cosmetic, such as topical minoxidil or sunscreens, whether or not prescribed for a medical reason;
- drugs or drug supplies not listed in the *Liste de médicaments* published by the *Régie de l'assurance-maladie du Québec* in effect on the date of purchase or which are received out-of-province, when prescribed for a dependent child who is a student over age 24 and you are a resident of Quebec.

Note: If you are age 65 or older and reside in Quebec, you cease to be covered under this plan for basic prescription drug coverage and are covered under the basic plan provided by the *Régie de l'assurance-maladie du Québec,* unless you elect to be covered under this plan as set out below.

A one-time election may be made to be covered under this plan. You must make this election and communicate it to your plan administrator by the end of the 60-day period immediately following:

- the date you reach age 65; or
- the date you become a resident of Quebec, within the meaning of the Health Insurance Act, Quebec, if you are age 65 or over.

While your election to be covered under this plan is in effect, you will be deemed not to be entitled to the basic plan provided by the *Régie de l'assurance-maladie du Québec*.

"Basic prescription drug coverage" means the portion of drug expenses that is reimbursed by the *Régie de l'assurance-maladie du Québec*.

PREFERRED VISION SERVICES (PVS)

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

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

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

You are eligible to receive the PVS discount through the network whether or not you are enrolled for the healthcare coverage described in this booklet. You can use the PVS network as often as you wish for yourself and your dependents.

Using PVS:

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

2. Arrange for a fitting, an eye examination, a hearing assessment or a hearing test, if needed.

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

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

CONTACT - EMPLOYEE ASSISTANCE PROGRAM

The “Contact” Employee Assistance Program (EAP) is an employee benefit paid for by your employer. EAPs are intended to help employees deal with work-related and personal problems that may impact their health, well-being and work performance. EAPs are voluntary, confidential short term counselling and referral services. Your Contact program services are provided by Shepell.fgi, one of the largest EAP firms in Canada.

As a member of Contact, you and your eligible family members have access to qualified professionals who provide counselling and a variety of resources to support you when dealing with personal, family, or work-related concerns and conflict. This service is available 24 hours a day, seven days a week at no-cost to you. Counselling is available by telephone, in-person, online, and text based self-help. Although not exhaustive, the list below describes the services offered by your EAP:

Family Support Services – professional support and resources to help solve family and personal life issues including finding a childcare service, help with aging parents etc.

Financial Support Services – advice from financial experts: budgeting and cash management, debt management, planning for retirement etc.

Legal Support Services –confidential consultation providing information and clarification concerning how the law applies to a specific situation: landlord and tenant, will and estates, civil litigation, criminal law matters etc. Shepell.fgi will also provide referrals if needed.

Physical Health Support – advice from health care and nutrition experts: weight management, health coaching programs, help with how to navigate health system in Canada etc.

On line Services - stress management program, online games to relieve stress, online smoking cessation program, video conference and chat room counselling with an EAP counsellor.

For more information or to access confidential EAP support call:

- 1.800.387.4765 for service in English,
- 1.800 361.5676 for service in French,
- Or visit www.workhealthlife.com.

BEST DOCTORS®

Best Doctors is a personal and confidential service offered to you and your eligible dependents as part of your employee benefits. When you are faced with a medical condition, they provide a suite of services that complement the care you are receiving from your treating physician. From basic medical advice to a comprehensive review of your medical files and treatment regimens, Best Doctors provides medical certainty when you need it most.

You can access Best Doctors services by calling **1-877-419-2378**. You will be connected to a Member Advocate, a Registered Nurse, who will assess your needs and provide you services designed to help you confidently move forward with your care.

Best Doctors Services:

- If you are faced with a serious medical condition, Best Doctors will examine your medical records to confirm that your diagnosis is correct and that you are pursuing the best treatment options. They will collect your medical information and records, including imaging and pathology specimens, and send them to a team of Harvard-trained physicians who will analyze your records and retest any pathology. An expert physician who specializes in your condition will review your case and provide you with a comprehensive written report that includes a diagnosis and treatment recommendations.

- If you are looking for a medical specialist, Best Doctors will conduct a customized search of leading Canadian specialists from their physician database, based on your criteria and geographic preference. They will also contact the specialists to ensure they are accepting new patients.[1]

- When an expert physician or leading care facility outside of Canada is required, Best Doctors will search their global database of over 53,000 peer-selected specialists to find the expert(s) best suited to your needs. They will also ensure the specialists or facilities are accepting new patients, inquire about costs and referral requirements, and help you provide them with your medical information.[2]

- When you have concerns regarding your health or would like advice and information, Best Doctors offers information resources, one-on-one support, and customized health coaching for a wide range of health concerns. They can also help identify support programs and services in your local area.

[1] Access to a Canadian specialist requires a referral from your treating physician. Expenses associated with treatment, travel and lodging are the responsibility of the member.
[2] Expenses associated with treatment, travel and lodging are the responsibility of the member.

DENTALCARE

DEFINITIONS

Where used in this coverage, the following words or phrases have the meanings set forth below:

(1) “Dentist” means a person, other than an insured or a member of an insured’s family, who is a licensed dentist in the province or territory where the dental care is received and who gives dental care within the scope of that license.

(2) “”Orthodontic treatment” means the fixed and removable appliances for orthodontic treatment. This includes related charges for observations, adjustments, repairs, alterations, removal and retention.

(3) “Orthodontic treatment plan” must contain the dental service provider’s confirmation of:

(a) the recommended treatment for complete correction of the person’s condition,
(b) estimates the duration over which treatment will be completed,
(c) the total charge for such treatment.

(4) “Customary charges” are the lowest of:

(a) prices shown for a general practitioner in the dental fee guide identified in the Benefit Summary. Denturist fee guides are applicable when services are provided by a denturist. Dental hygienist fee guides are applicable when services are provided by a dental hygienist practising independently. Specialist fee guides are applicable when a specialist provides services within his speciality;
(b) representative prices in the area where the treatment was provided;
(c) maximum prices established by law.

All expenses will be reimbursed based on the Leaf option you choose and at the applicable level shown in the **Benefit Summary**. Benefits may be subject to plan maximums and frequency limits. Check the **Benefit Summary** for this information.

The plan covers customary charges to the extent they do not exceed the dental fee guide level shown in the **Benefit Summary**. Denturist fee guides are applicable when services are provided by a denturist. Dental hygienist fee guides are applicable when services are provided by a dental hygienist practising independently.

All covered services and supplies must represent reasonable treatment. Treatment is considered reasonable if it is recognized by the Canadian Dental Association, it is proven to be effective, and it is of a form, frequency, and duration essential to the management of the person's dental health. To be considered reasonable, treatment must also be performed by a dentist or under a dentist’s supervision, performed by a dental hygienist entitled by law to practise independently, or performed by a denturist.

TREATMENT PLAN

Before incurring any large dental expenses, or beginning any orthodontic treatment, ask your dental service provider to complete a treatment plan and submit it to Great-West Life. Great-West Life will calculate the benefits payable for the proposed treatment, so you will know in advance the approximate portion of the cost you will have to pay.

BASIC COVERAGE

The following expenses will be covered:

- Diagnostic services including:

  - one complete oral examination every 36 months;
  - limited oral examinations once every 12 months (once every 6 months for dependent children under age 22), except that only one limited oral examination is covered in any 12-month period that a complete oral examination is also performed;
  - limited periodontal examinations once every 12 months (once every 6 months for dependent children under age 22);
  - complete series of x-rays every 36 months;
  - intra-oral x-rays to a maximum of 15 films every 36 months and a panoramic x-ray every 36 months. Services provided in the same 12 months as a complete series are not covered.

- Preventive services including:

  - polishing and topical application of fluoride each once every 12 months (once every 6 months for dependent children under age 22);
  - scaling, limited to a maximum combined with periodontal root planing of 8 time units each calendar year (a time unit is considered to be a 15-minute interval or any portion of a 15-minute interval);
  - oral hygiene instruction once in a person's lifetime;
  - pit and fissure sealants on bicuspids and permanent molars every 60 months;
  - space maintainers including appliances for the control of harmful habits;
  - finishing restorations;
  - interproximal disking;
  - recontouring of teeth.

- Minor restorative services including:

  - caries, trauma, and pain control;
  - amalgam and tooth-coloured fillings; replacement fillings are covered only if the existing filling is at least 2 years old or the existing filling was not covered under this plan;
  - retentive pins and prefabricated posts for fillings;
  - prefabricated crowns for primary teeth.

- Endodontics. Root canal therapy for permanent teeth will be limited to one course of treatment per tooth. Repeat treatment is covered only if the original treatment fails after the first 18 months.

- Periodontal services including:

  - root planing, limited to a maximum combined with preventive scaling of 8 time units each calendar year;
  - occlusal adjustment and equilibration, limited to a combined maximum of 4 time units every 12 months.

  A time unit is considered to be a 15-minute interval or any portion of a 15-minute interval.

- Denture maintenance, after the 3-month post-insertion care period, including:

  - denture relines for dentures at least 6 months old, once every 36 months;
  - denture rebases for dentures at least 2 years old, once every 36 months;
  - resilient liner in relined or rebased dentures, once every 36 months.

- Oral surgery.

- Adjunctive services.

MAJOR COVERAGE

- Crowns. Coverage for crowns on molars is limited to the cost of standard crowns. Coverage for complicated crowns is limited to the cost of standard crowns.

- Onlays. Coverage for tooth-coloured onlays on molars is limited to the cost of metal onlays.

  Replacement crowns and onlays are covered when the existing restoration is at least 5 years old and cannot be made serviceable.

- Standard complete dentures, standard cast or acrylic partial dentures or complete overdentures or bridgework when required to replace one or more teeth extracted while the person is covered. Overdentures and bridgework are covered only when standard complete or partial dentures are not viable treatment options. Coverage for tooth-coloured retainers and pontics on molars is limited to the cost of metal retainers and pontics. Replacement appliances are covered only when:

  - the existing appliance is a covered temporary appliance;
  - the existing appliance is at least 5 years old and cannot be made serviceable. If the existing appliance is less than 5 years old, a replacement will still be covered if the existing appliance becomes unserviceable while the person is covered and as a result of the placement of an initial opposing appliance or the extraction of additional teeth.

    If additional teeth are extracted but the existing appliance can be made serviceable, coverage is limited to the replacement of the additional teeth.

- Denture-related surgical services for remodelling and recontouring oral tissues.

- Denture and bridgework maintenance following the 3-month post-insertion period including:

  - denture remakes, once every 36 months;
  - denture adjustments, once every 12 months;
  - denture repairs and additions, tissue conditioning and resetting of denture teeth;
  - repairs to covered bridgework;
  - removal and recementation of bridgework.

ORTHODONTIC COVERAGE

- Orthodontics are covered for persons between ages 6 and 18 when treatment starts.

ACCIDENTAL DENTAL INJURY COVERAGE

- Treatment of injury to sound natural teeth. Treatment must start within 60 days after the accident unless delayed by a medical condition.

  A sound tooth is any tooth that did not require restorative treatment immediately before the accident. A natural tooth is any tooth that has not been artificially replaced.

LIMITATIONS

If you do not apply for dentalcare coverage within 90 days after you become eligible, benefits will be subject to the following restrictions, unless the expenses are incurred solely as a result of an accident occurring after the coverage takes effect:

- Basic Coverage expenses are limited to $250 during the first 90 days of your coverage.
- Major Coverage expenses are limited to $250 during the first 12 months of your coverage.
- Orthodontic Coverage expenses are limited to $250 during the first 12 months of your coverage.

No benefits are paid for:

- Duplicate x-rays, custom fluoride appliances, audio-visual oral hygiene instruction and nutritional counselling.
- The following endodontic services - root canal therapy for primary teeth, isolation of teeth, enlargement of pulp chambers and endosseous intra coronal implants.
- The following periodontal services - desensitization, topical application of antimicrobial agents, subgingival periodontal irrigation, charges for post surgical treatment and periodontal re-evaluations.
- The following oral surgery services - implantology, surgical movement of teeth, services performed to remodel or recontour oral tissues (other than minor alveoloplasty, gingivoplasty and stomatoplasty) and alveoloplasty or gingivoplasty performed in conjunction with extractions. Services for remodelling and recontouring oral tissues will be covered under Major Coverage.
- Hypnosis or acupuncture.
- Veneers, recontouring existing crowns, and staining porcelain.
- Crowns or onlays if the tooth could have been restored using other procedures. If crowns, onlays or inlays are provided, benefits will be based on coverage for fillings.
- Overdentures or initial bridgework if provided when standard complete or partial dentures would have been a viable treatment option.

  If overdentures are provided, coverage will be limited to standard complete dentures.

  If initial bridgework is provided, coverage will be limited to a standard cast partial denture and restoration of abutment teeth when required for purposes other than bridgework.

If additional bridgework is performed in the same arch within 60 months, coverage will be limited to the addition of teeth to a denture and restoration of abutment teeth when required for purposes other than bridgework.

Benefits will be limited to standard dentures or bridgework when equilibrated and gnathological dentures, dentures with stress breaker, precision and semi-precision attachments, dentures with swing lock connectors, partial overdentures and dentures and bridgework related to implants are provided.

- Expenses covered under another group plan's extension of benefits provision.
- Accidental dental injury expenses for treatment performed more than 12 months after the accident, denture repair or replacement, or any orthodontic services.
- Expenses private plans are not permitted to cover by law.
- Services and supplies you are entitled to without charge by law or for which a charge is made only because you have insurance coverage.
- Services or supplies that do not represent reasonable treatment.
- Treatment performed for cosmetic purposes only.
- Congenital defects or developmental malformations in people 19 years of age or over, except orthodontics.
- Temporomandibular joint disorders, vertical dimension correction or myofacial pain.
- Expenses arising from war, insurrection, or voluntary participation in a riot.

HEALTHCARE SPENDING ACCOUNT BENEFITS (HCSA)

A Healthcare Spending Account (HCSA) is like a bank account through which you may be reimbursed for health and dental expenses up to a predetermined annual credit amount. Your employer will establish the credits for your account prior to each plan year. The credits are based on the option you select as outlined in the **Benefit Summary**. These credits may be used to cover expenses not covered by group health plans or to top-up expenses not fully covered by group health plans, including deductibles and co-payment amounts. Credits are available for covered expenses incurred in a plan year. Unused credits at the end of any plan year are rolled over to your account for covered expenses incurred in the following plan year. If they are not used by the end of that year, they are automatically forfeited.

The maximum annual payment available under your account consists of the amount of credit directed to it at the beginning of the plan year plus any unused amount from the previous year.

ELIGIBILITY

You and your dependents are eligible for HCSA credits through your employer if you are covered for basic health benefits under the Green or Orange Leaf plan (including if you have waived Orange plan health coverage if you have comparable alternate coverage). In addition to the dependents eligible for coverage under your basic health plan, HCSA benefits are extended to any other person for whom you are entitled to claim a medical expense tax credit under the Income Tax Act (Canada).

TERMINATION

Your HCSA coverage terminates when your basic health coverage terminates, when you elect to discontinue coverage (at any plan enrolment date) or when your employer discontinues the plan.

Your dependents' HCSA coverage terminates when your coverage terminates or when they no longer qualify, whichever is earlier.

COVERED EXPENSES

The Income Tax Act (Canada) governs the types of expenses that can be reimbursed under the HCSA. Coverage is provided for those expenses that qualify for a medical expense tax credit. For a complete list of covered expenses, contact your Canada Revenue Agency District Office and ask for Income Tax Interpretation Bulletin IT-519R.

Benefits will be paid for 100% of covered expenses that are incurred while you and your dependents are covered, up to a maximum annual payment equal to the credits in your HCSA. Dental expenses, other than orthodontic expenses, are considered to be incurred when treatment is completed. Orthodontic expenses are considered to be incurred on a periodic basis throughout the course of treatment. All other expenses are considered to be incurred when they are received.

LIMITATIONS

No benefits are paid for:

- expenses that private benefit plans are not permitted to cover by law;
- services or supplies you are entitled to without charge by law or for which a charge is made only because you have coverage under a private benefit plan;
- any portion of the expense for services or supplies for which benefits are payable under your basic health plan, another group plan or a government plan.

SUMMARY OF COVERAGES)
(Underwritten by Manulife Financial)

Coverage	Benefit Amount	Termination Age
ACCIDENTAL DEATH & DISMEMBERMENT	• Non-retired members under age 65: $25,000 • Non-retired members age 65 and over and retired members: $5,000	Age 70
OPTIONAL ACCIDENTAL DEATH & DISMEMBERMENT	• For your spouse, if you also have children: 40% of your amount • For your spouse, if you have no children: 50% of your amount • For each of your children, if you have a spouse: 10% of your amount • For each of your children, if you have no spouse: 15% of your amount	• Member: your age 65 or retirement, whichever is earlier • Spouse: your or your spouse's age 65 or retirement, whichever is earlier • Children: your age 65 or retirement, whichever is earlier
MEMBER OPTIONAL CRITICAL ILLNESS INSURANCE	Units of $5,000, to a maximum of $150,000 (minimum benefit of $10,000)	Your benefit amount reduces by 50% at your age 65, to a maximum of $50,000 (minimum benefit of $10,000), and terminates at the earliest of age 70, your retirement, or your Critical Illness benefit is paid out.
SPOUSAL OPTIONAL CRITICAL ILLNESS INSURANCE	Units of $5,000, to a maximum of $150,000 (minimum benefit of $10,000)	Your spouse's benefit amount reduces by 50% at your spouse's age 65, to a maximum of $50,000 (minimum benefit of $10,000), and terminates at the earliest of your age 70, your retirement, or your Spousal Critical Illness benefit is paid out.
CHILD OPTIONAL CRITICAL ILLNESS INSURANCE	$10,000 each child	Your benefit terminates at the earliest of your age 70, your retirement, your child's limiting age as specified under Definitions or your Child Critical Illness benefit is paid out.

DEFINITIONS

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

AUTOMOBILE is a motorized land vehicle which does not operate on rails or crawler treads, not including a two-wheeled vehicle, farm-type tractor, or any equipment which is primarily designed for off-road use.

BIRTH is the complete expulsion or extraction of a child from its mother, in which, after such expulsion or extraction, there is breathing, beating of the heart, pulsation of the umbilical cord, or unmistakeable movement of voluntary muscle.

CHILD(REN) are your unmarried children (including adopted, foster and step-children) who are under age 22, or under age 25 if they are full-time students. Children who are incapable of supporting themselves because of physical or mental disorder are covered without age limit if the disorder begins before they turn 22, or while they are students under 25, and the disorder has been continuous since that time.

IMMEDIATE FAMILY MEMBER means you, your spouse or child, your parent or your spouse's parent, your brother or sister, or your spouse's brother or sister.

LOSS OF LIFE for Accidental Death and Dismemberment and Optional Accidental Death and Dismemberment, means death resulting from an accidental injury visible on the surface of the body or disclosed by an autopsy or a disease or infection resulting directly from an accidental injury.

NON-EVIDENCE LIMIT is the amount after which you must submit satisfactory medical evidence to Manulife Financial for Benefit coverage greater than this amount.

SPOUSE is a person who is either your legal, common-law or former spouse. A common-law spouse is a person who has been living with you in a conjugal relationship for at least 36 months or, if you are a Quebec resident, until the earlier birth or adoption of a child of the relationship. A former spouse means your divorced or ex-common-law spouse for whom insurance protection for some of the benefits available under the employer's benefit program is mandated by court order.

TOTALLY DISABLED means as defined and determined under your employer's Long Term Disability plan.

EVIDENCE OF INSURABILITY

Medical evidence is required for Optional Critical Illness Insurance if application is made more than 31 days after your date of eligibility and/or if application for insurance is in excess of the Non-Evidence Limit.

An application is considered late when you:

- apply for insurance after having been eligible for more than 31 days, or
- re-apply for insurance which had earlier been cancelled.

Medical evidence can be submitted by completing the evidence of insurability form, available from your plan administrator.

Further medical evidence may be requested by Manulife Financial.

EFFECTIVE DATE OF COVERAGE

If Evidence of Insurability is not required, your Group Benefits will be effective on the date you are eligible.

If Evidence of Insurability is required, your Group Benefits will be effective on the date you become eligible or the date the evidence is approved by Manulife Financial, whichever is later.

You must be actively at work for insurance to become effective. If you are not actively at work on the date your insurance would normally become effective, your insurance will take effect on the next day on which you are again actively at work.

CHANGE IN COVERAGE

To ensure that coverage is kept up-to-date for yourself and your dependents, it is vital that you report any changes to your plan administrator. Such changes could include:

- Change in dependent coverage,
- Change of beneficiary,
- Change in name,
- Applying for coverage previously waived.

To make such changes, you must complete the Application for Change form, available from your plan administrator.

BENEFICIARY DESIGNATION

Manulife Financial does not accept beneficiary designations for any benefits other than Member Basic or Optional Accidental Death and Dismemberment.

For the Critical Illness coverage, this policy contains a provision removing or restricting the right of the group life insured to designate persons to whom or for whose benefit insurance money is payable.

You should review your beneficiary designation to be sure that it reflects your current intent.

WHEN YOU HAVE A CLAIM

ACCIDENTAL DEATH & DISMEMBERMENT (BASIC OR OPTIONAL)

To submit an Accidental Death Claim, your beneficiary must complete a Life Claim form.

To submit a Dismemberment Claim, you must complete an Accidental Dismemberment Claim form. Both forms are available from your Plan Administrator, and require a physician's statement.

A completed claim form must be submitted within 90 days from the date of loss or expense, or in the case of loss of use, following the expiration of the 365 day period following such loss.

If, while the Group Policy is in force, you are in receipt of a benefit payment under your Long Term disability plan, the premium for this benefit will also be waived. The Waiver of Premium for this benefit ceases if the benefit terminates. Proof of such payment must be submitted within 12 months of becoming disabled.

CRITICAL ILLNESS (MEMBER, SPOUSE OR CHILD)

To submit a Critical Illness Insurance claim, the person must have survived their illness for 30 days or more past the date they were first diagnosed.

For all Critical Illness coverage, a completed claim form must be received within 90 days of date of diagnosis of the Critical Illness.

You can obtain a claim form directly from the Forms and Brochures section on the Manulife Financial Group Benefits Employee Internet Site, or you can get a form from your Plan Administrator.

The form shows all of the necessary documents you need to submit to support your claim.

You may not commence legal action against Manulife Financial less than 60 days after proof has been filed as outlined above. Every action or proceeding against Manulife Financial for the recovery of insurance money payable under the plan is absolutely barred unless commenced within the time set out in the Insurance Act or applicable legislation.

ACCIDENTAL DEATH & DISMEMBERMENT
(Underwritten by Manulife Financial)

If you sustain an accidental injury while insured and suffer a loss specified in the Schedule of Losses below, this benefit provides financial assistance to you or your beneficiary. In the event of your death, the benefit is payable to your beneficiary. If your beneficiary dies before you or if there is no designated beneficiary, this benefit is payable to your estate. For losses other than Loss of Life, the benefit is payable to you.

BASIC BENEFIT AMOUNT

- Non-retired members under age 65: $25,000.
- Non-retired members age 65 and over and retired members: $5,000.

TERMINATION AGE

- Age 70.

SCHEDULE OF LOSSES

A loss shown in this schedule is covered provided it:

- is a direct result of the accidental injury,
- occurs within 365 days from the date of the accidental injury,
- is total and irreversible or irrecoverable.

In the case of loss of speech or hearing, or loss of use of an arm, hand or leg, the loss must be continuous for 12 months and determined to be permanent, after which time the benefit is payable.

The amount payable for each loss is a percentage of your Accidental Death and Dismemberment benefit amount which was in effect as of the date of the injury.

Life	100%
Both hands or both feet	100%
Sight of both eyes	100%
One hand and one foot	100%
One hand and sight of one eye	100%
One foot and sight of one eye	100%
One arm or one leg	75%
One hand or one foot	66 2/3%
Sight of one eye	66 2/3%
Thumb and index finger of the same hand	33 1/3%
At least four fingers of the same hand	33 1/3%
All toes of one foot	25%
Hearing in both ears and speech	100%
Speech	66 2/3%
Hearing in both ears	66 2/3%
Hearing in one ear	25%
Use of both hands or both feet	100%
Use of one arm or one leg	75%
Use of one hand or one foot	66 2/3%

Hemiplegia	200%
Paraplegia	200%
Quadriplegia	200%

If you suffer more than one loss as a result of the same accident, the total benefit payable will not exceed the benefit amount, except for hemiplegia, paraplegia or quadriplegia, in which case the total benefit will not exceed 200%, provided such benefit is paid while the person is living.

No more than one loss, the largest, is payable for multiple injuries to the same limb.

EXPOSURE AND DISAPPEARANCE

The benefit for a loss will also be payable if, as a result of an accidental injury, you suffer a loss due to unavoidable exposure to the elements of nature, within 365 days of the accident.

If as a result of the disappearance, wrecking or sinking of the conveyance in which you were riding at the time of an accident, you disappear and the body is not found within 365 days following the accident, the benefit for loss of life will be payable on the presumption of death due to the accident.

REHABILITATION EXPENSES

If, as a result of an accidental injury, you suffer a loss and must participate in a rehabilitation program in order to qualify for employment, reimbursement will be made for reasonable and necessary expenses actually incurred within 3 consecutive years of the accident.

The maximum benefit is $10,000. Travelling, clothing and living expenses are not eligible.

REPATRIATION EXPENSES

If you should die as a result of an accidental injury which occurs while travelling 150 kilometers or more from home, reimbursement will be made for reasonable and necessary expenses actually incurred for preparation of the body and transportation to the first resting place nearest home.

The maximum benefit is $10,000.

FAMILY TRANSPORTATION EXPENSES

If you suffer a loss as a result of an accidental injury and are confined to a hospital which is 150 kilometers or more from home, reimbursement will be made for reasonable and necessary expenses actually incurred by an immediate family member as follows:

- for hotel accommodation in the vicinity of the hospital;
- for transportation to and from the hospital. When transportation is by other than a vehicle licensed for fare-paying passengers, $0.20 per kilometer will be payable.

The maximum benefit is $2,000.

DEPENDENT EDUCATION EXPENSES

If you should die as a result of an accidental injury, reimbursement will be made for tuition expenses actually incurred after your death for each child who is enrolled as a full-time student at an accredited institute of higher learning above the secondary school level. Post-secondary tuition expenses will also be

paid for each child who is enrolled at the secondary school level, provided the child enrols as a full-time student at an institute above the secondary school level within 365 days after your death.

The maximum benefit per child per year is the lesser of $5,000, or 5% of your benefit amount, for a maximum of 4 years. Travelling, clothing and living expenses are not eligible.

SPOUSAL OCCUPATIONAL TRAINING EXPENSES

If you should die as a result of an accidental injury and your spouse requires formal occupational training in order to qualify for employment in an occupation for which your spouse is not sufficiently qualified, reimbursement will be made for reasonable and necessary expenses actually incurred for such a program within 3 years following the accident.

The maximum benefit is $10,000. Travelling, clothing and living expenses are not eligible.

SEAT BELT BENEFIT

If you die as a result of an accidental injury while driving or riding in an automobile, an additional amount equal to 10% of the Principal Amount mentioned will be paid, provided all the following conditions are met:

- The automobile is equipped with seat belts.
- The seat belt was in actual use and properly fastened at the time of the accident.
- The position of the seat belt is certified in the official report of the accident or by the investigating police officer.

NON-DUPLICATION OF EXPENSES

Expenses which are eligible under this benefit for which you are also eligible under any other benefit, policy, or plan providing similar coverage will be paid first under such other benefit, policy or plan. Any expenses not paid will then be considered under this benefit, subject to any stated maximum.

The total amount of payments from all coverages combined will not exceed 100% of the eligible expenses incurred.

EXCEPTIONS

No benefit will be payable for any claim arising as a direct or indirect result of:

- suicide or self-inflicted injuries while sane or insane;
- war, or any act of war, whether declared or not;
- service in the armed forces of any country which is in a state of war;
- riding in, boarding or leaving, or descending from, any aircraft if:
    - you are the pilot, the operator, or a member of the crew;
    - the aircraft is owned, operated or leased by or on behalf of the employer;
    - the aircraft is piloted by an unlicensed person;
    - the aircraft does not have a valid certificate of airworthiness.

CONVERSION PRIVILEGE

If your Group Benefits terminate or reduce, you may be eligible to convert your Accidental Death & Dismemberment Insurance to a Personal AD&D policy. You must apply for the coverage, and pay the first monthly premium within 31 days of the termination of your Accidental Death & Dismemberment Insurance. If you suffer a loss during this 31-day period, the amount of Accidental Death & Dismemberment Insurance available for conversion will be payable, even if you didn't apply for conversion.

For more information on the conversion privilege, please see your plan administrator.

OPTIONAL ACCIDENTAL DEATH & DISMEMBERMENT
(Underwritten by Manulife Financial)

If you or one of your dependents sustains an accidental injury while insured and suffers a loss specified in the Schedule of Losses below, this benefit provides financial assistance to you or your beneficiary. In the event of your death, the benefit is payable to your beneficiary. If your beneficiary dies before you or if there is no designated beneficiary, this benefit is payable to your estate. All other benefits are payable to you.

BENEFIT AMOUNT

- For your spouse, if you also have children: 40% of your amount.
- For your spouse, if you have no children: 50% of your amount.
- For each of your children, if you have a spouse: 10% of your amount.
- For each of your children, if you have no spouse: 15% of your amount.

TERMINATION AGE

- Member: Member's age 65 or retirement, whichever is earlier.
- Spouse: Member's or spouse's age 65 or Member's retirement, whichever is earlier.
- Children: Member's age 65 or retirement, whichever is earlier.

SCHEDULE OF LOSSES

A loss shown in this schedule is covered provided it:

- is a direct result of the accidental injury,
- occurs within 365 days from the date of the accidental injury,
- is total and irreversible or irrecoverable.

In the case of loss of speech or hearing, or loss of use of an arm, hand or leg, the loss must be continuous for 12 months and determined to be permanent, after which time the benefit is payable.

The amount payable for each loss is a percentage of your Accidental Death and Dismemberment benefit amount which was in effect as of the date of the injury:

Life	100%
Both hands or both feet	100%
Sight of both eyes	100%
One hand and one foot	100%
One hand and sight of one eye	100%
One foot and sight of one eye	100%
One arm or one leg	75%
One hand or one foot	66 2/3%
Sight of one eye	66 2/3%
Thumb and index finger of the same hand	33 1/3%
At least four fingers of the same hand	33 1/3%

All toes of one foot	25%
Hearing in both ears and speech	100%
Speech	66 2/3%
Hearing in both ears	66 2/3%
Hearing in one ear	25%
Use of both hands or both feet	100%
Use of one arm or one leg	75%
Use of one hand or one foot	66 2/3%
Hemiplegia	200%
Paraplegia	200%
Quadriplegia	200%

If you or a covered dependent suffer more than one loss as a result of the same accident, the total benefit payable will not exceed the benefit amount for which you or a covered dependent are insured, except for hemiplegia, paraplegia or quadriplegia, in which case the total benefit will not exceed 200%, provided such benefit is paid while the person is living.

No more than one loss, the largest, is payable for multiple injuries to the same limb.

EXPOSURE AND DISAPPEARANCE

The benefit for a loss will also be payable if, as a result of an accidental injury, you or one of your dependents suffer a loss due to unavoidable exposure to the elements of nature within 365 days of the accident.

If as a result of the disappearance, wrecking or sinking of the conveyance in which you or one of your dependents were riding at the time of an accidental injury, you or one of your dependents disappear and the body is not found within 1 year following the accident, the benefit for loss of life will be payable on the presumption of death due to the accident.

REHABILITATION EXPENSES

If, as a result of an accidental injury, you suffer a loss and must participate in a rehabilitation program in order to qualify for employment, reimbursement will be made for reasonable and necessary expenses actually incurred within 3 consecutive years of the accident.

The maximum benefit is $10,000. Travelling, clothing and living expenses are not eligible.

REPATRIATION EXPENSES

If you or one of your dependents should die as a result of an accidental injury which occurs while travelling 150 kilometers or more from home, reimbursement will be made for reasonable and necessary expenses actually incurred for preparation of the body and transportation to the first resting place nearest home.

The maximum benefit is $10,000.

FAMILY TRANSPORTATION EXPENSES

If you or one of your dependents suffer a loss as a result of an accidental injury and are confined to a hospital which is 150 kilometers or more from home, reimbursement will be made for reasonable and necessary expenses actually incurred by an immediate family member as follows:

- for hotel accommodation in the vicinity of the hospital;
- for transportation to and from the hospital. When transportation is by other than a vehicle licensed for fare-paying passengers, $0.20 per kilometer will be payable.

The maximum benefit is $2,000.

DEPENDENT EDUCATION EXPENSES

If you should die as a result of an accidental injury, reimbursement will be made for tuition expenses actually incurred after your death for each child who is enrolled as a full-time student at an accredited institute of higher learning above the secondary school level. Post-secondary tuition expenses will also be paid for each child who is enrolled at the secondary school level, provided the child enrols as a full-time student at an institute above the secondary school level within 365 days after your death.

The maximum benefit per child per year is the lesser of $5,000, or 5% of your benefit amount, for a maximum of 4 years. Travelling, clothing and living expenses are not eligible.

SPOUSAL OCCUPATIONAL TRAINING EXPENSES

If you should die as a result of an accidental injury and your spouse requires formal occupational training in order to qualify for employment in an occupation for which your spouse is not sufficiently qualified, reimbursement will be made for reasonable and necessary expenses actually incurred for such a program within 3 years following the accident.

The maximum benefit is $10,000. Travelling, clothing and living expenses are not eligible.

SEAT BELT BENEFIT

If you or one of your dependents dies as a result of an accidental injury while driving or riding in an automobile, an additional amount equal to 10% of the Principal Amount mentioned will be paid, provided all the following conditions are met:

- The automobile is equipped with seat belts.
- The seat belt was in actual use and properly fastened at the time of the accident.
- The position of the seat belt is certified in the official report of the accident or by the investigating police officer.

NON-DUPLICATION OF EXPENSES

Expenses which are eligible under this benefit for which you are also eligible under any other benefit, policy, or plan providing similar coverage will be paid first under such other benefit, policy or plan. Any expenses not paid will then be considered under this benefit, subject to any stated maximum.

The total amount of payments from all coverages combined will not exceed 100% of the eligible expenses incurred.

EXCEPTIONS

No benefit will be payable for any claim arising as a direct or indirect result of:

- Suicide or self-inflicted injuries while sane or insane.

- War, or any act of war, whether declared or not.
- Service in the armed forces of any country, which is in a state of war.
- Riding in, boarding or leaving, or descending from, any aircraft if:
  - you are the pilot, the operator, or a member of the crew;
  - the aircraft is owned, operated or leased by or on behalf of the employer;
  - the aircraft is piloted by an unlicensed person;
  - the aircraft does not have a valid certificate of airworthiness.

CONVERSION PRIVILEGE

If your Group Benefits terminate or reduce, you may be eligible to convert your Optional Accidental Death & Dismemberment Insurance to a Personal AD&D policy. You must apply for the coverage, and pay the first monthly premium within 31 days of the termination of your Voluntary Accidental Death & Dismemberment Insurance. If you suffer a loss during this 31-day period, the amount of Voluntary Accidental Death & Dismemberment Insurance available for conversion will be payable, even if you didn't apply for conversion.

OPTIONAL CRITICAL ILLNESS
(Underwritten by Manulife Financial)

Please refer to your Critical Illness Brochure for more details on this benefit.

If, while you, your spouse or child are insured for this benefit, the insured is diagnosed with one of the covered Critical Illness conditions shown in the Covered Critical Illness Conditions Appendix, you can submit a claim for your Member Optional Critical Illness benefit. The insured must have survived the illness for 30 days or more past the date first diagnosed. Manulife Financial will evaluate the claim using the Entitlement Criteria.

THE BENEFIT

Benefit Amount. Member or spouse: increments of $5,000, to a maximum of $150,000 (minimum benefit of $10,000).

Benefit Amount. Child: $10,000 for each child.

Non-Evidence Limit. All amounts are subject to Evidence of Insurability. However, evidence of insurability will be waived for an amount of Optional Critical Illness Insurance which is $25,000 or less.

TERMINATION AGE

- Your benefit amount reduces by 50% at your age 65, to a maximum of $50,000 (minimum benefit of $10,000), and terminates at the earliest of age 70, your retirement, or your Critical Illness benefit is paid out.

- Your spouse's benefit amount reduces by 50% at your spouse's age 65, to a maximum of $50,000 (minimum benefit of $10,000), and terminates at the earliest of your age 70, your retirement, or your Spousal Critical Illness benefit is paid out.

- Your child benefit terminates at the earliest of your age 70, your retirement, your child's limiting age as specified under Definitions or your Child Critical Illness benefit is paid out.

ENTITLEMENT CRITERIA

Manulife Financial will apply the following criteria in determining your entitlement to Critical Illness Benefits:

- Manulife Financial receives medical evidence documenting your diagnosis of a covered Critical Illness condition.

- The diagnosis of any Critical Illness is made by a Physician practicing medicine in Canada, in a specialty relating to the applicable Critical Illness.

At any time, Manulife Financial may require you to submit to a medical examination or evaluation by an examiner selected by Manulife Financial.

CRITICAL ILLNESS COVERED CONDITIONS

Group Critical Illness Covered Conditions	You and your spouse	Your child
Alzheimer's Disease	X	X
Aortic Surgery	X	X
Benign Brain Tumour	X	X
Blindness	X	X
Cancer (Life-Threatening)	X	X
Coma	X	X
Coronary Artery Bypass Surgery	X	X
Deafness	X	X
Heart Attack (Myocardial Infarction)	X	X
Heart Valve Replacement	X	X
Kidney Failure (End Stage Renal Disease)	X	X
Loss Of Limbs	X	X
Loss Of Speech	X	X
Major Organ Failure On Waiting List For Transplant	X	X
Major Organ Transplant	X	X
Motor Neuron Disease	X	X
Multiple Sclerosis	X	X
Occupational HIV Infection	X	X
Paralysis	X	X
Parkinson's Disease	X	X
Severe Burns	X	X
Stroke (Cerebrovascular Accident)	X	X
Autism		X
Cerebral Palsy		X
Congenital Heart Disease (For Which Corrective Surgery Has Been Performed)		X
Cystic Fibrosis		X
Down Syndrome		X
Muscular Dystrophy		X
Type 1 Diabetes Mellitus		X

EXCLUSIONS

No benefits are payable for any Critical Illness related to:

- Any specific exclusions associated with a given condition set out in the Covered Critical Illness Conditions Appendix.
- Self-inflicted injuries or illnesses.
- Abuse of addictive substances, including drugs and alcohol.
- War, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion.
- The committing of or the attempt to commit an assault or criminal offence.

- Injuries sustained while operating a motor vehicle, either while under the influence of any intoxicant or if the Insured's blood contained more than 80 milligrams of alcohol per 100 milliliters of blood at the time of the injury.

- Taking a poisonous substance or inhaling toxic gases or fumes.

- A situation where your child is born and diagnosed with a condition within the first ten months of the effective date of child coverage.
- A pre-existing condition incurred or diagnosed during the 24 months prior to the effective date of coverage or latest reinstatement. This limitation applies whether or not the insured person was aware of their condition or had received a diagnosis prior to the effective date of coverage or latest reinstatement.

  A pre-existing condition is an illness or injury for which the Insured person has exhibited signs or symptoms, received medical treatment, care or services (including diagnostic measures), consulted a Physician or has been prescribed medication - or where treatment would have been received by a prudent individual - during the 24 months prior to the effective date of coverage or latest date of reinstatement for this Critical Illness Benefit.

- Cancer or benign brain tumour if within the first 90 days of your coverage effective date you have any of the following:

  - signs or symptoms that lead to a diagnosis of cancer or benign brain tumour, regardless of the date when the diagnosis is made;
  - medical consultations, tests or any form of clinical evaluation, that lead to a diagnosis of cancer or benign brain tumour, regardless of when the diagnosis is made;
  - a diagnosis of cancer or benign brain tumour.