Employee Benefits Handbook

Last Updated

July 2015

Employee Class

City of Revelstoke CUPE

Introduction

This handbook contains information about your group benefits. Please keep it in a safe place. It is intended to summarize the principal features of your plan. All rights to benefits are governed by the Group Contracts/Policies.

Possession of this handbook alone does not mean that you or your dependents are insured under your employer's group benefits program. Coverage must be in effect and you must satisfy all the enrollment requirements included in the Group Contracts/Policies. Please refer to the Table of Contents to help you locate the appropriate section in this handbook. If you require additional information, please contact your Plan Administrator.

Your Insurers, Service Providers, and Policy Numbers

Benefit	Provider	Policy Number
Basic Life Insurance	Manulife Financial	76636
Basic Accidental Death & Dismemberment	Industrial Alliance	100010662
Extended Health Care	Manulife Financial	77313
Dental Care	Manulife Financial	77313
Medical Absence	Disability Management Institute (DMI)	n/a

Who to Contact

Insurance companies and other service providers are both involved in the delivery of your benefits plan. They are listed above along with the policy numbers pertaining to their benefits. For claims concerns or inquiries please call the telephone numbers indicated below for assistance.

For Extended Health and Dental Claims
Manulife Customer Service Centre
Toll Free: **1.800.268.6195**

For Medical Absence Claims
Disability Management Institute (DMI)
Call: **604.552.3647** Toll Free: **1.866.963.9995**

Inquiries for all Other Topics
Morneau Shepell
Toll Free: **1.844.384.0822**

Southern Interior Municipal Employers' Association (SIMEA)

Group Policy Number: G0077313 (EHC/Dental) and G0076636 (Other Benefits)

Class: City of Revelstoke - CUPE

A message from your plan sponsor

Southern Interior Municipal Employers' Association (SIMEA) is pleased to be able to offer you medical and financial security by sponsoring your group benefits program. We have selected Manulife Financial as a partner to help us deliver the program. They are committed to providing excellent service for us.

At this point, you will have received some basic information about how you can connect with Manulife Financial and how to submit claims. Now, I would encourage you to spend a few moments reviewing our plan's coverage so you can better understand what's available. You'll learn about not only the more routine things, but also about some of the benefits available that you may need to draw on in a time of crisis. Your plan is here to offer you some support in the event you encounter unforeseen circumstances in the future.

After reviewing the coverage, if you have any questions, check in with our plan administrator.

Table Of Contents

A message from your plan sponsor ... 1
What you need to know about your plan ... 3
Core Coverage and Services ... 6
Dental ... 7
Extended Health Care Benefit ... 12
EHC - Drugs ... 14
EHC - Vision ... 16
EHC - Health Care Professionals (Professional Services) ... 17
EHC - Medical Supplies and Services ... 18
Private Duty Nursing Services ... 18
Hearing Aids ... 18
Orthopaedic Shoes ... 18
Medical Equipment ... 19
EHC - Hospital ... 21
EHC - Medical and Non-Medical Travel Emergencies ... 22
Health for Life® - Resources to help you and your family maintain overall good health and wellness ... 24
Health eLinks® - Online resources for better health ... 24
Survivor Benefit ... 25
Life Insurance ... 26
Individual plan options available to purchase if you are leaving the plan ... 28
Conversion Option ... 29
FollowMe™ Health ... 30
Definitions ... 31
Other Carrier Wording ... 35
Basic Accidental Death & Dismemberment Benefit ... 35
Medical Absence Benefit ... 38

What you need to know about your plan

Who and what your plan covers

We are Manulife Financial, your plan sponsor's partner in supporting the group benefits you receive at work. We know how important your coverage is and that you count on us to give you great tools to help you understand what you have.

Your dependants - your spouse, child or children who are insured under the Provincial Health Plan - may also be eligible for some of the coverage provided through this benefits program. Your plan sponsor's plan must be in effect and you and your dependants must have satisfied all of the participation requirements first, for your coverage to be active.

In the event that a provincial plan or government-sponsored program or plan or legally mandated program discontinues or reduces payment for any services, treatments or supplies formerly covered in full or in part by such plan or program, your group benefits plan will not automatically assume coverage of the charges for such treatments, services or supplies, but will reserve the right to determine, at the time of change, whether the expenses will be considered eligible or not.

The information provided here is an overview of the coverage and services your plan sponsor has chosen to offer as part of your group benefits program. It doesn't include reference to all of the plan details, limitations and exclusions or terms and conditions your employer has arranged. Those are set out in your plan sponsor's group benefits plan documents (for example, the policy or plan document and any plan amendments). Manulife's administrative team will refer to those plan documents when evaluating claims, your eligibility for coverage, and for the general administration of the program. In the event of a discrepancy between this coverage overview and the plan documents, the terms outlined in the plan documents will apply.

Where required by law, you or any claimant under the Policy have the right to request a copy of any or all of the following items:
- the Policy
- your application for group benefits and
- any Evidence of Insurability you submitted as part of your application for benefits

In the case of a claimant, access to these documents is limited to that which is relevant to the filing of a claim, or the denial of a claim under the policy.

Manulife Financial reserves the right to charge you for such documentation after your first request.

Time Limit on Legal Action
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.

Your plan sponsor is Southern Interior Municipal Employers' Association (SIMEA)

This booklet produced: August 24, 2015

Your plan numbers are G0077313 (EHC/Dental) and G0076636 (Other Benefits)

These are the main numbers you should provide as a reference when contacting Manulife Financial. Be sure to record these numbers and your plan member certificate number (from your benefits card) on all correspondence and claim forms.

Your coverage class is City of Revelstoke - CUPE

The plan effective date for G0077313 is May 01, 2009

The plan effective date for G0076636 is January 01, 2009

This is the official day when all of the coverage and services your plan sponsor has arranged with us begins. Coverage starts once you have fulfilled any waiting period requirements set for your plan.

Your plan may include a waiting period for some benefits.

The day after the waiting period has finished is the earliest date you can use this coverage.

Enhanced information is also available on the Internet

There may be times when you may not have coverage details with you, but you need to find out about some portion of your coverage quickly. Know that you can always find the most up-to-date plan information - including an electronic version of this document - on the Plan Member Secure Site. Once registered, you can log-in any time from any Internet connection. Go to **www.manulife.ca/groupbenefits** and input your plan number and plan member certificate number. The site will tell you everything else you need to do to finish the registration process.

The electronic version also includes links to definitions, forms, and enhanced information that may help you understand how your benefits program can support you.

HOW LONG COULD IT TAKE TO HAVE MY CLAIM PROCESSED?

This will depend largely on how you submit your claim and how you choose to receive payment. Send paper claims to the address printed on the claim form. Be sure to record your plan contract number and plan member certificate number on all correspondence and claim forms.

USE MORE THAN ONE PLAN TO GET MORE MONEY BACK
Did you know that you can recover up to 100% of your expenses if you coordinate claims with your spouse's group plan? This is called coordination of benefits and here's how it works.

CLAIM IS FOR...	FIRST...	THEN...
You	submit to Manulife	for any unpaid balance, send a copy of your Manulife claim statement and the other insurance company's claim form to the other insurance company for processing.
Your spouse	submit claim to spouse's insurance company	for any unpaid balance, send a copy of the other insurance company's claim statement with a completed Manulife claim form to us for processing
Your children	send to the insurance company of the partner who has the earlier birth month and day	submit any balance to the other insurance company

Manulife Financial does not accept beneficiary appointments for any benefits other than Life Insurance under this Plan.

Manulife Financial does not accept beneficiary appointments for any benefits under this Plan.

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 to be payable.

Core Coverage and Services

Your plan sponsor has chosen to offer the following benefits to form the coverage in this program.

Dental

<table>
<tr><td colspan="2">Your Dental Benefit is provided directly by Southern Interior Municipal Employers' Association (SIMEA)

Manulife Financial has been contracted to adjudicate and administer your claims for this benefit following standard insurance rules and practices. Payment of any eligible claim will be based on the provisions and conditions outlined in this booklet and your employer's Benefit Plan.</td></tr>
<tr><th>Benefit Details</th><th>Your Plan's Coverage</th></tr>
<tr><td>Waiting Period</td><td>earlier of 3 months or 60 days worked</td></tr>
<tr><td>Deductible</td><td>Nil</td></tr>
<tr><td>Dental Fee Guide</td><td>Current Fee Guide for General Practitioners and Specialists for the Province in which the services are rendered

If the services are rendered in Alberta, the current Fee Guide is considered to be the 1997 Alberta Dental Association Fee Guide for General Practitioners and Specialists plus inflationary adjustment as determined by Manulife Financial</td></tr>
<tr><td>Coverage ends</td><td>On the last day of the month in which you attain age 70</td></tr>
<tr><td>Combined Maximum applies to:
Level I
Level II
Level III</td><td>Unlimited</td></tr>
<tr><td>Maximum applies to:
Level IV</td><td>$750 per calendar year and $3,500 per lifetime</td></tr>
<tr><td>Maximum applies to:
Level V</td><td>$3,500 per lifetime</td></tr>
<tr><td>Level I - Basic Services

Includes items such as:
• complete oral exam, one per 2 calendar years
• full-mouth x-rays, one per 2 calendar years
• one unit of light scaling and one unit of polishing twice per calendar year for persons under age 18 and once per calendar year for persons age 18 and over, when the service is performed outside Quebec, or prophylaxis twice per calendar year for persons under age 18 and once per calendar year for persons age 18 and over, when the</td><td>100%</td></tr>
</table>

service is performed in Quebec • recall exams, bitewing x-rays, and fluoride treatments, twice per calendar year for persons under age 18 and once per calendar year for persons age 18 and over • routine diagnostic and laboratory procedures • fillings (amalgam, silicate, acrylic and composite), retentive pins and pit and fissure sealants. Composite fillings on all teeth are covered. Replacement fillings are covered provided: - the existing filling is at least 12 months old and must be replaced either due to significant breakdown of the existing filling or recurrent decay, or - the existing filling is amalgam and there is medical evidence indicating that the patient is allergic to amalgam • pre-fabricated full coverage restorations (metal and plastic) • space maintainers (appliances placed for orthodontic purposes are not covered) • minor surgical procedures and post surgical care • extractions (including impacted and residual roots) • consultations, anaesthesia, and conscious sedation • onlays when the function of a tooth is impaired due to cuspal or incisal angle damage caused by trauma or decay • inlays, covering at least 3 surfaces, provided the tooth cusp is missing • denture repairs, relines and rebases, only if the expense is incurred later than 3 months after the date of the initial placement of the denture • injection of antibiotic drugs when administered by a Dentist in conjunction with dental surgery	
Level II - Supplementary Services Includes items such as: • surgical procedures not included in Level I (excluding implant surgery) • periodontal services for treatment of diseases of the gums and other supporting tissue of the teeth, including:	100%

- scaling not covered under Level I, and root planing, up to a combined maximum of 16 units per calendar year(s) ; - provisional splinting; and - occlusal equilibration, up to a maximum of 8 units per calendar year(s) • endodontic services which include root canals and therapy, root amputation, apexifications and periapical services • root canals and therapy are limited to one initial treatment plus one re-treatment per tooth per lifetime • re-treatment is covered only if the expense is incurred more than 12 months after the initial treatment	
Level III - Dentures Includes items such as: • initial provision of full or partial removable dentures • replacement of removable dentures, provided the dentures are required because: - a natural tooth is extracted and the existing appliance cannot be made serviceable; - the existing appliance is at least 60 months old; or - the existing appliance is temporary and is replaced with the permanent dentures within 12 months of its installation	60%
Level IV - Major Restorative Services Includes items such as: • veneers when the function of a tooth is impaired due to cuspal or incisal angle damage caused by trauma or decay • crowns when the function of a tooth is impaired due to cuspal or incisal angle damage caused by trauma or decay • initial provision of fixed bridgework • replacement of bridgework, provided the new bridgework is required because: - a natural tooth is extracted and the existing appliance cannot be made serviceable; - the existing appliance is at least 60 months old; or - the existing appliance is temporary and is replaced with the permanent bridge within	60% to a maximum of $750 per calendar year and $3,500 per lifetime

12 months of its installation	
Level V - Orthodontics Includes items such as: • orthodontic services	50% to a maximum of $3,500 per lifetime

Exclusions

No Dental Care benefits will be payable for expenses resulting from:

- *self-inflicted injuries*
- *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 while under the influence of any intoxicant, including alcohol*
- *dental care which is cosmetic, unless required because of an accidental injury which occurred while the patient was insured under this benefit*
- *anti-snoring or sleep apnea devices*
- *broken dental appointments, third party examinations, travel to and from appointments, or completion of claim forms*
- *services which are payable by any government plan*
- *services or supplies provided by an employer's medical or dental department*
- *services or supplies for which no charge would normally be made in the absence of insurance*
- *treatment rendered for a full mouth reconstruction, for a vertical dimension or for a correction of temporomandibular joint dysfunction*
- *replacement of removable dental appliances which have been lost, mislaid or stolen*
- *laboratory fees which exceed reasonable and customary charges*
- *services or supplies which are performed or provided by the insured person, an immediate family member or a person who lives with the insured person*
- *implants, or any services rendered in conjunction with implants*
- *treatment which is not generally recognized by the dental profession as an effective, appropriate and essential form of treatment for the dental condition*
- *services or supplies which are not specified as a covered expense under this benefit*

If you anticipate charges for any treatment to exceed $500, please submit a pre-treatment plan before receiving the service so you can understand what portion your plan may cover.

Your plan will pay benefits for the least expensive course of treatment when there are two or more courses of treatment covered that would produce professionally adequate results for a given condition. Manulife's professional dental consultant will aid in evaluating the various courses of treatment available to determine which is professionally adequate.

If you apply for coverage for Dental insurance late, Late Dental Application insurance will be limited to $125 for each insured person for the first 12 months of coverage.

All claims must be submitted within 12 months after the date the expense was incurred. However, upon termination of your insurance, all claims must be submitted no later than 90 days from the termination date.

Extended Health Care Benefit

Your Extended Health Care Benefit is provided directly by Southern Interior Municipal Employers' Association (SIMEA)

Manulife Financial has been contracted to adjudicate and administer your claims for this benefit following standard insurance rules and practices. Payment of any eligible claim will be based on the provisions and conditions outlined in this booklet and your employer's Benefit Plan.

This benefit has many components that extend your coverage to a wide variety of health care providers and services. Under the broad category there may be coinsurances, deductibles, maximums and limitations that apply to specific components of the coverage.

Benefit Details	Your Plan's Coverage
Waiting Period	earlier of 3 months or 60 days worked
Maximum	$1,000,000 per lifetime
Deductible	$50 Individual, $50 Family, per calendar year(s) Not applicable to: • Out-of-Canada Emergency Medical Treatment Covered expenses used to satisfy the deductible in the last 3 months of the calendar year may also be used to satisfy the deductible in the following calendar year.
Co-insurance	80% until a maximum of $1,000 has been paid per person per calendar year; and 100% after a maximum of $1,000 has been paid for Hospital Care, Medical Services & Supplies, Professional Services, Vision 80% until a maximum of $1,000 has been paid per person per calendar year; and 100% after a maximum of $1,000 has been paid for Drugs **Note:** The Co-insurance applicable to Private Duty Nursing Services is shown below under EHC - Medical Supplies and Services.
Coverage Ends	On the last day of the month in which you attain age 70

Exclusions

No Extended Health Care benefits are payable for expenses related to:

- *self-inflicted injuries*
- *war, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion*
- *committing or attempting to commit an assault or criminal offence*
- *injuries sustained while operating a motor vehicle while under the influence of any intoxicant, including alcohol*
- *an illness or injury for which benefits are payable under any government plan or workers' compensation*
- *charges for periodic check-ups, broken appointments, third party examinations, travel for health purposes, or completion of claim forms*
- *services or supplies provided by an employer's medical or dental department*
- *services or supplies for which no charge would normally be made in the absence of insurance*
- *services and supplies where reimbursement would have been made under a government-sponsored plan, in the absence of insurance*
- *services or supplies which are not permitted by law to be paid*
- *services or supplies which are required for recreation or sports*
- *services or supplies which would have been payable by the Provincial Plan if proper application had been made*
- *medical treatment which is not usual or customary, or is experimental or investigational in nature*
- *medical or surgical care which is cosmetic, except for sclerotherapy injections*
- *services or supplies which are performed or provided by the insured person, an immediate family member or a person who lives with the insured person*
- *services or supplies which are provided while confined in a hospital on an in-patient basis*
- *services or supplies which are not specified as a covered expense under this benefit*

All claims must be submitted within 12 months after the date the expense was incurred. However, upon termination of your insurance, all claims must be submitted no later than 90 days from the termination date.

EHC - Drugs

80% **Co-insurance** until a maximum* of $1,000 has been paid per person per calendar year; and
100% after a maximum* of $1,000 has been paid

*maximum could apply to combined benefits (refer to Extended Health Care Benefit - Co-insurance for details)

Benefit Details	Your Plan's Coverage
Direct Drugs Includes the following drug classes: • oral contraceptives • injectable medications • life-sustaining drugs • diabetic supplies (excluding cotton swabs, rubbing alcohol, automatic jet injectors and similar equipment) No coverage for / excludes: • preventive vaccines and medicines (oral or injected) • fertility drugs • anti-smoking drugs • sexual dysfunction drugs • drugs, which are intended to be administered in a hospital on an in-patient or out-patient basis and are not intended for a patient's use at home • cotton swabs, rubbing alcohol, automatic jet injectors and similar equipment used in the treatment of diabetes • charges to administer serums, vaccines & injectable drugs • experimental or investigational drugs not approved or broadly accepted and recognized by the Canadian medical profession as an effective, appropriate and essential treatment of a sickness or injury, in accordance with Canadian medical standards • natural health products (products with a	*There is a limitation on quantity of drugs that can be dispensed and claimed at one time, to the lesser of:* *a) the quantity prescribed by the Physician or Dentist; or* *b) a 34 day supply; or* *c) up to a 100 day supply may be payable in long term therapy where the larger quantity is recommended as appropriate by the Physician and the Pharmacist.* *If you are a Quebec resident, your plan's coverage will coordinate with **RAMQ**.*

NPN)	

EHC - Vision

80% **Co-insurance** until a maximum* of $1,000 has been paid per person per calendar year and 100% after a maximum* of $1,000 has been paid

*maximum could apply to combined benefits (refer to Extended Health Care Benefit - Co-insurance for details)

Benefit Details	Your Plan's Coverage
Prescription Glasses, Contact Lenses, Eye Exams	$500 per 2 calendar year(s) (per calendar year if under 18) for prescription glasses, elective contact lenses , repairs and excluding safety goggles (prescription or non-prescription) If contact lenses are required to treat a severe condition, or if vision in the better eye can be improved to a 20/40 level with contact lenses but not with glasses, the maximum payable will be $200 per calendar year for persons under age 18 and $200 per 2 calendar year(s) for persons age 18 and over Eye Exams - $100 per 2 calendar year(s)
	*Find out about **discounts** available to you through Manulife Financial's relationship with Preferred Vision Services (PVS).*

EHC - Health Care Professionals (Professional Services)

80% **Co-insurance** until a maximum* of $1,000 has been paid per person per calendar year and 100% after a maximum* of $1,000 has been paid

*maximum could apply to combined benefits (refer to Extended Health Care Benefit - Co-insurance for details)

Benefit Details	Your Plan's Coverage
Services provided by the following licensed practitioners: Chiropractor (excluding x-rays)/Naturopath, Massage Therapist/Physiotherapist	$500 per calendar year for Chiropractor (excluding x-rays)/Naturopath $500 per calendar year for Massage Therapist/Physiotherapist
	Expenses for some of these professional services may be payable in part by provincial plans. Coverage for the balance of such expenses prior to reaching the provincial plan maximum may be prohibited by provincial legislation. In those provinces, expenses under this benefit program are payable after the Provincial Plan's maximum for the benefit year has been paid. *Recommendation by a physician for Professional Services is not required.*

EHC - Medical Supplies and Services

80% **Co-insurance** (unless otherwise stated) until a maximum* of $1,000 has been paid per person per calendar year and 100% after a maximum* of $1,000 has been paid

*maximum could apply to combined benefits (refer to Extended Health Care Benefit - Co-insurance for details)

For all medical equipment and supplies, coverage is limited to the cost of the device or item that adequately meets the patient's fundamental medical needs.

Benefit Details	Your Plan's Coverage
Private Duty Nursing Services Provided by a registered nurse either in the patient's home or in a Hospital or registered nursing assistant (or equivalent designation) who has completed an approved medications training program, in the patient's home. Excludes: • custodial care, homemaking duties or supervision • services performed by a nurse practitioner who is an immediate family member or who lives with the patient • services performed while confined to a nursing home or other similar institution • services that could be performed by a person with lesser qualifications, a relative, a friend or a member of the patient's household	100% Co-insurance 720 hours per calendar year(s) *Submit a detailed treatment plan estimate before Private Duty Nursing services begin so we can advise you of what benefit may be provided.*
Hearing Aids	$500 per 5 calendar year(s) *Includes cost, installation, repair and maintenance of Hearing Aids (excluding charges for batteries, recharging devices, or other such accessories)*
Orthopaedic Shoes	$200 per calendar year(s) for persons under age 18 and $400 per calendar year(s) for persons age 18 and over for Stock-item Orthopaedic Shoes

	Custom Made Shoes which are required because of a medical abnormality that, based on medical evidence, cannot be accommodated in a stock-item orthopaedic shoe or a modified stock-item orthopaedic shoe, up to a maximum of 1 pair per calendar year (must be constructed by a certified orthopaedic footwear specialist) *Must be recommended by a physician, podiatrist or chiropractor.*
Medical Equipment Includes items such as: • ambulance (licensed including air ambulance, provided in province of residence) • mobility equipment (crutches, canes, cane tips, walkers, wheelchairs) • manual hospital beds • respiratory and oxygen equipment • other equipment usually found only in hospitals • medical heart monitors • blood glucose monitors • cardiac screeners • breathing machines and appliances including respirators, compressors, percussors, suction pumps, oxygen cylinders, masks and regulators • non-dental external prostheses • braces (other than foot braces), trusses, collars, leg orthosis, casts and splints • ileostomy, colostomy and incontinence supplies • medicated dressings and burn garments • oxygen • charges for the treatment required as a result of an injury to natural teeth or jaw • surgical brassieres • wigs and hairpieces for patients with temporary hair loss associated with medical treatment, injury, alopecia areata,	$150 per calendar year for surgical brassieres $500 per lifetime for wigs and hairpieces $200 per calendar year(s) for stump socks $4,000 per 5 calendar year(s) for Speech Processor and Headset *Medical equipment dispensed by a hospital is not an eligible expense.* *In the province of Quebec, microscopic and other similar diagnostic tests and services rendered in a licensed laboratory are included.* *Accidental dental treatment must be provided within 12 months of the accident. The accident must be due to an external force or blow to the mouth or face resulting in immediate damage to the natural teeth or prosthetics and not by an object intentionally or unintentionally being placed in the mouth. Injuries sustained while biting or chewing are not covered.*

alopecia universalis, or alopecia totatlis • insulin infusion pumps for diabetics (when basic methods are not feasible) • Transcutaneous Electric Nerve Stimulators (TENS) • Transcutaneous Electric Muscle Stimulators (TEMS) • bi-osteogen systems (when recommended by an orthopaedic surgeon) and growth guidance systems • speech processors and headsets when prescribed for profound deafness • external prostheses (charges for myoelectric limbs are eligible up to the equivalent amount of a standard external prosthesis) • stump socks	

EHC - Hospital

80% **Co-insurance** until a maximum* of $1,000 has been paid per person per calendar year and 100% after a maximum* of $1,000 has been paid

*maximum could apply to combined benefits (refer to Extended Health Care Benefit - Co-insurance for details)

Benefit Details	Your Plan's Coverage
General or Rehabilitation hospitals	• in a Private Room • in excess of the hospital's public ward charge
	Manulife Financial will coordinate payment after any provincial plan coverage has first been applied.

EHC - Medical and Non-Medical Travel Emergencies

Benefit Details	Your Plan's Coverage
Emergency medical coverage Conditions: • Coverage is for immediate medical treatment required for: - a sudden, unexpected injury or a new medical condition which occurs while an insured person is travelling outside of their province of residence; or - a specific medical problem or chronic condition that was diagnosed but medically stable prior to departure. • Coverage is available for medical emergencies related to pregnancy as long as travel is completed at least 4 weeks before the due date. • Valid Government Health Insurance Plan (GHP) coverage is required for you and your dependants.	100% Stable means in the 90 days before departure, the insured person has not: • been treated or tested for any new symptoms or conditions; • had an increase or worsening of any existing symptoms; • changed treatments or medications (other than normal adjustments for ongoing care); • been admitted to the hospital for treatment of the condition. Coverage is not available if you (or your dependant) have scheduled non-routine appointments, tests or treatments for the condition or an undiagnosed condition. A medical emergency ends when the attending physician feels that, based on the medical evidence, a patient is stable enough to return to their home province or territory. *You are typically responsible for payment of medical expenses amounting to less than $200 CDN. When you return from your trip, you can submit a claim to be reimbursed for those expenses through the normal claim submission process.* *For charges over $200 CDN, contact the service partner shown on your benefits card as soon as possible to arrange for payment directly to the treating physician or facility.*
Emergency Travel Assistance Including: • 24 hour access to multi-lingual service representatives • referral to local medical care and treatment monitoring • payment of medical bills, medical	100% with all maximums below stated in Canadian Funds. $1,000 for return of vehicle $2,000 for meals and accommodations $5,000 for return of deceased

transportation, return home of dependant children, visit by a family member, trip interruption/delay coverage, support through convalescence after hospital discharge, identification and/or return of a deceased traveller, meals and accommodation, vehicle return, pre-trip advice on passport, visa, vaccination and inoculation requirements for a destination, assistance in replacing lost documents and tickets, referral to legal assistance in your foreign destination, telephone interpretation service, emergency message service, and • after-hours medical advice phone support	
	*See **www.manulife.ca/groupbenefits/ travel** for additional information, a list of phone numbers for frequent Canadian travel destinations and for participating countries.*

Health for Life® - Resources to help you and your family maintain overall good health and wellness

<table>
<tr><th>Benefit Details</th><th>Your Plan's Coverage</th></tr>
<tr><td colspan="2">Your plan also includes access to services and information you and your family can use to live healthier lives. You can access these services on the Plan Member Secure Site.</td></tr>
<tr><td colspan="2">Health eLinks® - Online resources for better health</td></tr>
<tr><td>Take the first step toward healthier living through online tools and resources such as:

Health Risk Assessment

Health Library, including:
• Conditions database
• Medications database
• Tests and procedures database
• Health features
• Personal Health Improvement Program</td><td>Included and available on the Plan Member Secure Site</td></tr>
</table>

Survivor Benefit

Benefit Details	Your Plan's Coverage
If you die while your dependants are insured under the program, Manulife Financial will continue coverage for some benefits without payment of premium: • Extended Health Care • Dental Care	Coverage will continue until the earliest of: • the end of the month in which you died. The maximum period for extended coverage is one month. • the date your dependant is no longer a dependant • the date similar coverage is obtained elsewhere • the date the Group Policy terminates

Life Insurance

<table>
<tr><td colspan="2">You may also wish to consider supplementing this coverage by purchasing any available FollowMe, Optional or Personal Benefits coverage available for your plan.</td></tr>
<tr><td colspan="2">These Benefits are insured by Manulife Financial. The plan number is G0076636.</td></tr>
<tr><th>Benefit Details</th><th>Your Plan's Coverage</th></tr>
<tr><td colspan="2"></td></tr>
<tr><td>Waiting Period</td><td>earlier of 3 months of employment or 60 days worked</td></tr>
<tr><td>Benefit Amount</td><td>2 times your annual earnings, to a maximum of $150,000</td></tr>
<tr><td>Non-Evidence Limit</td><td>$150,000</td></tr>
<tr><td>Reduction and Termination Age</td><td>Your benefit amount terminates at age 70 or retirement, whichever is earlier</td></tr>
<tr><td>Qualifying Period for Waiver of Premium</td><td>6 months</td></tr>
<tr><td>Waiver of Premium</td><td>If you become Totally Disabled while insured and prior to age 65 and meet the Waiver of Premium Entitlement Criteria, your Life Insurance will continue without payment of premium.

Totally Disabled means a restriction or lack of ability due to an illness or injury which prevents you from performing the essential duties of:
• your own occupation, during the Qualifying Period and the 2 years immediately following the Qualifying Period
• any occupation for which you are qualified, or may reasonably become qualified by training, education or experience, after the 2 years specified above
The availability of work will not be considered by Manulife Financial in assessing your disability.

If you must hold a government permit or licence to perform the duties of your job, you will not be considered Totally Disabled solely because your permit or licence has been withdrawn or not renewed.</td></tr>
<tr><td>Conversion Privilege</td><td>If your Group Benefits terminate or reduce, you may be eligible to convert your Life Insurance to an individual policy, without needing to provide medical evidence. Your application for the</td></tr>
</table>

<table>
<tr><td></td><td>individual policy along with the first monthly premium must be received by Manulife Financial within 31 days of the termination or reduction of your Life Insurance. If you die during this 31-day period, the amount of Life Insurance available for conversion will be paid to your beneficiary or estate, even if you didn't apply for conversion.

See the conversion option details in the Individual plan options section.</td></tr>
<tr><td colspan="2">Your beneficiary or estate must submit a claim within 90 days of the date of death. He or she can obtain the necessary paperwork from your plan sponsor. Claims for Waiver of Premium must be submitted within 180 days of the end of the qualifying period.

If you are terminally ill and not expected to live more than 24 months, and you require financial assistance, you may qualify for a Compassionate Assistance loan.

You have the right to designate and/or change a beneficiary, subject to governing law. The necessary forms are available from your Plan Administrator.

You should review your beneficiary designation to be sure that it reflects your current intent.</td></tr>
</table>

Individual plan options available to purchase if you are leaving the plan

When your group coverage ends, your relationship with Manulife doesn't have to stop there. You have the option to purchase your own personal plans.

Conversion Option

Some core coverage benefits (Life, Optional Life, Critical Illness, Optional Critical Illness) give you the option to purchase individual coverage when your group benefits terminate or reduce, without needing to provide medical evidence. Your application for the individual policy along with the first monthly premium must be received by Manulife Financial within 31 days of the termination or reduction of your coverage. Other specific conditions for coverage may be noted in each benefit information section of this document.

For more information on the conversion privilege, please see your Plan Administrator. Provincial differences may exist.

FollowMe™ Health

The FollowMe Health plan is specially designed for those whose group health coverage has recently or will soon come to an end. FollowMe Health allows you to continue enjoying health and dental benefits without completion of a medical questionnaire, so there's no need to worry about interruption of coverage for you or your loved ones.

If you apply within 60 days of your loss of group health and dental benefits, you will qualify without having to complete a medical questionnaire.

With four different plans and levels of coverage to choose from, you're certain to find the FollowMe Health plan that meets your needs.

To find out more, request a brochure, get a quote, apply online or print an application, go to ***www.coverme.com*** *or call 1-877-COVER ME® (1-877-268-3763)*

Definitions

Explanation of some of the terms used in this document

Co-insurance

The way the cost of a service is shared between you and your plan. It exists in addition to any deductibles. So for example, an 80% co-insurance means that after the deductible has been satisfied, your plan will cover up to 80% of the bill and you would pay the rest.

Co-payment

The fixed amount that you must pay towards the cost of a service each time you use your plan. Most often, co-payments exist in situations where a claim is settled at point of sale. For instance, you might see a drug benefit with a $2.00 co-pay amount. Regardless of the cost of the prescription being filled, you are required to pay $2.00.

Dependant

Your Spouse or Child who is insured under the Provincial Plan.

Spouse

- your legal spouse, or a person continuously living with you in a role like that of a marriage partner for at least one year.

Child

- your natural or adopted child, or stepchild, who is:
  - unmarried
  - under the age stated below:
    for Dental coverage - under age 21, or who is a full-time student;
    for Extended Health Care coverage - under age 21, or who is a full-time student;
  - not employed on a full-time basis
  - not eligible for insurance as an employee under this or any other Group Benefit Program
- a child who is incapacitated on the date he or she reaches the age when insurance would normally terminate will continue to be an eligible dependant. However, the child must have been insured under this Benefit Program immediately prior to that date
- a child is considered incapacitated if he or she is incapable of engaging in any substantially gainful activity and is dependant on the employee for support, maintenance and care, due to a mental or physical disability. Manulife Financial may require written proof of the child's condition as often as may reasonably be necessary
- a stepchild must be living with you to be eligible

Drugs

- must be prescribed in writing by a physician, dentist or other health care professional whose scope of practice within their province permits them to write a prescription;
- must be dispensed by a licensed pharmacist;
- must have been approved for use by Health Canada and have a drug identification number(DIN).

RAMQ - Drug Benefit for persons who reside in Quebec
If you and your dependants reside in Quebec, the following provisions apply to your drug benefit coverage:

- drugs that are on the List of Insured Drugs that is published by the Régie de l'assurance-maladie du Québec (RAMQ List), provided such drugs are on the list at the time the expense is incurred; and
- drugs that are listed as a covered expense under your drug plan but are not on the RAMQ List.

The following provisions apply only to the coverage of drugs that are on the RAMQ List, as legislated by An Act Respecting Prescription Drug Insurance (R.S.Q. c., A-29-01). Coverage for all other drugs will be subject to the regular provisions included in your benefit plan.

a) Benefit Percentage
Prior to the annual out-of-pocket maximum being reached, the percentage of covered drug expenses payable under this benefit will be as follows:

i) For any drug on the RAMQ List which is not otherwise covered under the terms of this benefit, the percentage payable is the percentage as set out by legislation.

ii) For any drug on the RAMQ List which is covered under the terms of this benefit, the percentage payable is the greater of:

- the benefit percentage stated under the benefit; or
- the percentage as set out by legislation.

After the annual out-of-pocket maximum has been reached, the percentage of covered drug expenses payable under this benefit will be 100%.

b) Annual Out-of-Pocket Maximum
The annual out-of-pocket maximum is the portion of covered drug expenses which must be paid by you and your spouse in a calendar year, before the percentage payable under this benefit will be 100%. Amounts that will be applied to the annual out-of-pocket maximum are:

i) deductible amounts, and

ii) the portion of covered drug expenses that is paid by an insured person, when the percentage of covered expenses payable under this benefit is less than 100%.

The annual out-of-pocket maximum for you and your spouse is as stipulated in the legislation and includes those portions of covered drug expenses paid for your dependant children.

For the purposes of calculating the out-of-pocket maximum for you and your spouse, those portions of covered drug expenses paid for your dependant children will be applied to the person who is closest to reaching the annual out-of-pocket maximum.

c) Deductible
Deductible amounts (if any) for the drug benefit will apply, until the annual out-of-pocket maximum is

reached. Thereafter, the deductible will not apply.

d) Lifetime Maximums
Lifetime maximums (if any) for the drug benefit will not apply. Drug coverage provided after the lifetime maximum stated under this plan is reached is subject to the following conditions:
i) only drugs that are on the RAMQ List are covered, and
ii) the percentage payable by Manulife Financial for covered expenses is the percentage as set out by legislation.

e) Eligible Dependant Children
Your eligible dependant children who are in full-time attendance at an accredited educational institution will be covered until the later of:
i) the age specified in this Benefit Booklet or
ii) age 26.

Drug coverage provided for dependant children after the age stated in this Benefit Booklet is subject to the following conditions:

- only drugs that are on the RAMQ List are covered, and
- the percentage payable by Manulife Financial for covered expenses is the percentage as set out by legislation.

f) Termination Age
Provided you are otherwise eligible for the drug benefit, the termination age (if any) for the drug benefit will not apply. Drug coverage provided after the termination age specified under The Benefit is subject to the following conditions:
i) only drugs that are on the RAMQ List are covered,
ii) the percentage payable by Manulife Financial for covered expenses is the percentage as stipulated in the legislation
iii) the Annual Out-of-Pocket Maximum is as stipulated in the legislation

Coverage for drugs that are listed as a covered expense under this Benefit but not on the RAMQ List will be subject to all the standard provisions included in this Benefit Booklet.

Earnings

Earnings are your regular rate of pay from your employer (prior to deductions)
- including regular bonuses
- including regular overtime pay

Earnings may include other income as agreed to in writing by your employer and Manulife Financial.

If you are being paid on a commission basis, your earnings will be as reported on your T4/T4A form for the previous year. If you have less than one year of service with your employer, your earnings will include an average of the total commissions paid over your actual period of employment.

For the purposes of determining the amount of your benefit at the time of claim, your earnings will be the lesser of:
- the amount reported on your claim form, or
- the amount reported by your employer to Manulife Financial and for which premiums have been paid.

Experimental or Investigational

Treatment not approved or broadly accepted and recognized by the Canadian medical profession, as an effective, appropriate and essential treatment of a sickness or injury, in accordance with Canadian medical standards.

Medical and Non Medical Travel Emergencies

Sudden, unexpected injuries which occur or unforeseen illnesses which begin while travelling out-of-province or out-of-Canada for business or pleasure and for accidents or illnesses that were not previously diagnosed or treated in Canada.

Medically Necessary

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

Non-Evidence Limit

The amount of insurance benefits you can receive without needing to provide proof of good health. Anything over this figure means that Manulife must review medical evidence before you are approved for the higher amount.

Out-Of-Pocket Maximum

This is the maximum amount of money you will have to pay on your own before your insurance benefits begin to take over and pay. It includes things like deductibles, and co-insurance, but not things like co-payments or your monthly premium.

Reasonable and Customary Charges

The lowest of:

- the prevailing amount charged for the same or comparable service or supply in the area in which the charge is incurred, as determined by Manulife Financial; or
- the amount shown in the applicable professional association fee guide; or
- the maximum price established by law

Other Carrier Wording

Basic Accidental Death & Dismemberment Benefit

This Benefit is insured by Industrial Alliance Insurance and Financial Services Inc. The wording has been provided by Industrial Alliance Insurance and Financial Services Inc. who assumes sole responsibility in the case of any discrepency between this wording and the policy 100010662 issued by them.

BASIC A.D.& D. INSURANCE

Coverage

Any accident resulting in: death, dismemberment, loss of sight, or paralysis - anywhere in the world - 24 hours a day - on or off the job.

Eligibility

All permanent, full time employees of the Policyholder. (Employees must be regularly scheduled to work for a minimum of 35 hours per week or a shift schedule based on 35 hours per week.)

Amount of Insurance

An amount equal to the amount of Basic Group Life Insurance in effect under the Policyholder's current Group Life Policy or its replacement subject to a maximum of $400,000

Benefits

Accidental Death, Dismemberment and Specific Loss Indemnity

The policy provides benefits for Injury resulting in Loss of, **or permanent and total Loss of Use of,** which occurs within **12 months** after the date of the accident as follows:

Life - The Principal Sum
Both Hands - The Principal Sum
Both Feet - The Principal Sum
Entire Sight of Both Eyes - The Principal Sum
One Hand and One Foot - The Principal Sum
One Hand and the Entire Sight of One Eye - The Principal Sum
One Foot and the Entire Sight of One Eye - The Principal Sum
Speech and Hearing in Both Ears - The Principal Sum
One Arm - Three-Quarters of the Principal Sum
One Leg - Three-Quarters of the Principal Sum
One Hand - Two-Thirds of the Principal Sum
One Foot - Two-Thirds of the Principal Sum
Entire Sight of One Eye - Two-Thirds of the Principal Sum
Speech or Hearing in Both Ears - Two Thirds of the Principal Sum
Thumb and Index Finger of Either Hand - One-Third of the Principal Sum
Four Fingers of Either Hand - One-Third of the Principal Sum
Hearing in One Ear - One-Third of the Principal Sum
All Toes of One Foot - One-Quarter of the Principal Sum

PARALYSIS BENEFITS

Quadriplegia (complete paralysis of both upper and lower limbs). - Two Times the Principal Sum
Paraplegia (complete paralysis of both lower limbs) - Two Times the Principal Sum

Hemiplegia (complete paralysis of upper and lower limbs of one side of body) - Two Times the Principal Sum

Indemnity provided under this part for all losses sustained by an Insured Person as the result of any one accident will not exceed the following:

(a) With the exception of Quadriplegia, Paraplegia and Hemiplegia, the Principal Sum;

(b) With respect to Quadriplegia, Paraplegia and Hemiplegia, two times the Principal Sum or the Principal Sum if loss of life occurs within 90 days after the date of the accident.

In no event will indemnity payable for all losses under this part exceed, in the aggregate, two times the Principal Sum as the result of the same accident.

"Injury" whenever used in the policy means bodily injury caused by an accident occurring while the policy is in force as to the Insured Person whose injury is the basis of claim and resulting directly and independently of all other causes in loss covered by the policy, and that is not caused or contributed to, directly or indirectly, by physical or mental illness or disease, or treatment for the illness or disease.

"Loss" whenever used in the policy with reference to hand or foot means complete severance at or above the wrist or ankle joint but below the elbow or knee joint; as used with reference to arm or leg means complete severance at or above the elbow or knee joint; as used with reference to thumb and fingers means complete severance at or above the metacarpophalangeal joint; as used with reference to toes means complete severance at or above the metatarsophalangeal joint; as used with reference to eye means the irrecoverable loss of the entire sight thereof; as used with reference to speech means the total and irrecoverable loss thereof; as used with reference to hearing means the total and irrecoverable loss thereof; and as used with reference to Quadriplegia, Paraplegia and Hemiplegia means the permanent and irrecoverable paralysis of such limbs.

"Loss of Use" whenever used in the policy means a loss which is permanent, total, irrecoverable and continuous for a period of 12 months from the date of the accident.

DAY CARE BENEFIT

If injury causes loss of life within 12 months of the date of the accident, the Company will pay the reasonable and necessary expenses actually incurred, subject to five percent of the Insured Person's Principal Sum to a maximum of $5,000.00 for each year a Dependent Child is enrolled in a legally licensed Day Care Centre, but not to exceed four years which must run consecutively with respect to any one Dependent Child. In the event the Dependent Child does satisfy the requirements indicated above, the Day Care Benefit will be payable to the surviving Spouse.

EDUCATION BENEFIT

If injury results in the loss of life of an Insured Person within 12 months of the date of the accident, the Company will pay, in addition to all other benefits, five percent of the Insured Person's Principal Sum to a maximum of $5,000.00 to any Dependent Child, who on the date of accident was enrolled as a full-time student in any institution of higher learning beyond the secondary school level but not to exceed four consecutive annual payments.

FAMILY TRANSPORTATION BENEFIT

When, as a result of loss covered by the policy, an Insured Person is confined as an inpatient in a hospital located from a point of not less than 150 kilometers from his/her normal place of residence, the Company will pay the reasonable expenses actually incurred by all members of the immediate family of the Insured Person for hotel accommodation and transportation by the most direct route to the confined Insured Person, not to exceed in the aggregate the amount of $15,000.00 for all such expenses.

HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT

If an injury sustained by an Insured Person does not cause loss of life, but results in a loss for which indemnity becomes payable under the part titled "Accidental Death, Dismemberment and Specific Loss Indemnity", and such Insured Person subsequently requires the use of a wheelchair to be ambulatory, the

Company will pay the cost of alterations to the Insured Person's principal residence and/or the cost of modifications to one motor vehicle utilized by the Insured Person, when such modifications are approved by licensing authorities where required for the purpose of making them wheelchair accessible to a maximum of $15,000.00.

REHABILITATION BENEFIT

When, as a result of loss covered by the policy, an Insured Person undergoes special training in order to be qualified to engage in a special occupation in which he/she would not have engaged except for such injury, the Company will pay the reasonable and necessary expense incurred for such training by the Insured Person within two years of the date of the accident, subject to a maximum amount of $15,000.00 as the result of any one accident.

REPATRIATION BENEFIT

If injury results in the loss of life of an Insured Person within 12 months of the date of the accident, the Company will pay the actual expense incurred for preparing the deceased for burial or cremation and the shipment of the body of the Insured Person to the city of residence of the deceased, subject to a maximum amount of $15,000.00.

SPOUSAL RETRAINING BENEFIT

In the event loss of life as the result of an injury is sustained by an Insured Person, the Company will pay the reasonable and necessary expenses actually incurred within three years from the date of such accident by the Spouse of the Insured Person who engages in a formal occupational training program in order to become specifically qualified for active employment in an occupation for which he/she would not otherwise have sufficient qualifications, not to exceed in the aggregate the amount of $15,000.00 for all such expenses.

WAIVER OF PREMIUM

In the event an Insured Person becomes totally disabled for more than six months prior to age 65, the insurance of the Insured Person will continue without payment of premium during the continuance of such total disability.

Aggregate Limit of Indemnity

The policy is subject to an Aggregate Limit of Indemnity of $2,500,000.00 for all losses resulting from any one accident. This means that in the event of an accident that results in an accumulation of losses exceeding $2,500,000.00, the amount payable with respect to each Insured Person will be reduced proportionately.

Exclusions

Cover does not apply to any loss caused or contributed to by:

- declared or undeclared war or any act of war;
- active full-time service in the armed forces of any country;
- suicide or self-destruction, while sane or insane;
- flying as a pilot or crew member in any aircraft;
- flying in owned, operated or leased aircraft of your employer.

Exposure and Disappearance

If due to accident you are unavoidably exposed to the elements and such exposure, within 12 months of the date of the accident, results in a Loss for which indemnity would otherwise have been payable under the policy, such Loss will be deemed to be the result of Injury.

Where, due to the accidental wrecking, sinking or disappearance of a conveyance in which you were riding, you disappear, and if your body is not found within 12 months after the date of such wrecking, sinking or disappearance, it will be presumed, subject to there being no evidence to the contrary and subject to all other terms and conditions of the policy, that you suffered loss of life as a result of Injury.

Beneficiary

Indemnity payable in the event of the loss of life of an Insured Person is payable to the beneficiary or beneficiaries designated in writing by the Insured Person and on file with the or Policyholder, or, if there is no such beneficiary designation with respect to the Insured Person, such indemnity is payable to the Estate of the Insured Person. All other indemnities are payable to the Insured Person.

Termination of Insurance

This policy may be terminated by the Company or by the Policyholder by one giving to the other 30 days notice in writing of such intention to terminate, delivered to the latest address of the Company or the Policyholder. This policy may be terminated by the Company in the event of failure by the Policyholder to remit premiums to the Company as and when due.

A.D.& D. Claims Procedures

Claim forms are available from your plan administrator or from the insurer. The insurer reserves the right to request additional information when processing the claim. Written notice of accidental death, dismemberment, loss of sight, hearing, paralysis or loss of use of limbs is to be given to the insurer within a period of 30 days from the date of the accident. For all other claims, completed claim forms must be filed with the insurer within 90 days after the date of the Injury.

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.

This wording is for illustrative purposes only and carries no contractual or other rights. All rights with respect to the benefits of an Insured Person will be governed by the Group Master Policy, a copy of which is filed with your employer.

Medical Absence Benefit

MEDICAL ABSENCE

This benefit is insured by Disability Management Institute (DMI). The wording for this benefit has been provided by Disability Management Institute (DMI) who assumes sole responsibility in the case of any discrepancy between this wording and the policy issued by them.

Waiting Period

The date following the earlier of 3 months of employment or 60 days worked

Weekly Benefit Amount

70% of weekly earnings rounded to the next higher $1.00 if not already a multiple thereof. The employer tops up the benefit to 100% of the take home pay if you participate in a return to work program while collecting weekly income benefits.

Note: benefits and elimination period are based on working days or shift schedule - not including weekends or non-scheduled work days.

Maximum Weekly Benefit

Unlimited

Elimination Period

Injury/Accident - 5 days
Hospital - 5 days
Sickness - 5 days

Maximum Benefit Period

Up to 26 weeks

Total Disability Definition

Means you are unable to perform a substantial portion of the duties of your own occupation or regular employment as a result of an Accident or Illness. Further, you must be under the continuous care and treatment of a physician and not engaged in any occupation or employment for wage or profit except as described under Rehabilitation in the benefit booklet.

Tax Status

Non-Taxable

Termination Age

Age 65 or earlier retirement

General Description of This Coverage

Medical Absence coverage provides a weekly benefit if you become totally disabled as a result of an accident or an illness. You qualify for this benefit if you present proof of claim acceptable to GroupHEALTH Global that:

- you became totally disabled for a continuous period of time while covered,
- you are under the regular care and attendance of a physician and
- you have been following appropriate treatment for the disability.

For the purposes of your Medical Absence benefit, you will be considered totally disabled while you are continuously unable to perform the essential duties of your own occupation and are not engaged in any occupation for wage or profit, except as described under Rehabilitation.

When Medical Absence Payments Begin

Your Medical Absence benefits become payable at the later of:

- the date the Elimination Period (shown in the Summary of Benefits) has been completed
- the date you are first seen and treated by a physician for the disabling condition

The Elimination Period is the period of uninterrupted total disability that must be completed before disability benefits become payable.

What Will Be Paid

You will receive a weekly benefit as indicated in the Summary of Benefits. The benefit is paid weekly in advance.

If the Benefit Period payment represents a period of disability other than one week, then the payment will be equal to the weekly benefit otherwise payable divided by the scheduled shift days, multiplied by the number of shift days for which payment is being made.

The benefit amount will be directly reduced by the sum of the following:

- any income provided to you under a motor vehicle insurance plan, which provides disability benefits as long as any benefits payable under the Employment Insurance Act are not taken into account when determining

the amount of benefits payable under the motor vehicle insurance plan and as long as the law does not prohibit such a deduction.
- any benefit you are entitled to under the Canadian Pension Plan (primary benefit only)
- any income or benefit received as a result of a disability or medical condition under a retirement or pension plan funded in whole or in part by your employer.

If you are eligible for any income amounts noted above and do not apply for them, GroupHEALTH Global may estimate those benefits and reduce your Medical Absence benefit accordingly.

If you receive any of the income amounts noted above in a lump sum, GroupHEALTH Global will determine, using generally accepted accounting principles, the equivalent weekly compensation and will reduce your Medical Absence benefit accordingly.

GroupHEALTH Global will not take into account any benefits that began before your disability began. However, increases in any of those benefits as a result of your disability will be taken into account.

Recurrent Periods Of Disability

Successive periods of Total Disability occurring while this benefit is in force will be considered to be one period of Total Disability if:

- they result from the same or related causes, unless they are separated by an interval of at least thirty days during which you are Actively Employed on a full-time basis, or
- they result from entirely unrelated causes, unless they are separated by any interval during which you are Actively Employed on a full-time basis.

The benefit will be based on the same earnings level as on the original date of disability and will be paid for no longer than the remainder of the maximum benefit period indicated in the Summary of Benefits.

Rehabilitation Program

GroupHEALTH Global may at any time require you to join a program of rehabilitation that is appropriate for your circumstances. Participation in a program of rehabilitation will not disqualify you for disability benefits under this Plan while the Rehabilitation Program continues and while you continue to be otherwise eligible for benefits. Refusal to enter and participate in a Rehabilitation Program considered appropriate by GroupHEALTH Global will result in the termination of benefit payments.

A rehabilitation program must be approved in by GroupHEALTH Global and will consist of:

- full-time or part-time work or employment for compensation or profit engaged in by an employee who is totally disabled under the terms of the Plan, or
- any vocational training or re-training program or period of work for the purpose of rehabilitation.

As long as you continue to satisfy the definition of total disability following the Elimination Period, and yet are able to return to the workforce in a reduced capacity, GroupHEALTH Global will apply the regular provisions of the Medical Absence plan.

When Payments End

Medical Absence Benefit payments will cease on the earliest of the following dates:

- the date you cease to be Totally Disabled as defined in the Definitions provision;
- the date you engage in any occupation for wages or profit other than under an approved Rehabilitation Program;
- the date on which the maximum benefit period, indicated in the Summary of Benefits, has been reached. Any period of the benefit that commences prior to you turning the termination age, indicated in the Summary of Benefits, will continue until the earliest of:
- 15 weeks,
- the date you are no longer disabled, or
- the date of your death.
- the date you are no longer under continuing medical supervision and treatment considered appropriate by

GroupHEALTH Global;
_ the date on which you fail to furnish satisfactory proof of the continuance of Total Disability, or fail to submit to an examination requested by GroupHEALTH Global;
- the date you retire with a pension;
- the date upon which you have failed to comply with a duly qualified physician's recommended program of treatment and recovery;
- the date of your death.

Exclusions and Limitations

Medical Absence Benefits are not payable for any of the following:

- any period during which you are not under the continuous care and treatment of a physician (medical doctor);
- any period of absence normally required for medical treatment that is not medically necessary (i.e. cosmetic surgery or treatments);
- any period you are imprisoned;
- any disability resulting directly or indirectly from self-inflicted injury;
- any disability resulting directly or indirectly from participation in insurrection, war (whether declared or not) or the hostile actions of the armed forces of any country, service in the armed forces or participation in any riot, civil commotion or any other act of aggression;
- any disability resulting directly or indirectly from committing or attempting to commit a criminal act as defined under legislation in the jurisdiction where the act was committed;
- any disability caused by the use of drugs or alcohol unless you are engaged in, and complete, a recognized rehabilitation program considered appropriate by GroupHEALTH Global, specifically for the treatment of substance abuse. Benefits are payable only for the period in which you prove your attendance at such a recognized program. Benefits will not continue beyond the program duration. This exclusion will not apply if total disability is the result of a related organic condition.
- any disability resulting directly or indirectly from any cause for which indemnity or compensation is provided under the Workers' Compensation law or other legislation of similar purpose;
- any disability during the longer of:
  - any period of formal maternity leave that you take pursuant to provincial or federal law, or pursuant to mutual agreement between you and your Employer, or
  - any period in which the unemployment insurance maternity benefits are being paid or would be paid if you were eligible
- any period during which you are absent from Canada longer than 4 weeks due to any reason, unless GroupHEALTH Global agrees in writing in advance to pay benefits during this period.

When and How To Make A Claim

To make a claim, complete the claim forms for Medical Absence Benefits that are available from your employer.

Part of the application process will include filling out claim forms that provide as many details of the disabling condition as possible. You, your attending physicians and your employer will all have to complete claim forms.

In order for you to receive benefits, GroupHEALTH Global must receive the completed forms no later than 30 days after your total disability begins.

From time to time, GroupHEALTH Global can require that you provide proof of your total disability. If you do not provide this information within 10 days of the request, you will not be entitled to Medical Absence benefits. Charges for physicians' statements, including additional medical information that GroupHEALTH Global requires for initial claim assessment, are your responsibility.