YOUR GROUP BENEFITS FLEX PLAN MEMBER GUIDE

for active employees of
CBM Office staff, CBOQ, CBWC and FBU

Updated for January 1, 2025

BENEFIT DETAILS

Canada Life is a leading Canadian life and health insurer. Canada 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.

Canada Life Online

Information and details on Canada Life's corporate profile, our products and services, investor information, news releases and contact information can all be found at www.canadalife.com.

Canada Life Online Services for Plan Members

As a Canada Life plan member, you can register for *My Canada Life at Work* at my.canadalife.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, Dental care and Health Care Spending Account sections of this booklet;
- extensive health and wellness content.

Using the *My Canada Life at Work* app, you can:

- submit most of your claims online – part of our industry-leading 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.

Canada Life's Toll-Free Number

Contact a customer service representative at Canada 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.

For Treasurers:

- For assistance please call 1-877-883-7072.

This booklet describes the principal features of the group benefit plan sponsored by your employer, but Group Policy **Nos. 156241 and 156243** issued by Canada Life, and Group Policy **Nos. AB10518101 OE10518101** issued by Chubb, 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

and

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 Canada 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 Canada Life sends you a notice of the overpayment, or within a longer period if agreed to in writing by Canada 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 Canada Life's right to use other legal means to recover the overpayment.

PROTECTING YOUR PERSONAL INFORMATION

At Canada Life, we recognize and respect the importance of privacy. Personal information about you is kept in a confidential file at the offices of Canada Life or the offices of an organization authorized by Canada Life. Canada Life may use service providers located within or outside Canada. We limit access to personal information in your file to Canada Life staff or persons authorized by Canada 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 Canada 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 Canada Life's Chief Compliance Officer or refer to www.canadalife.com/.

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YOU SHOULD KNOW

Effective Date of Plan: July 1, 2012 (April 1, 2017 for CBWC)

Covered Classes: Active employees of CBM, CBOQ, CBWC 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 Canada 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. AB10518101 and OE10518101 issued by Chubb.

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:

- Executive staff and pastors: coverage from date of hire
- All other employees: coverage on the 1st of the month following 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.

SUMMARY OF COVERAGES – CANADA LIFE

COVERAGES FOR YOU AND YOUR ELIGIBLE DEPENDENTS

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

	GREEN LEAF	ORANGE LEAF	BLUE LEAF
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	$20,000	$20,000	$20,000
Child	$8,000	$8,000	$8,000
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	ORANGE LEAF	BLUE LEAF
Healthcare			
Deductible	Nil		
Reimbursements			
Global Medical Assistance Expenses	100%		
Prescription Drug Expenses (In-Canada)			
- Dispensing Fee	100% up to $5 per prescription		
Drug Charge - Formulary - Non-Formulary	70% 50% For first $2,000/year paid out-of-pocket, per person, then 100% thereafter	80% 60% For first $1,000/year paid out-of-pocket, per person, then 100% thereafter	90% 70% For first $500/year paid out-of-pocket, per person, then 100% thereafter
	Out-of-pocket maximum for Quebec Residents If you live in Quebec, an out-of-pocket maximum is applied to in-province expenses for provincial formulary drug expenses listed in the *Régie de l'assurance-maladie du Québec* (RAMQ): *Liste de medicaments.* If the sum of the non-reimbursable amounts you are required to pay for provincial formulary drug expenses incurred in a calendar year for you, your dependent children, or your spouse reaches the maximum out-of-pocket level established by law, the amount payable for provincial formulary drug expenses will be adjusted. For the remainder of the calendar year: 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%	90%

	GREEN LEAF	ORANGE LEAF	BLUE LEAF
Basic Expense Maximums			
Home Nursing Care	$5,000 every 3 calendar years		$10,000 every 3 calendar years
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	1 in a lifetime to a maximum of $2,000		
Flash glucose monitors and Continuous glucose monitors (CGMs)	Coverage subject to reasonable and customary limits, CGMs have an annual maximum of $4,000.		
Insulin Infusion Pumps	$5,000 per pump once every 5 years		
Insulin Jet Injectors	Not covered	1 in a lifetime to a maximum of $1,000	
Transcutaneous Nerve Stimulators	$700 lifetime		
Extremity Pumps for Lymphedema	1 in a lifetime to a maximum of $1,500		
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 Dental care)	
Ambulance (Including Air Ambulance)	Included		
Diagnostic Supplies	Included		

	GREEN LEAF	ORANGE LEAF	BLUE LEAF
Paramedical Expense Maximums	**70% reimbursement**	**80% reimbursement**	**90% reimbursement**
Physiotherapists Speech Therapists Psychologists/Social Workers	$1,500 per year for each service	$1,500 per year for each service	$1,500 per year for each service
Combined maximum for all practitioners listed below	*Combined annual maximum of $600* in addition to the specific per practitioner maximum indicated below	*Combined annual maximum of $1,500* in addition to the specific per practitioner maximum indicated below	*Combined annual maximum of $2,000* in addition to the specific per practitioner maximum indicated below
Chiropractor Naturopath Registered Massage Therapists (RMT) Osteopaths	Up to $200 per year for each service	Up to $500 per year for each service	Up to $750 per year for each service
Podiatrist/Chiropodist Acupuncturist Homeopath Occupational Therapist	Not included; can be claimed under your HCSA*	Not included; can be claimed under your HCSA*	
Vision care Expense Maximums			
Eye Examinations	Not included; can be claimed under your HCSA*	$50 every 24 months	$90 every 24 months
Glasses, Contact Lenses and Laser Eye Surgery			
- Dependent Children Under Age 18		$150 every 12 months	$200 every 12 months
- All Others		$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	ORANGE LEAF	BLUE LEAF
Dental Care			
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	50%
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	
You + 2 or More Dependents	$1,600	$700	
Optional Critical Illness Insurance			
Member Optional Critical Illness	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	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.	

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 Canada Life for inclusion under the contract.

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.

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.

  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 Canada Life.

- **Re-enrolment occurs every 2 years** (typically in even years, for example 2022, 2024, etc.): 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.

- **Life events:** 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 **You Should Know** page.

- 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 for a period of 2 years or until they no longer qualify, whichever happens first. Your spouse will no longer qualify when he/she:

- reaches age 65;

- remarries; or

- attains other coverage.

For the end of the qualification period for a dependent child, please refer to the DEPENDENT CHILD definition.

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.

CRITICAL ILLNESS

To claim benefits, obtain a claim form at *My Canada Life at Work*. Complete it and return it to the address shown on the form. Claims should be submitted as soon as possible, but no later than 3 months after the end of the benefit payment waiting period or 3 months after the plan terminates, whichever is earlier.

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.

HEALTHCARE

Claims for expenses incurred in Canada, for paramedical services and vision care, may be submitted online. To use this online service, you will need to be registered for *My Canada Life at Work*, and signed up for direct deposit of claim payments. For online claim submissions, your Explanation of Benefits will only be available online.

Claims must be submitted to Canada 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 Canada Life as a record of the transaction, and you must submit it to Canada Life on request.

For all other Healthcare claims, access *My Canada Life at Work* to get 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 Canada 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 Canada Life as soon as possible after the expense is incurred. It is very important that you send your claims to the Canada Life Out-of-Country Claims Department immediately as your Provincial Medical Plan has very strict time limitations.

Access *My Canada Life at Work* 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 Canada 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 Canada Life. When you receive your Explanation of Benefits back from the territory, please send the following to the Canada 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 Canada 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 Canada Life's Out-of-Country Claims Department at 1-800-957-9777.

DENTAL CARE

Claims for expenses incurred in Canada may be submitted online. Access *My Canada Life at Work* 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 *My Canada Life at Work* and signed up for direct deposit of claim payments. For online claim submissions, your Explanation of Benefits will only be available online.

Claims must be submitted to Canada 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 Canada Life as a record of the transaction, and you must submit it to Canada Life on request.

For all other Dental care claims, access *My Canada Life at Work* 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 Canada Life Benefit Payment Office as soon as possible, but no later than 15 months after the dental treatment.

HEALTH CARE SPENDING ACCOUNT

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 Canada 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

Canada 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 Canada 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 Canada 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 Dental care 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, Canada 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, Canada Life will pay you the dependent life insurance benefit according to the plan you select as described in the **Summary of Coverages – Canada Life**. 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 **Summary of Coverages – Canada Life** 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 Canada 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 Canada Life on behalf of your child will be required before coverage takes effect.

On your death, Canada 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, Canada 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, Canada Life refunds the premiums that have been received. This limitation does not apply to coverage for a dependent child.

OPTIONAL CRITICAL ILLNESS INSURANCE

If you are diagnosed with one of the illnesses defined below while you are insured, Canada Life will pay you the optional critical illness insurance benefit. Check the **Summary of Coverages – Canada Life** for the amount of insurance available. The benefit is payable after a waiting period of 30 days following the date of diagnosis or at the end of the waiting period, if any, specified for the condition below, whichever is longer. In addition to this benefit, provided it is $10,000 or more, Canada Life will make a $500 donation in your name to a registered charitable organization of your choice.

If you apply for this optional benefit, you may be required to provide proof of your insurability satisfactory to Canada Life, except for the first $25,000 if you apply for coverage within 31 days of becoming eligible.

Your optional critical illness insurance will not continue past the end of the day before the date you reach age 65.

Covered Illnesses

Any of the following conditions is considered a critical illness if it meets the defined criteria and has been diagnosed by a physician practicing medicine in Canada or the United States who is recognized by the physician's medical licensing body as a specialist in the field of medicine relating to the applicable critical illness. The diagnosis must be supported by objective medical evidence.

- **"heart attack"** – means the death of heart muscle due to obstruction of blood flow, that results in the rise and fall of biochemical cardiac markers to levels considered diagnostic of myocardial infarction, with at least one of the following:

  - heart attack symptoms;
  - new electrocardiogram (ECG) changes consistent with a heart attack; or
  - development of new Q waves during or immediately following an intra-arterial cardiac procedure including, but not limited to, coronary angiography and coronary angioplasty.

  No benefits will be paid under this condition for:

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

- **"stroke"** – means an acute cerebrovascular event caused by intra-cranial thrombosis or haemorrhage, or embolism from an extra-cranial source, with:

  - acute onset of new neurological symptoms, and
  - new objective neurological deficits on clinical examination,

  persisting for more than 30 days following the date of the condition. These new symptoms and deficits must be corroborated by diagnostic imaging testing.

No benefits will be paid under this condition for:

- transient ischaemic attacks; or
- intracerebral vascular events due to trauma.

For greater certainty, lacunar infarcts which do not have the neurological symptoms and deficits set out above, persisting for more than 30 days, do not satisfy the definition of stroke.

- **"coronary artery bypass surgery"** – means the undergoing of heart surgery to correct narrowing or blockage of one or more coronary arteries with bypass graft(s). The surgery must be determined to be medically necessary by a specialist.

  No benefits will be paid under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

- **"cancer (life-threatening)"** – means a tumour, which must be characterized by the uncontrolled growth and spread of malignant cells and the invasion of tissue.

  Types of cancer include carcinoma, melanoma, leukemia, lymphoma, and sarcoma.

  No benefits will be paid under this condition for the following:

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

  For purposes of the policy, the terms Tis, Ta, T1a, T1b, T1 and AJCC Stage 2 are to be applied as defined in the American Joint Committee on Cancer (AJCC) cancer staging manual, 7th Edition, 2010.

  For purposes of the policy, the term Rai staging is to be applied as explained in KR Rai, A Sawitsky, EP Cronkite, AD Chanana, RN Levy and BS Pasternack: Clinical staging of chronic lymphocytic leukemia. Blood 46:219, 1975.

  Cancer exclusion period

  No benefits will be paid under this condition if, within the first 90 days following the later of the person's effective date of insurance or, for an increase, the effective date of the increase, the person has any of the following:

  - signs, symptoms or investigations that lead to a diagnosis of cancer (covered or excluded under the policy), regardless of when the diagnosis is made; or
  - a diagnosis of cancer (covered or excluded under the policy).

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to Canada Life within six months of the date of the diagnosis. If this information is not provided within this period, Canada Life has the right to deny any claim for cancer or any critical illness caused by any cancer or its treatment.

- **"kidney failure"** – means chronic irreversible failure of both kidneys to function, as a result of which regular haemodialysis, peritoneal dialysis or renal transplantation is initiated.

- **"blindness"** – means the total and irreversible loss of vision in both eyes, evidenced by:

  - the corrected visual acuity being 20/200 or less in both eyes; or
  - the field of vision being less than 20 degrees in both eyes.

- **"major organ transplant"** – means irreversible failure of the heart, both lungs, liver, both kidneys, or bone marrow, and transplantation must be medically necessary. To qualify under major organ transplant, the person must undergo a transplantation procedure as the recipient of a heart, lung, liver, kidney or bone marrow, and limited to these entities.

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

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

  The person must exhibit:

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

  No benefits will be paid under this condition for affective or schizophrenic disorders, or delirium.

  For purposes of the policy, reference to the Mini Mental State Exam is to Folstein MF, Folstein SE, McHugh PR, J Psychiatr Res. 1975;12(3):189.

- **"Parkinson's Disease and Specified Atypical Parkinsonian Disorders"** – Parkinson's Disease means primary Parkinson's Disease, a permanent neurologic condition which must be characterized by bradykinesia (slowness of movement) and at least one of:

  - muscular rigidity; or
  - rest tremor.

  The person must exhibit objective signs of progressive deterioration in function for at least one year, for which the treating neurologist has recommended dopaminergic medication or other generally medically accepted equivalent treatment for Parkinson's Disease.

Specified Atypical Parkinsonian Disorders mean progressive supranuclear palsy, corticobasal degeneration, or multiple system atrophy.

No benefits will be paid under this condition for any other type of parkinsonism.

Parkinson's Disease and Specified Atypical Parkinsonian Disorders exclusion period

No benefits will be paid under this condition if, within the first year following the later of the person's effective date of insurance or, for an increase, the effective date of the increase, the person has any of the following:

- signs, symptoms or investigations that lead to a diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism, regardless of when the diagnosis is made; or
- a diagnosis of Parkinson's Disease, a Specified Atypical Parkinsonian Disorder or any other type of parkinsonism.

Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to Canada Life within six months of the date of the diagnosis. If this information is not provided within this period, Canada Life has the right to deny any claim for Parkinson's Disease or Specified Atypical Parkinsonian Disorders or, any critical illness caused by Parkinson's Disease or Specified Atypical Parkinsonian Disorders or its treatment.

- **"paralysis"** – means total loss of muscle function of two or more limbs as a result of injury or disease to the nerve supply of those limbs, for a period of at least 90 days following the precipitating event.

- **"multiple sclerosis"** – means at least one of the following:

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

- **"deafness"** – means the total and irreversible loss of hearing in both ears, with an auditory threshold of 90 decibels or greater within the speech threshold of 500 to 3000 hertz.

- **"loss of speech"** – means the total and irreversible loss of the ability to speak as a result of physical injury or disease for a period of at least 180 days.

  No benefits will be paid under this condition for all psychiatric related causes.

- **"coma"** – means a state of unconsciousness with no reaction to external stimuli or response to internal needs for a continuous period of at least 96 hours, and for which period the Glasgow coma score must be four or less.

  No benefits will be paid under this condition for a medically induced coma.

- **"severe burns"** – means third degree burns over at least 20% of the body surface.

- **"aortic surgery"** – means the undergoing of surgery for disease of the aorta requiring excision and surgical replacement of any part of the diseased aorta with a graft. Aorta means the thoracic and abdominal aorta but not its branches. The surgery must be determined to be medically necessary by a specialist.

  No benefits will be paid under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures.

- **"benign brain tumour"** – means a non-malignant tumour located in the cranial vault and limited to the brain, meninges, cranial nerves or pituitary gland. The tumour must require surgery or radiation treatment or cause irreversible objective neurological deficits.

  No benefits will be paid under this condition for pituitary adenomas less than 10 mm.

  Benign brain tumour exclusion period

  No benefits will be paid under this condition if, within the first 90 days following the later of the person's effective date of insurance or, for an increase, the effective date of the increase, the person has any of the following:

  - signs, symptoms or investigations that lead to a diagnosis of benign brain tumour (covered or excluded under the policy), regardless of when the diagnosis is made; or
  - a diagnosis of benign brain tumour (covered or excluded under the policy).

  Medical information about the diagnosis and any signs, symptoms or investigations leading to the diagnosis must be reported to Canada Life within six months of the date of the diagnosis. If this information is not provided within this period, Canada Life has the right to deny any claim for benign brain tumour or any critical illness caused by any benign brain tumour or its treatment.

- **"heart valve replacement or repair"** – means the undergoing of surgery to replace any heart valve with either a natural or mechanical valve or to repair heart valve defects or abnormalities. The surgery must be determined to be medically necessary by a specialist.

  No benefits will be paid under this condition for angioplasty, intra-arterial procedures, percutaneous trans-catheter procedures or non-surgical procedures

- **"loss of independent existence"** – means the total inability to perform, by oneself, at least two of the following six activities of daily living for a continuous period of at least 90 days with no reasonable chance of recovery.

  Activities of daily living are:

  - bathing – the ability to wash oneself in a bathtub, shower or by sponge bath, with or without the aid of assistive devices;
  - dressing – the ability to put on and remove necessary clothing, braces, artificial limbs, or other surgical appliances with or without the aid of assistive devices;
  - toileting – the ability to get on and off the toilet and maintain personal hygiene with or without the aid of assistive devices;

- bladder and bowel continence – the ability to manage bowel and bladder function with or without protective undergarments or surgical appliances so that a reasonable level of hygiene is maintained;
- transferring – the ability to move in and out of a bed, chair or wheelchair, with or without the aid of assistive devices; and
- feeding – the ability to consume food or drink that already has been prepared and made available, with or without the use of assistive devices.

- **"loss of limbs"** – means the complete severance of two or more limbs at or above the wrist or ankle joint as the result of an accident or medically required amputation.

- **"motor neuron disease"** – means one of the following: amyotrophic lateral sclerosis (ALS or Lou Gehrig's disease), primary lateral sclerosis, progressive spinal muscular atrophy, progressive bulbar palsy, or pseudo bulbar palsy, and limited to these conditions.

- **"occupational HIV infection"** – means infection with Human Immunodeficiency Virus (HIV) resulting from accidental injury during the course of the person's normal occupation, which exposed the person to HIV contaminated body fluids. The accidental injury leading to the infection must have occurred following the later of the person's effective date of insurance or, for an increase, the effective date of the increase.

  Payment under this condition requires satisfaction of all the following:

  - the accidental injury must be reported to Great-West within 14 days of the accidental injury;
  - a serum HIV test must be taken within 14 days of the accidental injury and the result must be negative;
  - a serum HIV test must be taken between 90 days and 180 days after the accidental injury and the result must be positive;
  - all HIV tests must be performed by a duly licensed laboratory in Canada or the United States; and
  - the accidental injury must have been reported, investigated and documented in accordance with current Canadian or United States workplace guidelines.

  No benefits will be paid under this condition if:

  - the person has elected not to take any available licensed vaccine offering protection against HIV; or
  - a licensed cure for HIV infection has become available prior to the accidental injury.

  For greater certainty, non-accidental injury including, but not limited to, sexual transmission or intravenous (IV) drug use does not satisfy the definition of Occupational HIV Infection.

- **"bacterial meningitis"** – means meningitis, confirmed by cerebrospinal fluid showing growth of pathogenic bacteria in culture, resulting in neurological deficit documented for at least 90 days from the date of diagnosis.

  No benefits will be paid under this condition for viral meningitis.

- **"aplastic anaemia"** – means chronic persistent bone marrow failure, confirmed by biopsy, which results in anaemia, neutropenia and thrombocytopenia requiring blood product transfusion, and treatment with at least one of the following:

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

Limitations

No benefits are paid for:

- a critical illness that is directly or indirectly related to a condition for which you received medical care within 24 months before your insurance started. This limitation does not apply:
  - if your illness is diagnosed after you have been continuously insured for 24 months, or
  - to any amounts of insurance for which evidence of insurability is required.

- a critical illness resulting directly or indirectly from or associated with any of the following:
  - intentionally self-inflicted injury, or attempt at suicide, while sane or insane
  - war, insurrection or voluntary participation in a riot
  - participation in a criminal offence or provoking an assault
  - use of any drug, poisonous substance, intoxicant, or narcotic, unless prescribed for the person by a licensed physician and taken in accordance with directions given by the licensed physician
  - operating a motorized vehicle while the blood alcohol level is higher than 80 milligrams of alcohol per 100 millilitres of blood.

No benefits are paid if death or irreversible cessation of all functions of the brain occurs during the benefit payment waiting period.

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 **Summary of Coverages – Canada Life** 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 Canada 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 **Summary of Coverages – Canada Life**. Benefits may be subject to plan maximums and frequency limits. Check the **Summary of Coverages – Canada Life** 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 **Summary of Coverages – Canada Life**.

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.

  Interchangeable Drug Limitation

  Canada Life can limit the covered expense for any drug to that of a lower-cost interchangeable drug determined in accordance with Canada Life’s adjudication practices at the time of claim.
  An interchangeable drug includes but is not limited to:

  a) a generic equivalent to the brand name drug deemed to be interchangeable by law where the drug is dispensed; or
  b) a subsequent entry biologic.

  The right to limit the covered expense does not apply if medical evidence has been provided that indicates a contraindication to the 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 Canada 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.

- Flash glucose monitors and continuous glucose monitors (CGMs) for active members (CBWC, CBM, CBOQ and FBU divisions). Coverage is subject to reasonable and customary limits (as set by our insurer, Canada Life), and CGMs have an annual maximum of $4,000.

- 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.

SMART DRUG PLAN

Your coverage includes the Canada Life SMART plan, specifically designed to target high-dollar-impact prescription drugs. The SMART plan is comprised of:

- SMART assessment, which reviews new drugs (or new indications on existing drugs) to determine if they should be excluded from coverage; and
- SMART claims management, including enhanced prior authorization, step therapy, coordination with other payers, lower-cost alternatives and health case management.

The goal is to help address the pace of increasing drug costs and keep the benefits plan sustainable.

VISION CARE

- 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.

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 Canada 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 Canada 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 Dental care 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 Canada 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;
- vision care 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*.

HEALTHCARE ONLINE BY CONSULT+

Consult+ is a virtual healthcare service that is available to *CBBenefits* members, including your spouse and dependent children.

Consult+ provides you with 24/7 secure online access to Canadian healthcare professionals on demand. **Get care through your mobile device or computer – when and where you need it.**

These services are especially helpful for those who travel a lot or who work hours that may make it difficult to get – or keep – an appointment with your primary healthcare provider. It's all part of supporting the overall wellbeing of you and your family.

SERVICES

Offered in partnership with Canada Life, Consult+ services are made available through Dialogue – a leading Canadian telemedicine provider.

You and your eligible family members can register and have **unlimited use** of Consult+ for many of the same things you would usually go to your primary healthcare provider for, including:

- Allergies, colds and flu
- Depression and anxiety
- Skin and eye issues
- …and more

The Consult+ clinicians can provide:

- Diagnoses and advice
- Prescriptions (new and renewals)
- Lab and imaging orders
- Specialist referrals

Consult+ can be a great addition to your regular healthcare team. With your consent, medical notes from your virtual consults can even be shared with your family doctor. Of course, your medical information will never be shared with *CBBenefits* or with Canada Life.

ACCESSING CONSULT+

You can enroll yourself and add any eligible dependent family members to get access to Consult+ care.

To create your account, you'll need your member ID and plan number (either 156241 or 156243).

Just sign in to *My Canada Life at Work*, go to Coverage & Balances, select Health and scroll down to Other coverage, then follow the instructions.

If you have family members, use the drop-down box beside your name to select Family. Add dependants under age 14 to your account. You can also send an email invite to your spouse and eligible dependants over age 14 to create their own accounts.

CORECONTACT – EMPLOYEE ASSISTANCE PROGRAM

The “CoreContact” Employee Assistance Program (EAP) is an employee benefit paid for by your employer. EAPs are intended to help employees and their families 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 CoreContact program services are provided by *LifeWorks by Morneau Shepell*, one of the largest EAP firms in Canada.

As a member of CoreContact, 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. 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. LifeWorks 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.

Online 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

Go to login.lifeworks.com or download the LifeWorks app (Android or iOS).

Username: canadalife
Password: lifeworks

Or, you can call toll free:

1.800.387.4765 for service in English
1.800.361.5676 for service in French

TELEDOC (FORMERLY BEST DOCTORS®)

Teledoc (formerly 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, Teledoc provides medical certainty when you need it most.

You can access Teledoc 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.

Teledoc Services:

- If you are faced with a serious medical condition, Teledoc 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, Teledoc 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, Teledoc 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, Teledoc 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.

DENTAL CARE

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 **Summary of Coverages – Canada Life**. Benefits may be subject to plan maximums and frequency limits. Check the **Summary of Coverages – Canada Life** for this information.

The plan covers customary charges to the extent they do not exceed the dental fee guide level shown in the **Summary of Coverages – Canada Life**. 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 Canada Life. Canada 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 dental care 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 **Summary of Coverages – Canada Life**. 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 – CHUBB

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

DEFINITIONS

BRAIN DEATH means irreversible unconsciousness with total loss of brain function; and complete absence of electrical activity of the brain, even though the heart is still beating.

COMA means the Insured has been in a state of unconsciousness for a continuous period of at least 96 hours, during which external stimulation produced no more than primitive avoidance reflexes. A Physician who is certified as a neurologist must confirm diagnosis in writing.

COMMON ACCIDENT means the same accident or separate accidents occurring within the same 24-hour period.

DEPENDENT CHILD means the Member's eligible unmarried natural, adopted, step child or common law child who is principally dependent on the Member or the Member's spouse for financial support.

FAMILY MEMBER means spouse, parent or stepparent, child or stepchild or brother or sister, stepbrother or stepsister, brother-in-law or sister-in-law, mother-in-law or father-in-law, and son-in-law or daughter-in-law.

HOSPITAL as used herein means a legally constituted establishment which meets all of the following requirements: (1) operates primarily for the reception, care and treatment of sick, ailing or injured persons as in-patients; (2) provides 24 hour a day nursing service by registered or graduate nurses; (3) has a staff of one or more licensed physicians available at all times; (4) provides organized facilities for diagnosis and surgical facilities; and (5) is not primarily a clinic, nursing home or convalescent home or similar establishment nor, other than incidentally, a place for alcoholics or drug addicts.

IN-PATIENT means a person admitted to a hospital as a resident or bed-patient and who is provided at least one day's room and board by the hospital.

LOSS shall mean with respect to hand or foot, the actual severance through or above the wrist or ankle joint; with respect to arm or leg, the actual severance through or above the elbow or knee joint; with respect to eye, the total and irrecoverable loss of sight; with respect to speech, the total and irrecoverable loss of speech which does not allow audible communication in any degree; with respect to hearing, the total and irrecoverable loss of hearing which cannot be corrected by any hearing aid or device; with respect to thumb and index finger or four fingers, the actual severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand); with regard to toes, the actual severance through or above the metatarsophalangeal joints (the joints between the toes and the foot) of the same foot. If an Insured Person suffers complete severance of a hand, foot, arm or leg as described above, then Chubb Life will pay the amount specified in the Schedule of Losses even if the severed limb is surgically reattached, whether successful or not.

“Loss” as used with reference to quadriplegia (paralysis of both upper and lower limbs), paraplegia (paralysis of both lower limbs), and hemiplegia (total paralysis of upper and lower limbs of one side of the body), means the complete and irrecoverable paralysis of such limbs, provided such loss of function is continuous for 180 consecutive days and such loss of function is thereafter determined on evidence satisfactory to Chubb Life to be permanent.

LOSS OF USE shall mean the total and irrecoverable loss of function of an arm, hand, foot, leg or thumb and index finger of the same hand provided such loss of function is continuous for 12 consecutive months and such loss of function is thereafter determined on evidence satisfactory to Chubb Life to be permanent.

PROFESSIONAL COUNSELLOR means a therapist or counsellor who is licensed, registered or certified to provide such treatment.

SEAT BELT means those belts that form a restraint system.

SURVIVING CHILDREN means your dependent children as defined in the definition of "eligible dependents" applicable to the policy provided such children survive both you and your spouse by at least 24 hours.

THE CHILD’S PRINCIPAL SUM means the applicable percentage of the employee's amount of insurance for which application has been made. The maximum benefit payable will be $100,000.

TOTALLY DISABLED OR TOTAL DISABILITY with respect to Waiver of Premium means disability resulting from injury or sickness which prevents engagement in an Insured Member’s own occupation for twenty-four (24) consecutive months.

VEHICLE means a private passenger car, station wagon, van, or jeep-type automobile.

WHEN YOU HAVE A CLAIM

In the event of a claim, claim forms can be obtained from the Plan Administrator.

Notice of claim must be given to Chubb Life within 30 days from the date of the accident, the beginning of the disability or after the survival period, and subsequent proof of claim must be submitted to Chubb Life within 90 days from the date of the accident or after survival period.

Failure to give notice of claim or furnish proof of claim within the time prescribed in the policy condition will not invalidate the claim if the notice or proof is given or furnished as soon as reasonably possible and if it is shown that it was not reasonably possible to give notice or furnish proof within the time so prescribed. In no event, will Chubb Life accept notice of claim beyond one year.

BENEFICIARY DESIGNATION

A member has the right to name a beneficiary when he applies for insurance. It is understood that the beneficiary designation made under the Policyholder's Group Life Insurance Policy shall be recognized as the beneficiary under the policy, unless a further designation has been made that specifically identifies the policy. Failing such designation, all benefits will be paid to the estate of the insured person.

All other indemnities of the policy will be payable to the insured person.
An insured person can change his beneficiary at any time, where permitted by law. The Company assumes no responsibility for the validity of such designation or change of beneficiary.

The policy contains a provision removing or restricting the right of the insured person to designate persons to whom or for whose benefit insurance money is to be payable.

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

The plan offers you full 24-hour protection against accidents, on or off the job, on business, on vacation, at home, regardless of your health history.

ELIGIBILITY

All active, eligible members of the Canadian Baptist Ministries and it's named Conventions and unions.

BENEFIT AMOUNT

- Flat $25,000
- Benefit reduces to a Flat $5,000 at age 65 and terminates at retirement
- In the event of your death, the benefit amount is payable to the beneficiary you have named under your Group Life Insurance Plan or in the absence of such designation, to your Estate.

Benefits payable under the following section will be limited to only one policy in the event the benefits are contained in two or more policies issued to the Policyholder by Chubb Life (not applicable to the Schedule of Losses, Exposure and Disappearance, Conversion and Cosmetic Disfigurement).

SCHEDULE OF LOSSES

Accidental Death & Dismemberment
If such injuries shall result in any one of the following specific losses within one year from the date of the accident, Chubb Life will pay the percentage of the benefit amount, based on the amount stated under the benefit amount section, however, that not more than one (the largest) of such benefits shall be paid with respect to injuries resulting from one accident.

	Percentage of Benefit Amount
Loss of Life	100%
Loss of Entire Sight of Both Eyes	100%
Loss of One Hand and One Foot	100%
Loss of Use of One Hand and One Foot	100%
Loss of One Hand and Entire Sight of One Eye	100%
Loss of One Foot and Entire Sight of One Eye	100%
Loss of Speech and Hearing in Both Ears	100%
Brain Death	100%
Coma	100%
Loss of Both Arms, Both Hands, Both Legs or Both Feet	200%

Loss of Use of Both Arms, Both Hands, Both Legs or Both Feet 200%

Quadriplegia 200%

Paraplegia 200%

Hemiplegia 200%

Loss of One Arm or One Leg 75%

Loss of Use of One Arm or One Leg.....75%

Loss of One Hand or One Foot.....75%

Loss of Use of one Hand or One Foot 75%

Loss of Entire Sight of One Eye.....75%

Loss of Speech or Hearing in Both Ears.....75%

Loss of Thumb and Index Finger of Same Hand 33 1/3%

Loss of Use of Thumb and Index Finger of Same Hand.....33 1/3%

Loss of Four Fingers of Same Hand 33 1/3%

Loss of Hearing One Ear.....33 1/3%

Loss of All Toes of Same Foot.....25%

All benefits that are payable at 200% of the Principal Sum are subject to an all policies combined maximum benefit amount of $1,000,000.

REPATRIATION BENEFIT

When injuries result in loss of life of an Insured outside 150 kilometers from their city of permanent residence or outside Canada and the loss of life occurs within 365 days from the date of the accident, Chubb Life will pay the actual expense incurred for preparing the deceased for burial and shipment of the body to the city of residence of the deceased, but not to exceed $15,000.

REHABILITATION BENEFIT

When injuries result in a payment being made by Chubb Life under any benefit excluding the Loss of Life Benefit, Chubb Life will also pay the reasonable and necessary expenses actually incurred up to a limit of $15,000 for special training of an Insured provided:

a. such training is required because of such injuries and in order for an Insured to become qualified to engage in an occupation in which he or she would not have been engaged except for such injuries;
b. expenses are to be incurred within two years from the date of the accident;
c. no payment will be made for ordinary living, travelling, or clothing expenses.

FAMILY TRANSPORTATION BENEFIT

When injuries result in an Insured's confinement as an in-patient in a hospital outside 150 kilometers from an Insured's city of permanent residence or outside Canada and requires personal attendance of a "Family Member" as recommended by the attending physician, in writing, Chubb Life will pay for the expense incurred by the member of the family, for the transportation by the most direct route by a licensed common carrier to the Insured, while confined, but not to exceed $15,000.

SPOUSAL OCCUPATIONAL TRAINING BENEFIT

When injuries result in a payment being made by Chubb Life under the Loss of Life Benefit, Chubb Life will pay in addition the expenses actually incurred, within 365 days from the date of the accident, by the spouse of an Insured for a formal occupation training program for the purpose of specifically qualifying such spouse to gain active employment in an occupation for which the spouse would otherwise not have sufficient qualifications. The maximum payable hereunder is $15,000.

HOME ALTERATION AND VEHICLE MODIFICATION BENEFIT

In the event an Insured sustains an injury which results in a payment being made under the Schedule of Losses, excluding the Loss of Life Benefit, and such injury subsequently requires the use of a wheelchair to be ambulatory, Chubb Life will pay the reasonable and necessary expenses actually incurred within 365 days from the date of the accident for:

1. the one-time cost of alterations to an Insured's principal residence to make it wheelchair accessible and habitable; and
2. the one-time cost of modifications necessary to a motor vehicle utilized by an Insured to make the vehicle accessible or operable for an Insured.

Benefit payments herein will not be paid unless:

i. home alterations are made by a person or persons experienced in such alterations and recommended by a recognized organization, providing support and assistance to wheelchair users; and
ii. vehicle modifications are carried out by a person or persons with experience in such matters and modifications are approved by the Provincial vehicle licensing authorities.

The maximum payable under both items 1 and 2 shall be 10% of an Insured's Principal Sum amount to a maximum of $50,000.

DAY CARE BENEFIT

If an Insured suffers a loss of life in a covered accident while the policy is in force, Chubb Life will pay, in addition to all other benefits payable under the policy a Day Care Benefit equal to the reasonable and necessary expenses actually incurred, subject to the lesser of 5% of an Insured's Principal Sum amount or a maximum of $5,000 per year, on behalf of any dependent child who is enrolled in a legally licensed day care centre on the date of the accident or who enrolls in a legally licensed day care centre within 365 days following the date of the accident.

The "Day Care Benefit" will be paid each year for four consecutive years, but only upon receipt of satisfactory proof that a child is enrolled in a legally licensed day care centre.

SPECIAL EDUCATION BENEFIT

If an Insured suffers a loss of life in a covered accident while the policy is in force, Chubb Life will pay, in addition to all other benefits payable under the policy, a Special Education Benefit up to 5% of an Insured's Principal Sum amount, (subject to a maximum of $5,000 per year), on behalf of any dependent child who, on the date of the accident, is enrolled as a full-time student in any post-secondary institution of higher learning or was at the 12th grade level and subsequently enrolls as a full-time student in any post-secondary institution of higher learning within 365 days following the date of the accident.

The "Special Education Benefit" is payable annually for a maximum of four consecutive annual payments but only if the dependent child continues his or her education as a full-time student in an institution of higher learning.

BEREAVEMENT BENEFIT

When injuries covered by the policy result in loss of life of an Insured within 365 days from the date of the accident, Chubb Life will pay the reasonable and necessary expenses actually incurred by the spouse and dependent children of an Insured for up to six sessions of grief counseling, by a "Professional Counsellor", subject to a maximum of $1,000.

IN-HOSPITAL CONFINEMENT MONTHLY INCOME

In the event an Insured sustains an injury which results in a payment being made under the Schedule of Losses, excluding the Loss of Life Benefit, and the Insured is hospital confined as an in-patient and is under the care of a legally qualified and registered physician or surgeon other than himself or herself, Chubb Life will pay for each full month, 1% of an Insured's Principal Sum amount, subject to a maximum amount of $2,500, or 1/30 of such monthly benefit for each day of partial month, retroactive to the 1st full day of such confinement but not to exceed 365 days in the aggregate for each period of hospital confinement.

COSMETIC DISFIGUREMENT

If an Insured suffers a third degree burn due to an accident, Chubb Life will pay a percentage of the Principal Sum depending on the area of the body which was burned according to the following table, subject to a maximum benefit payable of $25,000:

Body Part	% of Principal Sum Payable
Face, Neck, Head	100%
Hand & Forearm	25%
Either Upper Arm	15%
Torso (Front or Back)	35%
Either Thigh	10%
Either Lower Leg (below knee)	25%

In the event of a 50% surface burn, the % of benefit is reduced by 50%. This table only represents the maximum percent of the Principal Sum payable for any one accident. If the Insured suffers burns in more than one area as a result of any one accident, benefits will not exceed a maximum of $25,000.

SEAT BELT BENEFIT

In the event an Insured sustains an injury which results in a payment being made under the Schedule of Losses, an Insured's Principal Sum amount will be increased by 10% to a maximum of $25,000 if, at the time of the accident, the Insured was driving or riding in a vehicle and wearing a properly fastened seat belt. Due proof of seat belt use must be provided as part of the written proof of loss.

IDENTIFICATION BENEFIT

In the event accidental loss of life is sustained by an Insured not less than 150 kilometers from an Insured's normal place of residence and identification of the body by a "Family Member" has been requested by the police or a similar governmental authority, Chubb Life will reimburse the reasonable expenses actually incurred by such member for:

a. transportation by the most direct route to the city or town where the body is located; and
b. hotel accommodation in such city or town, subject to a maximum duration of three days.

The reimbursement of such expenses incurred is subject to the accidental Loss of Life Benefit being subsequently payable in accordance with the terms of the policy following the identification of the body as an Insured. The maximum amount payable will not exceed $15,000 for all such expenses.
Payment will not be made for board or other ordinary living, travelling or clothing expenses, and transportation must occur in a vehicle or device operated under a license for the conveyance of passengers for hire.

CONVERSION PRIVILEGE

On the date of termination of employment or during the 31-day period following termination of employment, an Insured Person may convert his or her insurance to an individual ACCIDENTAL DEATH and DISMEMBERMENT only insurance policy of Chubb Life. The individual policy will be effective either as of the date that the application is received by Chubb Life or on the date that coverage under the group policy ceases, whichever occurs later. The premium will be the same, as a person would ordinarily pay when applying for an individual policy at that time.

EXPOSURE AND DISAPPEARANCE

Loss resulting from unavoidable exposure to the elements shall be covered to the extent of the benefits afforded an Insured.

If the body of an Insured Member has not been found within one year of disappearance, stranding, sinking or wrecking of the conveyance in which an Insured was riding at the time of the accident, it shall be presumed, subject to all other conditions of the policy, that an Insured Member suffered a loss of life resulting from bodily injuries sustained in the accident covered under the policy.

WAIVER OF PREMIUM

If an Insured Member, under age 65, becomes totally disabled for six consecutive months and an Insured Member provides evidence of total disability satisfactory to Chubb Life Insurance, Chubb Life Insurance will then waive the payment of each premium which falls due with respect to an Insured Member and any Insured Dependents. Subject to all the terms and conditions of the policy, waiver of any premium as herein provided will continue with respect to an Insured Member until age 65 or earlier termination of the policy. If an Insured Member ceases to be disabled and an Insured Member returns to employment and is a member of an eligible class, insurance with respect to an Insured Member may be continued upon resumption of premium payments by an Insured Member or the Policyholder.

If after 120 days, an Insured receives approval of any long term disability claim provided under a policy of group insurance through the Policyholder, Chubb Life will then waive the payment of each Accidental Death and Dismemberment insurance premium subject to the terms stated above.

RECURRENT DISABILITIES

When an Insured Member becomes totally disabled again from the same or related causes within six months of cessation of the Waiver of Premiums, then all such recurrences will be considered a continuation of the same disability and Chubb Life will waive the six-month qualification period.

If the same disability recurs more than six months after cessation of the Waiver of Premiums, such disability will be considered a separate disability. Two disabilities which are due to unrelated causes are considered separate disabilities if they were separated by a return to work of at least one day.

TERMINATION OF WAIVER OF PREMIUM

Waiver of Premiums will cease on the earliest of:

a. the date an Insured Member ceases to meet the policy's definition of totally disabled;
b. the date an Insured Member does not supply Chubb Life with appropriate medical evidence as deemed necessary by Chubb Life;
c. the date an Insured Member is no longer receiving regular, ongoing care and treatment of a Physician appropriate for the disabling condition, as determined by Chubb Life;
d. the date an Insured Member does not attend a medical, psychiatric, psychological, functional, educational and/or vocational examination evaluation by an examiner selected by Chubb Life;
e. the date the policy terminates;
f. the date an Insured Member turns 65; or
g. the date an Insured Member dies.

COVERAGE DURING WAIVER OF PREMIUM

While premiums are being waived, Basic Accidental Death and Dismemberment Insurance under the policy on an Insured Member will continue to be in force. The amount of such insurance will be the amount of insurance that was in effect on the date of commencement of the disability, subject to any age reduction or termination shown in the policy.

CONTINUANCE OF COVERAGE

If an Insured Member is: (1) laid off on a temporary basis; (2) temporarily absent from work due to short-term disability; (3) on leave of absence; or (4) on maternity leave, coverage shall be extended for 12 months, subject to the payment of premiums. If an Insured Member assumes other occupational duties during the leave or lay-off period, no benefits shall be payable for a loss occurring during the performance of such other occupation.

Benefits payable under this section will be limited to only one (1) policy in the event the benefits are contained in two (2) or more policies issued to the Policyholder by the Company *(not applicable to Common Disaster).*

EXCLUSIONS

The plan does not cover any loss, which is the result of:

a. Intentionally self-inflicted injury, suicide or any attempt thereat;
b. Declared or undeclared war, or any act of war, terrorism, riot or insurrection, or service in the armed forces of any country, government or international organization;
c. Travel or flying in an aircraft owned or leased by the Policyholder, an Insured or a member of an Insured's household, or aircraft being used for any test or experimental purpose, firefighting, power line inspection, pipeline inspection, aerial photography or exploration except to the extent such travel or flight is provided in the "Hazards Insured Against" section of this policy, if applicable);
d. Losses occurring while the Insured is serving on full-time active duty in the Armed Forces of any country or international authority (any premium paid to be returned by the Company pro-rata for any such period of full-time active duty.
e. This insurance does not apply to the extent that trade or economic sanctions or other laws or regulations prohibit us from providing insurance, including, but not limited to, the payment of claims. All other terms and conditions of the policy remain unchanged.

GENERAL PROVISIONS

Beneficiary
A member has the right to name a beneficiary when he applies for insurance. It is understood that the beneficiary designation made under the Policyholder's Group Life Insurance Policy shall be recognized as the beneficiary under the policy, unless a further designation has been made that specifically identifies the policy. Failing such designation, all benefits will be paid to the estate of the insured person.

All other indemnities of the policy will be payable to the insured person.

An insured person can change his beneficiary at any time, where permitted by law. The Company assumes no responsibility for the validity of such designation or change of beneficiary.

The policy contains a provision removing or restricting the right of the insured person to designate persons to whom or for whose benefit insurance money is to be payable.

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, Limitations Act, 2002 or other applicable legislation in the Insured's province of residence.

Change of Insurer
An insured member under a former policy may not be excluded from the new policy or be denied benefits solely because of a pre-existing condition limitation that was not applicable or that did not exist in the former policy, or because the person is not at work on the date of coming into force of the new policy.

The insured and any claimant under the policy has the right, as determined by law applicable in the insured's province of residence, to obtain a copy of his/her application, any written evidence of insurability (as applicable) and the Policy, on request, subject to certain access limitations.

VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) COVERAGE

COVERAGE

The plan offers you full 24-hour protection against accidents, on or off the job, on business, on vacation, at home, regardless of your health history.

ELIGIBILITY

All active members of the policyholder under age 70 enrolled in the CB Benefits program.

Under the Family Plan, you insure your family members as follows:

Your spouse, (legally married or domestic partner) under age 70 and your unmarried, dependent children, including natural, legitimate, illegitimate, adopted, step child or common law child, who are under age 21, or under age 26, if the child is a full-time student and dependent on you or your spouse for financial support, or over age 21 if the child is dependent by reason of mental or physical infirmity and incapable of self-sustaining employment and dependent upon you or your spouse for financial support.

BENEFIT AMOUNT

You may choose the benefit amount and the type of plan.

Member Only Plan You may choose any amount of insurance from $10,000 to $250,000 in units of $5,000 or;

You may prefer to become insured under the **Family Plan** under which your spouse and dependent children will automatically become insured. The amount of insurance which may be applied to members of your family is expressed as a percentage of the amount which you select for yourself and is based on the composition of the family at the time of loss, as follows:

Composition of Family	Spouse	Each Child
Spouse & Eligible Dependent Children	40% of the employee's elected amount	10% of the employee's elected amount to a maximum of $50,000
Spouse & No Eligible Dependent Children	50% of the employee's elected amount	N/A
No Spouse but Eligible Dependent Children	N/A	15% of the employee's elected amount to a maximum of $50,000

COMMON DISASTER BENEFIT (only applicable in the case of Family Coverage)

If as a result of a "common accident" you and your spouse should both lose your lives within one (1) year of such "common accident", your spouse's loss of life benefit shall be increased to equal 100% of your (employee) benefit amount.

The benefit will be payable to and equally divided among your "surviving children", or, in the case of any "surviving child" who is a minor or otherwise not competent to give valid release, Chubb Life may pay such benefit to the guardian, trustee or other person deemed by Chubb Life to be equitably entitled to receive such benefit. Any payment made by Chubb Life in good faith pursuant to this provision shall fully discharge Chubb Life to the extent of such payment.

EXTENDED FAMILY BENEFIT (only applicable in the case of Family Coverage)

If an Insured Member, who had insured his family members, suffers loss of life in a covered accident, coverage may be extended for the spouse and dependent children for a maximum of six (6) months if premiums are paid.

SPECIAL BENEFIT FOR DEPENDENT CHILDREN (only applicable in the case of Family Coverage)

	Child's Principal Sum
Loss of Life	100%
Loss of Two Hands, Two Arms, Two Legs, Two Feet, One Hand and One Foot, Entire Sight of Both Eyes, Speech and Hearing	400%
Quadriplegia	400%
Paraplegia	400%
Hemiplegia	400%
Loss of One Arm or One Leg, Speech or Hearing	200%
Loss of One Hand or One Foot	100%