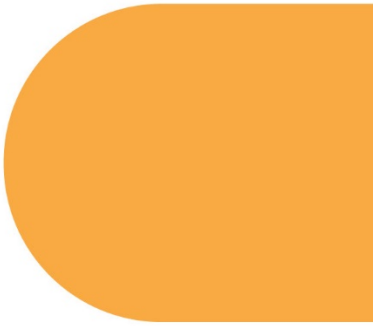
Benefits Guide

HOUR BANK BENEFIT PLAN



OpenCircle™

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Principal Sum	$100,000

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Spousal Benefit	$10,000
Child Benefit	$5,000

Extended Health Care for Employees & Dependents page 30

Prescription Drugs	80%
All Other Covered Health Expenses	100% (to specified limits)
Vision Care Maximum	$350
Prescription Safety Glasses	$150 (employees only)

Dental Care for Employees & Dependents page 40

Basic Services	80%
Major Services	50%
Maximum for Basic & Major Services Combined	$2,500
Orthodontic Services	50%
Maximum for Orthodontic Services	$2,500 lifetime
Fee Guide	Current general practitioner or specialist

Long Term Disability Insurance* page 48

Monthly Benefit	$2,500 per month for the first 24 months increasing to $3,000 thereafter

**Eligibility for benefit payment is subject to age restrictions, see page 48 for details.*

Short Term Disability Insurance* page 54

Weekly Benefit	$800

**Eligibility for benefit payment is subject to age restrictions, see page 54 for details.*

General Information

Your Plan Information

Benefit Plan Administrator

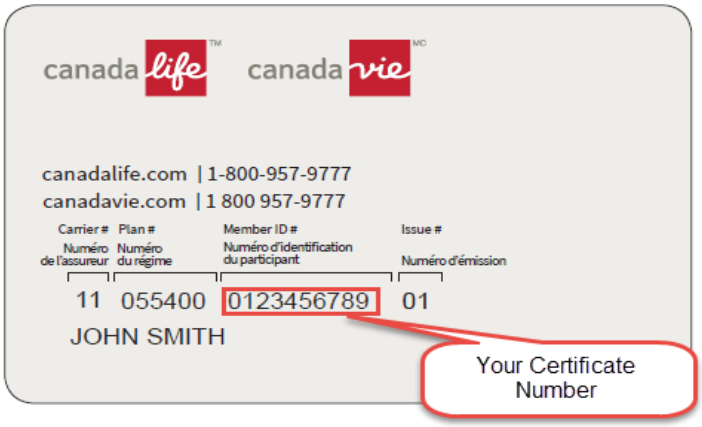
OpenCircle Benefits is the administrator of your benefit plan. OpenCircle Benefits' staff can answer your questions, help you complete claim forms, find your claims status, help with changes to your account, and help with any problems that may arise.

Contact information for OpenCircle Benefits

Phone:	780.455.5845
Toll-free:	1.877.263.7266
Email:	inquiries@opencirclebenefits.ca
Website:	www.opencirclebenefits.ca
Mail:	OpenCircle Benefits 104-13025 St. Albert Trail Edmonton AB T5L 4H5

Plan and Certificate Numbers

Your **Plan Number** for health and dental benefits is 55400.
Your **Certificate Number** is on your Pay-Direct Benefit Card:



About This Booklet

This booklet outlines your plan in general terms. If the booklet is different from the contracts with Canada Life and iA Financial Group, the contracts will prevail to the extent permitted by law. Canada Life adjudicates claims on behalf of the OpenCircle plan for the extended health and dental portions of the benefit plan, which are self-insured.

Access to Documents

We will provide, when asked, a copy of the policy, your application, and other records you have provided to the insurer, subject to certain limitations.

Protecting Your Personal Information

We recognize and respect the importance of privacy. Personal information about you is kept in a confidential file at the OpenCircle Benefits office or the offices of an organization authorized by OpenCircle Benefits. Your personal information may be subject to disclosure to those authorized under applicable law within or outside Canada.

Appeals

If you are denied all or part of a benefits claim, you or your employer may appeal within one year, in writing with additional supporting documents if applicable and with reasons that you believe the denial is incorrect. If you have questions regarding a declined claim, or you wish to file a complaint, please contact OpenCircle Benefits in writing at:

Mail:	OpenCircle Benefits 104-13025 St. Albert Trail Edmonton AB T5L 4H5
Fax:	780.455.6068
Email:	inquiries@opencirclebenefits.ca

Legal Action

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* (for actions or proceedings governed by the laws of Alberta and British Columbia), *The Insurance Act* (for actions or proceedings governed by the laws of Manitoba), the *Limitations Act, 2002* (for actions or proceedings governed by the laws of Ontario), or other applicable legislation. For those actions or proceedings governed by the laws of Quebec, the prescriptive period is set out in the Quebec Civil Code.

In no case can legal action to recover non-insured benefits under this plan be introduced 60 days after notice of claim is submitted, or two years after a benefit has been denied.

Enrolment

It is your responsibility to complete enrolment in full, and to update your information with OpenCircle Benefits if it changes. Changes can be made on the Member Portal, or by contacting OpenCircle Benefits. You must be enrolled to access benefits; you may be denied benefits if your information is not accurate and current.

The Employee Life Insurance beneficiary form must be signed in ink and returned to OpenCircle Benefits. If you do not, death benefits will be paid to your estate.

Residency Requirement

You and your dependents must live in Canada year-round to be covered by this plan.

Apprenticeship Training Hours

For questions regarding continuation of benefits during your apprenticeship, please contact OpenCircle Benefits.

Hour Bank

Initial Eligibility

Your employer will report your hours worked and remit payment for those hours to OpenCircle Benefits. Your benefit plan starts on the 1st day of the 2nd month after your hour bank account has accumulated 300 hours. Please see the example below:

Example: You begin work for ABC Company in January and work 160 each month. On February 28, you have accumulated over 300 hours.

Working Month	Opening Balance	Hours Reported	Hours Deducted	Hours Remaining	Month of Benefit Coverage
January	0	160	0	160	N/A
February	160	160	150	170	**April**

You are eligible for benefits on April 1.

You have 8 months to build up 300 hours, if you do not build 300 hours in 8 months, your hours will be forfeited, and your account will go to zero hours.

Deduction of Hours for Coverage

For each month of benefit coverage, 150 hours are deducted from your Hour Bank account.

Example: You continue to work for ABC Company and work 160 hours monthly. On February 28, you have accumulated over 300 hours and begin coverage in April. Your coverage continues – 150 hours are deducted each month, and the remaining hours are banked for future use.

Working Month	Opening Balance	Hours Reported	Hours Deducted	Hours Remaining	Month of Benefit Coverage
January	0	160	0	160	N/A
February	160	160	150	170	April
March	170	160	150	180	May

The maximum number of hours that can be in your account at a given time is 1,200. Hours over 1,200 are forfeited. As long as you work for a company participating in the OpenCircle Hour Bank Plan, your hours will continue to build up in your account.

Termination of Coverage

Your coverage under the benefit plan will terminate on the last day of the month after the balance of your account falls below 150 hours. Disability benefits terminate when hours stop being reported for you.

Example: You continue to work for ABC Company and your hours of work vary for the year.

Working Month	Opening Balance	Hours Reported	Hours Deducted	Hours Remaining	Month of Benefit Coverage
April	180	160	150	190	June
May	190	145	150	185	July
June	185	200	150	235	August
July	235	190	150	275	September
August	275	120	150	245	October
September	245	80	150	175	November
October	175	50	150	75	December
November	75	40	0	115	N/A
December	115	0	0	115	N/A

On December 31, your coverage will terminate because you had less than 150 hours remaining in your bank for coverage in January. Your disability benefits will end in December as no hours were reported for you. You cannot receive a refund for any paid hours.

Self-Pay Option

When you fall out of benefit, you may be able to extend your benefits by self-paying, as set out below. Your disability benefits cannot continue through self-payment (except for Maternity/Parental Leave Self-Pay, as outlined below).

The self-pay option is a flat rate per month – you cannot purchase hours to top up your remaining Hour Bank balance.

Please contact OpenCircle Benefits for information.

Self-Pay Option – Hours below 150

If your balance falls below 150 hours, you may pay to extend your benefits (except disability benefits) for up to 6 months. Details of the price and deadlines will be in the letter that you receive advising of your last day of benefits.

Self-Pay Option – Continued Benefits while Disabled

If you become disabled while eligible for benefits under this plan, you may pay to continue your benefits (except disability benefits), for up to 24 months from the date you become disabled.

Self-Pay Option – Continued Benefits while on a Maternity/Parental Leave of Absence

You may pay to continue your benefits under this plan (including disability benefits) for up to 78 weeks (total extension) during a scheduled Maternity or Parental Leave of Absence.

Reinstatement

If your benefits end because you have less than 150 hours in your account, your benefits will be reinstated if your hour bank account reaches at least 150 hours (including hours on hand at the time your benefits terminated) within 8 months. Your benefits will be reinstated the 1st day of the 2nd month after the 150th hour is recorded in your account.

Example: Your hours are reduced working for ABC Company in September, and you stop working in December. You resume working regular hours with ABC Company in January.

Working Month	Opening Balance	Hours Reported	Hours Deducted	Hours Remaining	Month of Benefit Coverage
September	245	80	150	175	November
October	175	50	150	75	December
November	75	40	0	115	N/A
December	115	0	0	115	N/A
January	115	160	150	125	March

On December 31, your coverage terminated due to less than 150 hours in your account. Your coverage resumes March 1 due to hours reported for January.

If you do not build up 150 hours in 8 months of your coverage terminating, your hours will be forfeited. You will then have to build up 300 hours to have your benefits reinstated.

Benefit Limitation for Overpayment

If benefits are paid that were not payable under the policy, you are responsible for repayment within 30 days of the insurer sending you a notice of the overpayment, or within a longer period if agreed to in writing by the insurer. If you fail to fulfil this responsibility, no further

benefits are payable under the policy until the overpayment is recovered. This does not limit the insurer's right to use other legal means to recover the overpayment.

Who is Covered?

My Eligible Dependents

Eligible dependents have coverage for the same benefits as you, except for disability and Accidental Death & Dismemberment.

To be covered, your **eligible dependents** must:

a. live in Canada; and
b. must be listed on your enrolment form.

A **dependent spouse** includes either:

a. a person to whom you are **legally married**, or
b. a person **continuously living with you** for a period of at least one year and who is represented by you publicly as your spouse.

Only one spouse will be eligible for benefits, as indicated on your enrolment form.

A **dependent child** is eligible if he or she is:

a. a natural child, stepchild, or legally adopted child of you or your covered spouse,
b. unmarried and fully dependent on you for support, and
c. under the age of 21 or under the age of 25 if a **full-time student** (with satisfactory proof of attendance).

If you are living in a common-law relationship, the **child of the common-law spouse** will be eligible for benefits if he/she is in the care and custody of both you and your spouse and living with you.

If you are in possession of **legal guardianship** papers for a dependent child under the age of 18, that child will also be eligible for dependent benefits. In certain cases, children who are dependent because of a **mental or physical disability** may also be entitled to coverage outside the age limits.

If you have question about eligible dependents, contact OpenCircle Benefits.

Membership and Portability

An “OpenCircle Member” owns a share of OpenCircle and is entitled to all of the services, privileges, and benefits of membership. Employees of Members are entitled to Hour Bank portability between OpenCircle Members as well as a suite of member benefits and services.

Claims Instructions

If you have any questions regarding the information provided in this section, please contact OpenCircle Benefits.

Extended Health and Dental Claims

All Extended Health and Dental claims for a calendar year must be submitted no later than June 30th of the following year to be eligible for reimbursement.

Pay-Direct at Provider

All claims for eligible drugs can be made directly by your pharmacist at the time that you fill your prescription, just present your Pay-Direct Benefit Card issued by Canada Life. You will not have to pay any amount of the prescription that is covered by the plan, but you will have to pay any amounts that are not covered by the plan.

For certain other providers (dentists, massage therapists, etc.), your provider may be able to submit the claim to Canada Life directly. If your provider can direct bill, you will not have to pay any amount that is covered by the plan, but you will have to pay any amount that is not covered by the plan. Please consult your provider to see if they direct bill.

If you are required to pay for the claim in full, and submit it to Canada Life, please see the **Online Health and Dental Claims Submissions** section for assistance with online claims. For assistance with paper claim forms, see the **Paper Claim Form Submissions** section. Paper claim forms may be printed by going to www.opencirclebenefits.ca, or by contacting OpenCircle Benefits.

Online Health and Dental Claim Submissions

To submit Health and Dental claims online, you register on Canada Life's website, **GroupNet for Plan Members** or download the GroupNet app.

To register, go to **canadalife.com/sign-in** and follow these steps:

1. Click on **Sign In**, and then click on **Register.**
2. Select the **Benefits** option, and enter your Plan and Member Number these are outlined on your Pay-Direct Benefit Card.
3. Once you have registered, follow the onscreen instructions for **Direct Deposit**, enabling Canada Life to deposit claim payments directly to your bank account. Claims cannot be submitted on GroupNet unless direct deposit has been enabled.
4. Sign up for **eDetails**, enabling Canada Life to notify you by email when claims are

adjudicated.

Once registration is completed, online claims processed will be enable. To submit an online claim, sign into GroupNet for Plan Members and choose the Submit Online Claims option. You will be required to enter the type of claim, the service provider, the patient's name, and expense details. You will also be required to upload a picture of your receipt. Claims are normally processed within three business days, at which time payment for approved claims will be deposited into your bank account.

Once you have set up direct deposit, any future paper claims submitted (where benefits are to be paid to you and not the provider) will be paid via direct deposit.

Canada Life has extensive safeguards in place to protect you and the OpenCircle Benefit Plan from fraud or misuse. Online claims will be selected randomly for audit, where additional information may be requested. Failure to provide the requested information may result in withdrawal of online claims access. **All receipts must be retained for a minimum of 12 months in the event of an audit.**

Paper Claim Form Submissions

This section is a step-by-step outline of the procedure you should follow for all paper extended health and dental claims. Please send completed paper claim forms directly to:

Canada Life
Winnipeg Benefit Payments
PO Box 3050
Winnipeg MB R3C 0E6

If your Health or Dental claim is sent to OpenCircle Benefits or one of the OpenCircle offices, it will be forwarded to Canada Life by regular mail, adding to the time you will have to wait for reimbursement.

Some providers may allow for an Assignment of Benefits. This means Canada Life will pay the provider directly once the claim has been submitted.

If you require assistance completing your claim form, or to request an Assignment of Benefits form, please contact OpenCircle Benefits.

Extended Health Care Expenses:

To submit an extended health claim by paper, please follow the directions below:

1. Obtain a "Healthcare Expenses Statement".
2. Itemize the expenses for covered services and supplies for each family member (which can all be put on the same form).

3. Keep a copy of the statement and receipts for your records.
4. Attach original paid-in-full receipts (or invoices if an Assignment of Benefits is in place) and send to Canada Life.
5. Canada Life will mail a cheque for the eligible expenses to you, unless you have enabled direct deposit claim payments, in which eligible expenses will be paid to you by direct deposit.
6. If you have made a claim under another plan first (e.g., through your spouse) you must also attach a copy of the Explanation of Benefits showing any amounts that have been paid by the other plan, or if the claim has been denied by the other plan.

Dental Expenses:

To submit a dental claim by paper, please follow the directions below:

1. Obtain a Standard Dental Claim Form and have your dentist complete his/her portion (many dentists also now have these forms available online and may be able to complete and submit them electronically).
    - A separate claim form must be used for each individual.
2. Complete your portion of the form and send directly to Canada Life.
3. Canada Life will mail a cheque for the eligible expenses to you or to your dentist (if you assigned payment of your dental expenses directly to your dentist by signing the top right hand corner of the claim form).
4. If you have made a claim under another plan first (e.g., through your spouse) you must also attach a copy of the Explanation of Benefits showing any amounts that have been paid by the other plan, or if the claim has been denied by the other plan.

Out-of-Province/Canada Expenses:

To submit an out-of-province/Canada expense, please follow the directions below:

1. Obtain a "Statement of Claim Out-of-Country Expenses" and the appropriate form that allows Canada Life to co-ordinate your benefits with the applicable provincial medical plan (available by contacting OpenCircle Benefits).
2. Itemize the expenses for covered services and supplies on the form.
3. Keep a copy of the statement and receipts for your records.
4. Attach original paid-in-full receipts (or invoices if an Assignment of Benefits is in place) and send to Canada Life.
5. Canada Life will either mail a cheque for the eligible expenses to you or will pay the health care provider(s) directly, if an Assignment of Benefits is in place.

Canada Life will coordinate payment of benefits directly with your provincial health care plan (provided you have completed the appropriate form).

If you have made a claim under another plan first (e.g. through your spouse) you must also attach a copy of the Explanation of Benefits showing any amounts that have been paid by the other plan, or if the claim has been denied by the other plan.

Life Insurance and Accidental Death and Dismemberment (AD&D) Claims

Life Insurance and Accidental Death and Dismemberment claim forms should be returned to OpenCircle Benefits, who will submit them to the appropriate Insurer. Canada Life is the Insurer for Employee and Dependent Life Insurance, and iA Financial Group is the Insurer for AD&D.

Employee and Dependent Life Insurance

To submit a Life Insurance claim, please follow the directions below:

1. Notify OpenCircle Benefits as soon as possible, and we will provide you with the necessary claim forms.
2. Obtain an original death certificate or funeral directors statement.
3. Send the completed forms and documents to OpenCircle Benefits.
4. The benefit will be paid as soon as eligibility has been confirmed and satisfactory proof of death and beneficiary designations have been verified by Canada Life.

Accidental Death and Dismemberment (AD&D) Insurance

To submit an AD&D claim, please follow the directions below:

1. Within 30 days of the accident, notify OpenCircle Benefits, who will provide you with the necessary claim forms.
2. Obtain an original death certificate, medical examiner's report or other proof of loss.
3. Send the completed forms and documents to OpenCircle Benefits no later than 90 days from the date of the accident, OpenCircle Benefits will send the forms to iA Financial Group.
4. Failure to furnish proof of claim within the time prescribed may 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 the Insurer accept notice of claim beyond one year.
5. The AD&D benefits will be paid as soon as eligibility has been confirmed and proof of death or loss has been verified by iA Financial Group.

Disability and Waiver of Premium Claims

Canada Life is the Insurer for disability benefits and provides assessment of waiver of premium. The claims should be submitted to Canada Life directly at the address, fax or email on the forms. Disability and waiver forms can be obtained by contacting OpenCircle Benefits.

Disability

To submit a Long Term Disability (LTD) or Short Term Disability (STD) claim, where applicable, please follow the directions below:

1. Notify OpenCircle Benefits of your disability as soon as possible.

2. Notice of all LTD and STD claims must be provided to Canada Life within 180 days after the end of the Qualifying Period.
3. OpenCircle Benefits will provide the necessary forms for completion by you, your employer, and your doctor.
4. Submit your claim to Canada Life directly.
5. The disability benefit will be paid as soon as eligibility has been confirmed and satisfactory proof of your disability claim has been provided to Canada Life.

Waiver of Premium for Life Insurance Benefits Due to Disability

If you are receiving benefit payments for a workplace accident through Worker's Compensation, you may qualify to maintain your Life and AD&D benefits with no further premiums while you remain disabled (up to age 65). To apply for waiver of premium, please follow the directions below:

1. Notify OpenCircle Benefits of your disability as soon as possible.
2. Notice of all waiver of premium claims must be provided to Canada Life within 300 days of the onset of your disability.
3. OpenCircle Benefits will provide the necessary forms for completion by you, your employer, and your doctor.
4. Waiver of premium will be approved as soon as satisfactory proof of your disability has been provided to Canada Life.

Employee Life Insurance

If you have any questions regarding the benefits outlined in this section, please contact OpenCircle Benefits.

Benefit

You are eligible for $100,000 of Employee Life Insurance. The policy insures you for death from any cause.

Beneficiary

If you die while insured, the Benefit is payable to your beneficiary. You designate a beneficiary at the time you complete enrolment and sign the designation in ink. If the beneficiary designation form is not signed by you in ink, it will be invalid, and the Benefit will be payable to your estate.

You may make, alter, or revoke a designation of beneficiary as permitted by law. Any designation of beneficiary you made under your employer's previous policy prior to the effective date of this policy applies to this policy until you make a change to that designation. You should review your beneficiary designation from time to time to ensure that it reflects your current intentions.

You can change your beneficiary any time by completing a new beneficiary designation form.

Waiver of Premium Due to Disability

If you become disabled, you may be eligible to waive your Life Insurance premiums. You must apply for the waiver of premiums within 300 days of the onset of your disability and you must be under age 65. You are automatically approved for waiver of premium if you are on an approved Long Term Disability claim with Canada Life.

Please contact OpenCircle Benefits to apply.

Conversion of Benefit

If your Employee Life Insurance terminates, you may be able to convert the amount of insurance that you had to an individual policy without evidence of insurability if you are under age 71. Your application for an individual policy must be made within 31 days after your insurance coverage terminates.

If you die within 31 days of the date your Employee Life Insurance has terminated, the amount that could have been converted to an individual policy will be paid to your beneficiary. For complete details of the conversion option, contact OpenCircle Benefits.

Accidental Death and Dismemberment (AD&D)

If you have any questions regarding the benefits outlined in this section, please contact OpenCircle Benefits.

Provisions

Coverage

This coverage provides you with 24-hour protection against on or off-the-job accidents, whether on business, vacation, or at home.

Effective Date of Insurance

You are eligible for coverage under this policy while you are in benefit under the OpenCircle Benefit Plan.

Waiver of Premium Due to Disability

If premiums for your basic life insurance are being waived, then premiums for the AD&D benefit will also be waived. Please contact OpenCircle Benefits to apply.

Benefit Amount

The amount of AD&D Insurance for which you are covered (the Principal Sum) is equal to your Employee Life Insurance benefit.

Notice Periods

Notice of a claim must be given within **30 days** from the date of the Accident, or **30 days** from the date of diagnosis in the case of the Critical Disease benefit. There are various important timelines and notice periods.

Please contact OpenCircle Benefits as soon as possible after any accident or diagnosed covered condition (see the Critical Disease section below) to start the process.

Exposure & Disappearance

If, due to a covered accident, you are unavoidably exposed to the elements and such exposure, within 12 months of the date of the accident, results in a loss for which benefits would have been payable under the policy, such loss will be deemed as a result of the injury. Where, due to the accidental wrecking, sinking or disappearance of a conveyance in which you were riding, you disappear, and your body is not found within 12 months after the date of the wrecking, sinking or disappearance, it will be presumed, subject to no evidence of the contrary, that you suffered loss of life as a result of the injury.

Schedule of Losses

If, within 12 months of the date of the accident, injury results in any of the following losses (including permanent and total loss of use), the Insurer will pay the following, subject to limitations:

Two Times the Principal Sum:	Loss of both arms Loss of both hands Loss of both legs Loss of both feet
Two Times the Principal Sum:	Loss of one arm and one leg on same side of body Quadriplegia (total paralysis of both upper and lower limbs) Paraplegia (total paralysis of both lower limbs) Hemiplegia (total paralysis of upper and lower limbs on one side of the body)
One Times the Principal Sum:	Loss of life Brain death Loss of entire sight of both eyes Loss of one hand and one leg Loss of one arm and one leg Loss of one hand and one foot Loss of one hand and entire sight of one eye Loss of one foot and entire sight of one eye Loss of speech and hearing in both ears
Portion of the Principal Sum: ***Varies per type of loss***	Loss of one arm Loss of one leg Loss of one hand Loss of one foot Loss of entire sight of one eye Loss of speech or hearing in both ears Loss of thumb and index finger of either hand Loss of four fingers of either hand Loss of hearing in one ear Loss of all toes on one foot

Limitations

Covered losses are subject to AD&D definitions outlined by the Insurer.

In no event will the Benefit Amount payable as the result of any single or multiple losses exceed the Principal Sum (except for those losses specified as payable at "**Two Times the Benefit Amount**").

For losses payable at two times the Principal Sum, if loss of life occurs within 90 days following the date of accident, the loss will be payable at one times the Principal Sum.

Other Benefits

Bereavement Benefit

If injury results in your loss of life and indemnity becomes payable under this policy, the Insurer will pay the reasonable and necessary expenses actually incurred by your spouse and dependent children for up to six sessions of grief counselling by a professional counselor, subject to a maximum of $2,500.

Cosmetic Disfigurement Benefit

When, as a result of a non-occupational injury, you suffer cosmetic disfigurement due to a third-degree burn, the Insurer will pay a percentage of the Principal Sum based on the amount of body surface burned as determined by the attending physician.

If you suffer burns in more than one area as a result of any one accident, benefits will not exceed a maximum of $25,000.

Critical Disease Benefit

If, prior to age 65, you are diagnosed by a specialist with a Covered Disease while the policy is in force and you are totally disabled from that Covered Disease for at least nine months following the date of diagnosis, the Insurer will pay 10% of the Principal Sum to a maximum of $50,000. This benefit is payable only if investigations leading to the diagnosis of a Covered Disease are initiated more than 90 days following the effective date of your insurance. Payment of the Critical Disease Benefit is limited to only the first Covered Disease to occur.

Covered Diseases are: Alzheimer's Disease, Amyotrophic Lateral Sclerosis (ALS), Huntington's Chorea, Multiple Sclerosis, Necrotizing Fasciitis, Parkinson's Disease, Peripheral Vascular Disease, Poliomyelitis and Type 1 Diabetes (insulin dependent).

Day Care Benefit

If a covered injury results in loss of life within 12 months of the date of the accident, the Insurer will pay the reasonable and necessary expenses actually incurred, subject to 5% of the Principal Sum to a maximum of $5,000 for each of your dependent children under age 13 who are:

- Enrolled in a legally licensed Day Care centre on the date of your passing, or
- Enroll in a legally licensed Day Care centre within 12 months of the date of your passing.

The benefit will be paid each year immediately upon receipt of satisfactory proof that the dependent child is enrolled in a legally licensed day care centre. Benefit payments will not

exceed four years, which must run consecutively, with respect to any one dependent child, subject to an overall maximum of $20,000.00. Expenses incurred prior to your passing and expenses for room, board or ordinary living, travel or clothing are not payable under this benefit.

Education Benefit

If a covered injury results in loss of life within 12 months of the date of the accident, the Insurer will pay the reasonable and necessary expenses actually incurred, subject to 5% of the Principal Sum to a maximum of $10,000, for each of your dependent children who are enrolled as full-time students:

- In a school for higher learning above the secondary school level as defined in the province or territory of residence, or
- At the secondary school level, but who enroll as full-time students in a school for higher learning within 12 months of the date of your passing.

The benefit will be paid each year upon receipt of satisfactory proof that the dependent child is enrolled as a full-time student in a school for higher learning. Benefit payments will not exceed four consecutive annual payments with respect to one dependent child. If, at the time of loss, none of your dependent children are eligible for the Education Benefit, the Insurer shall pay an additional amount of $2,500 to your designated beneficiary.

Expenses incurred prior to your passing and expenses for room, board or ordinary living, travel or clothing are not payable under this benefit.

Family Transport Benefit

If, following a covered injury, you are confined as an in-patient in a hospital located from a point of not less than 150 kilometers from your normal place of residence, the Insurer will pay the reasonable and necessary expenses actually incurred by any one immediate family member for hotel accommodations and transportation by the most direct route to you, subject to a maximum of $20,000 for all such expenses.

Payment will not be made for board or other ordinary living, travel or clothing expenses. If transportation is by a vehicle, reimbursement of transportation will be limited to $0.35 per kilometer travelled.

Funeral Expense Benefit

If a covered injury results in your loss of life, the Insurer will pay the reasonable and necessary expenses actually incurred for your funeral, subject to a maximum of $5,000.

Home Alteration and Vehicle Modification Benefit

If, following a covered injury, you are required to use a wheelchair to be ambulatory, the Insurer will pay the reasonable and necessary expenses actually incurred within three years of the date of the accident causing such loss for:

- The cost of alterations on your principal residence, and/or
- The cost of modifications to one motor vehicle utilized by you, where such modifications are approved by the provincial vehicle licensing authorities.

In such cases, modifications must be required for the purpose of making the residence/vehicle wheelchair accessible. Costs are subject to a maximum of $50,000 as the result of any one Accident.

Hospital Indemnity Expense

A daily benefit of one-thirtieth of 1% of your Principal Sum, to a maximum monthly benefit of $2,500 will be payable when you are in a hospital and under the regular care and attendance of a physician, but only if such period of hospitalization is necessary for the treatment of a covered injury and begins while insurance under this policy is in force as to that Insured Person. Such daily benefit will be paid from the first day of a necessary period of hospitalization as an in-patient, for which a full day's room and board is charged, but in no event for more than 12 months per accident.

A period of hospitalization which becomes necessary for the treatment of an injury other than for a Loss covered by the policy will be covered in accordance with the above terms, and the daily benefit will be paid from the first day of hospitalization of at least a four-day period of hospitalization.

If a particular condition causes more than one period of hospitalization due to the same or related causes, then the maximum benefit (12 months in a hospital) will be reinstated, provided a period of six months has elapsed between periods of hospitalization.

Identification Benefit

If a covered injury results in your loss of life and provided identification of your body is required by the police or similar law enforcement agency, the Insurer will pay the reasonable and necessary expenses actually incurred by a member of your immediate family for lodging and board (not to exceed a maximum of three consecutive nights) and transportation by the most direct route to and from the location of the body.

The body's location must not be less than 150 kilometers from the immediate family member's normal place of residence. Benefits payable are subject to a maximum of $20,000.

Psychological Therapy Benefit

If, following a covered loss, you require psychological therapy as prescribed by a physician, the Insurer will pay the reasonable and necessary expenses actually incurred, subject to a maximum of $5,000. Benefits will be payable until the earlier of the maximum has been paid, two years from the date of the injury has elapsed, or you die.

Rehabilitation Benefit

If, following a covered injury, you require special training in order to be qualified to engage in a special occupation in which you would not have engaged except for such injury, the Insurer will pay the reasonable and customary expense incurred for training within three years of the date of the accident, subject to a maximum of $20,000 as the result of any one accident.

Repatriation Benefit

If an injury results in loss of life covered under this policy, the Insurer will pay the reasonable and necessary expenses actually incurred for the preparation and transportation of your body to your city of residence, subject to a maximum of $20,000.

Seat Belt Benefit

If a covered injury is due to a vehicular accident, the benefit payable under the schedule of losses will be increased by 10% to a maximum of $25,000 if, at the time of the accident, you were driving or riding in a vehicle and wearing a properly fastened seat belt. The driver must hold a current and valid driver's license authorizing them to operate such a vehicle and could not have been intoxicated or under the influence of drugs at the time of the accident. Due proof of seat belt use must be provided as part of the written proof of loss.

Spousal Training Benefit

If an injury results in loss of life covered under this policy, the Insurer will pay the reasonable and necessary expenses actually incurred by your spouse who engages in a formal occupational training program in order to become specifically qualified for active employment in an occupation which they would not otherwise have sufficient qualifications.

Expenses must be incurred within three years of the date of the accident and are subject to a maximum of $20,000 for all such expenses. Expenses incurred for room, board or ordinary living, travel or clothing are not payable under this benefit.

Workplace Modification and Accommodation Benefit

If, following a covered injury, you require special adaptive equipment and/or workplace modification in order to reasonably accommodate your return to fulltime employment with your current OpenCircle employer, the insurer will pay the reasonable and necessary expenses actually incurred by your employer subject to a maximum of $5,000 as the result of any one accident. Your employer must agree to provide the required equipment and/or make modifications to your workplace and acknowledge performance of the essential duties

of your occupation may be altered. All required equipment and/or workplace modification must have prior approval from the Insurer.

Exclusions and Termination of Coverage

Exclusions

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

- Intentionally self-inflicted injuries, suicide or any attempt thereof, while sane or insane.
- Declared or undeclared war or any act thereof.
- Travel or flying in an aircraft owned, operated, leased or chartered by your employer.
- Losses occurring while you are serving on full-time active duty in the Armed Forces of any country or international authority.
- Flying as a pilot or crew member in any aircraft.

Please contact OpenCircle Benefits for information about other air travel related exclusions.

Change in Information, Coverage or Benefit Continuation

Please contact OpenCircle Benefits for information about and change in coverage, change in beneficiary or continuation of coverage if your coverage terminates.

Termination of Policy

Insurance will immediately terminate on the earliest of:

- The date the policy is terminated,
- The date the Employer or Policyholder fails to pay the premiums for you, or
- The date you cease to be in benefit under the OpenCircle Benefit Plan.

Dependent Life Insurance

If you have any questions regarding the benefits outlined in this section, please contact OpenCircle Benefits.

Benefit

Your spouse (if any) is covered for $10,000 of Dependent Life Insurance. Each of your eligible children (if any) is covered for $5,000 of Dependent Life Insurance. Your eligible spouse and children are covered for this benefit during the same period that you are covered for Employee Life Insurance. Note that your dependents will be covered under the Dependent Life Insurance benefit only if they are listed as dependents on your enrolment form.

In the event your spouse or an eligible child dies from any cause, the benefit will be paid to you. If you should die prior to the benefit being paid, the benefit will be paid to your estate.

Waiver of Premium Due to Disability

If premiums for your basic life insurance are being waived, then premiums for the Dependent Life Insurance will also be waived. Please contact OpenCircle Benefits to apply.

Conversion of Benefit

If your coverage terminates, your spouse may be able to convert the amount of insurance that he/she had to an individual policy without proof of insurability. If your spouse dies within 31 days of the date your Employee Life Insurance has terminated, the amount that could have been converted to an individual policy will be paid to you.

For complete details of the conversion option, contact OpenCircle Benefits.

Extended Health Care

The extended health care benefits are self-insured under the OpenCircle Benefit Plan. Canada Life adjudicates dental claims for the OpenCircle Benefit Plan.

If you have any questions regarding the benefits outlined in this section, please contact OpenCircle Benefits.

Provisions

Benefit Coverage

This section outlines the details of your extended health care benefits. The payment of any extended health care expense is subject to reasonable and customary pricing, any benefit levels and maximum benefit amounts indicated.

Eligible Expenses

Eligible expenses are generally charges for services and supplies that are medically necessary and customarily provided in relation to the nature and severity of the illness. Eligible expenses are generally included to the extent that:

- All expenses must occur and be paid for while you and your dependents are eligible for benefits
- They are reasonable and customary, professionally recognized and medically necessary
- Except where otherwise indicated, they are prescribed by a physician
- They exceed the amount payable under any other provision of the plan document or, subject to the Co-ordination of Benefits provision, any other plan that provides similar benefits

Coordination of Benefits

If you are also eligible for benefits under another extended health care plan, any claim under this plan will be coordinated and limited to the extent that benefits payable from all plans do not exceed 100% of eligible expenses.

Survivor Benefit

If you die while covered for benefits, extended health care coverage will be continued for your eligible dependents without any further payment of contributions. This extension will terminate 24 months from the date of your death.

Extended Benefits

If you are disabled when coverage would otherwise terminate, payment for medical expenses ***relating to the disability*** will be continued for 12 months from the date you become disabled. To be eligible for the extension, you must either be in receipt of Workers'

Compensation or Long Term Disability benefits or be approved for waiver of premium under the Employee Life Insurance benefit.

Prescription Drug Benefit

The OpenCircle Benefit Plan will provide coverage for 80% of the Eligible Drugs and 80% of the Eligible Dispensing Fee in Canada. When an individual has incurred $5,000 or more in eligible prescription drug claims in a calendar year, prescription drug coverage will increase to 90% for that individual only for the remainder of the calendar year. Coverage will revert back to 80% every January 1st.

All claims for Eligible Drugs and certain diabetes supplies can be made directly by your pharmacist at the time that you fill your prescription by presenting your Pay-Direct Benefit Card. You will not have to pay any amount of the prescription that is covered by the plan, but you will have to pay any amounts that are not covered by the plan. Alternatively, you can pay for the drugs at the time you receive them from your pharmacist and submit your paid receipt for reimbursement.

Eligible Drugs

The following are considered Eligible Drugs under the OpenCircle Plan:

- Drugs which by law may only be obtained with a prescription and are dispensed by a licensed pharmacist
- Smoking cessation aids are covered to a lifetime maximum of $500 per person (includes drugs, gum, patches, lozenges and inhalers)
- Fertility drugs are covered to a lifetime maximum of $2,500

The plan will cover only the cost of the lowest-priced equivalent generic drug unless medical evidence is provided by the prescribing physician that a brand name drug cannot be substituted.

There is a maximum limit of a 100-day supply for each prescription, subject to certain exceptions.

Some specific drugs may require prior authorization by OpenCircle Benefits to determine whether they meet clinical criteria for the particular health condition.

Eligible Dispensing Fee

The plan will allow a maximum dispensing fee of $9.00 for most prescriptions. Dispensing fees will vary between pharmacies.

The plan covers a maximum of five dispensing fees per maintenance medication per year where the drug is not legally limited in quantity. To maximize your amount of coverage, we

recommend filling maintenance medication in 90-day quantities. There is no annual dispending fee limit on acute medications or medications legally limited in quantity.

Diabetic Supplies

The following diabetic supplies are covered at 100%: insulin syringes, disposable needles for use with non-disposable insulin injection devices, test strips, sensors for flash glucose monitoring machines, lancets.

Exclusions

The following will not be considered eligible drug expenses, whether prescribed or not:

- Drugs dispensed during treatment as an in-patient or as an out-patient in a hospital
- Any drugs not approved for sale in Canada
- Charges for the administration of drugs, serums or vaccines
- Vitamins
- Proteins and dietary or food supplements
- Erectile dysfunction drugs
- Drugs that are considered cosmetic, whether or not prescribed for a medical reason

This list of exclusions is not exclusive, please contact OpenCircle Benefits if you have questions regarding your drug coverage.

Medical Services and Supplies

The OpenCircle plan will provide for 100% of the following eligible medical services and supplies, subject to reasonable and customary pricing limitations.

Hospital

The difference between the charges for a standard ward and a semi-private room in an active treatment hospital in Alberta.

Convalescent Care

The charge for a standard ward or semi-private room for convalescent care for a condition that is likely to improve as a result of the care, where the eligible person is admitted within 24 days of being hospitalized for acute care. There is a maximum of 180 days per illness.

Home Care Nursing

The charges for nursing services provided in the patient's home when certified in writing by the attending physician as medically necessary for the condition of the patient. A registered nurse, licensed practical nurse or registered nursing assistant must provide the nursing services. A relative of the patient or a resident in the patient's home must not provide the nursing services. To establish the amount of coverage available before home nursing begins, you should apply for a pre-care assessment. The maximum amount of expenses that will be paid is $10,000 during any one calendar year per person.

Charges for custodial care or any service within the capabilities and competence of a member of the household are not eligible.

Ambulance

Ambulance services, including air ambulance services, are covered if they are provided by a licensed ambulance company. Transportation must be to the nearest centre where essential treatment is available. If transportation is to a further centre, the plan provides alternative benefits based on coverage for transportation to the nearest centre where essential treatment is available. Alternative benefits are available on the same basis as they are for ambulance services provided in Canada.

Hearing Aids

The plan covers hearing aids, including tubing and ear molds provided at the time the hearing aid is purchased. The maximum amount payable is $1,000 every 5 calendar years.

Orthopedic Footwear and Orthotics

The plan covers:

- The cost of custom fitted orthopedic footwear, including orthopedic alteration to standard footwear. Must be prescribed by a physician, podiatrist or chiropodist. Up to a maximum of $400 per person per calendar year.
- The cost of custom made foot orthotics up to a maximum of $350 per person per calendar year. To be eligible, the orthotics must be prescribed by a physician, podiatrist or chiropodist.

Braces

The purchase or replacement of custom braces which incorporate a rigid support of metal or plastic, prescribed by a physician. The repair of a custom fitted brace does not require a prescription.

Prosthetics

Where prescribed by a physician, and reasonable for the diagnosed condition, the following prosthetics are covered:

- Charges for artificial limbs, artificial eyes, artificial nose or artificial larynx
- Myoelectric arms including repairs to a maximum of $10,000 per prostheses (charges for duplicate prostheses are not eligible)
- Charges for external prostheses following a mastectomy (to a maximum of $400 every two calendar years)

Medical Aids

It is recommended that you verify the reasonable and customary maximum allowed prior to purchasing covered items.

Where prescribed by an authorized medical professional, charges for the following medical aids, subject to reasonable and customary pricing and any maximums indicated:

- Continuous or Automatic Positive Airway Pressure (CPAP/APAP) machines
- Splints, trusses, crutches, casts, canes, walkers, cervical collars, parapodiums, ileostomy and colostomy supplies, urinary kits and catheterization supplies
- Rental or purchase (at the discretion of the plan) of manual wheelchairs, hospital beds, iron lungs or oxygen
- Purchase of an electric wheelchair to a lifetime maximum of $4,000 per person
- Rental or purchase (at the discretion of the plan) of medical durable equipment and supplies
- Diaphragms (whether or not prescribed by a doctor); intra-uterine devices, if inserted by a physician
- Up to two mastectomy bras per person per calendar year and mastectomy bra pads, when used in conjunction with an external mastectomy prosthesis (no prescription required)
- Up to two pairs of custom-fitted graduated compression hose per person per calendar year and reimbursement amount is dependent upon the compression factor and whether hose are stock items or custom-made
- An aerochamber device, once every two calendar years
- Wigs required as a result of chemotherapy, to a lifetime maximum of $500 per person
- Laboratory services, diagnostic services, blood and blood plasma, x-rays, oxygen and the administration
- Blood testing monitors, to a lifetime maximum of $700
- Insulin pumps when recommended by a physician once every five calendar years
- Allergy testing materials, provided the testing is performed by a physician, to a maximum of $40 per test and a lifetime maximum of $200 per person
- Blood pressure monitors, to a maximum of $150 per person in any three consecutive calendar year period
- Intra-venous supplies

This list is not exclusive. If you have questions on coverage for a particular medical device, and for assistance submitting an estimate for applicable coverage, please contact OpenCircle Benefits.

Paramedical Practitioners

Charges for the services are covered to the calendar year maximum outlined below per practitioner per person, subject to reasonable and customary pricing limitations. To be eligible, services:

- Must be provided by a practitioner who is registered/licensed with the appropriate provincial regulatory body in the specialty matching the service provided,
- Must be provided in the province where the practitioner is registered/licensed in that

specialty,

- Must be provided by an eligible practitioner, as outlined below:

    - **Acupuncturist** $500 per person per calendar year
    - **Chiropodist or Podiatrist*** $500 per person per calendar year
    - **Chiropractor** $500 per person per calendar year
    - **Dietician** $500 per person per calendar year
    - **Massage Therapist** $500 per person per calendar year
    - **Naturopath** $500 per person per calendar year
    - **Osteopath** $500 per person per calendar year
    - **Psychologist or Social Worker** $500 per person per calendar year
    - **Physiotherapist/Athletic Therapist** $600 per person per calendar year
    - **Speech Therapist** $500 per person per calendar year

    Diagnostic X-Rays
    Maximum of one x-ray in each calendar year for each eligible person, per specialty, where applicable (chiropractor, chiropodist/podiatrist, osteopath)

    **Excludes coverage for surgical tray fees and facility fees.*
    **Hourly maximums also apply. Please contact OpenCircle Benefits to verify amounts.*

Vision Care Expenses

General Expenses

The following expenses are covered under the Vision Care benefit:

- Eye exams by a licensed ophthalmologist or optometrist where not covered by a provincial plan
- Eyeglass lenses and frames for you and your dependents (including tinting, anti-reflective or anti-scratch coating of prescribed lenses), prescription sunglasses, contact lenses, prescription safety glasses or laser eye surgery, when prescribed by a doctor, ophthalmologist or optometrist, which are purchased while eligible for benefits.

These benefits are provided every two calendar years for participants age 19 and over (every calendar year for participants under age 19), to a maximum of $75 per person for eye exams, and $350 per person for eyewear.

Special Benefits

The benefits indicated below are in addition to the benefit maximum indicated in **General Expenses** above.

- Prescription safety glasses for you (dependents are not eligible) when prescribed by a doctor, an ophthalmologist or optometrist, which are purchased while eligible for

benefits, to a maximum of $150 every two calendar years.

- Visual training for you and your dependents, prescribed by a doctor, an ophthalmologist or optometrist, to a lifetime maximum of $200 per person.
- Contact lenses for you and your dependents, prescribed by a doctor, an ophthalmologist or optometrist if considered to be medically necessary (e.g., for severe corneal astigmatism, severe corneal scarring, keratoconus or aphakia) and required to improve vision in the better eye to at least 20/40 if this is not possible to do with conventional glasses, to a lifetime maximum of $500 per person.

Out-of-Province/Canada Medical Benefits

Medical Emergency Benefits

The OpenCircle Extended Health Plan provides for 100% of the following expenses when you or your eligible dependents are traveling outside of your province of residence or outside of Canada, to a maximum of $2,000,000 in Canadian funds. To be eligible, the person must be covered by the government health plan in his or her home province.

This coverage is for ***medical emergencies only*** arising while you or your dependent are travelling for vacation, business or education, and is limited to coverage for 60 days of travel per trip. Coverage for travel within Canada is limited to emergencies arising more than 500 kilometers from the person's home. If you will be working outside of Canada or have an eligible dependent that will be studying outside of Canada, you should consider purchasing additional non-emergency medical coverage. A ***medical emergency*** is either a sudden, unexpected emergency or a sudden, unexpected illness or acute episode of disease that could not have been reasonably anticipated based on the person's prior medical condition.

There are limitations to this benefit, please contact OpenCircle Benefits for more information on your situation. **Claim forms must be completed for any out-of-country expenses.**

The following expenses for emergency medical treatment are covered:

- 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 services and supplies provided during a covered hospital confinement
- Physician services
- Hospital out-patient services and supplies
- Provided during a covered hospital confinement

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. No benefits are paid for expenses incurred more than 60 days after the date of departure from Canada. If you or your dependent is hospital confined at the end of the 60-day period, benefits will be extended to the end of the confinement.

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.
- 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.

GLOBAL MEDICAL ASSISTANCE PROGRAM – GROUP 55400/158080

Phone Numbers: **Toll Free in Canada and USA 1.855.222.4051**
Cuba call collect 1.204.946.2946

In all other countries call collect 1.204.946.2577

Limitations

No benefit will be paid for:

- Any further medical care related to a medical emergency after the initial acute phase of treatment. This includes non-emergency continued management of the condition originally treated as an emergency.
- Any subsequent and related episodes during the same absence from Canada.
- Expenses related to pregnancy and delivery including infant care after the 34th week of pregnancy or at any time due to the pregnancy if the person's medical history indicates a higher than normal risk of an early delivery or complication.

Non-Emergency Care

is covered for you and your dependents if:

- It is required as a result of a referral from your usual Canadian physician,
- It is not available in any Canadian province and must be obtained elsewhere for reasons other than waiting lists or scheduling difficulties,
- You are covered by the government health plan in your home province for a portion of the cost, and
- A preauthorization of benefits is approved by Canada Life before you leave Canada for treatment.

Non-Emergency Care Outside Canada benefits are payable at 50% to a lifetime maximum of $25,000 per person.

Limitations

No benefit will be paid for:

- Investigational or experimental treatment, or
- Transportation or accommodation charges.

Exclusions

No Extended Health Care Benefits will be paid for:

- Expenses that private benefit plans are not permitted to cover by law
- Service or supplies the person is entitled to without charge by law or for which a charge is made only because the person has coverage under a private benefit plan
- The portion of the expense for services or supplies that is payable by the government health plan in the person's home province, whether or not the person is actually covered under the government health plan
- Service or supplies that do not represent reasonable treatment
- Services or supplies associated with treatment performed for cosmetic purposes only, except cosmetic surgery as a result of an accidental injury
- Services or supplies associated with recreation or sports rather than with other regular

daily living activities

- Services or supplies associated with the diagnosis or treatment of infertility, except as may be provided under the prescription drug provision
- Services or supplies associated with covered items, unless specifically listed as a covered expense
- Extra medical supplies that function as spares or alternates
- Services or supplies received outside Canada except as provided under the Out of Province/Canada Medical Emergency Benefits
- Services or supplies received out-of-province in Canada unless the person is covered by the government health plan in his home province or the government coverage replacement plan sponsored by the employer and this plan would have paid benefits for the same services or supplies if they had been received in the person's home province
- Expenses arising from war, insurrection or voluntary participation in a riot
- Services of physicians and surgeons (except when provided under Out of Canada Medical Emergency Benefit)
- Services provided by any other insurance or benefit plan
- Interest charges
- A service or supply which is experimental or investigative in nature
- Medical treatment not approved or recognized by the provincial government health program
- Treatment or services provided by a person who is related to or resides with the individual
- An examination by, or the services of, a physician, if required solely for third party use
- Any services or supplies to which the individual is entitled under any Workers' Compensation statute or any other legislation
- Charges for missed appointments or the completion of claim forms
- Routine examination or routine general checkup required for the use of a third party
- Stock item footwear
- Charges for the administration of injectable drugs

Dental Care

The dental care benefits are self-insured under the OpenCircle Benefit Plan. Canada Life adjudicates dental claims for the OpenCircle Benefit Plan.

If you have any questions regarding the benefits outlined in this section, please contact OpenCircle Benefits.

Provisions

Benefit Coverage

The OpenCircle dental plan will pay up to the **lower** of the amounts specified in the current Provincial General Practitioners or Denturist Society Fee Guide where the dental service is provided, and the amount charged by your dentist/denturist. If dental services are provided by a specialist, then the applicable specialist fee guide will be used.

Some dentists may charge more while other dentists may charge less than what will be paid by the OpenCircle dental plan. Therefore, you should **ask your dentist** what the charge for dental services would be prior to having any dental work done. Your dental office will also be able to tell you what portion of the dental services will be paid by the OpenCircle dental plan.

The payment of any dental expenses is subject to any benefit levels and maximum benefit amounts indicated.

Pre-determination of Benefits

If you will be undergoing extensive dental treatment, it is recommended that your dentist submit the proposed course of treatment before treatment begins. The plan will not determine the appropriateness of the treatment but will advise you, of the amount that is payable by the OpenCircle dental plan.

Eligible Expenses

Eligible expenses are described in the Dental Services sections that follow. All expenses must occur while you or your eligible dependents are eligible for benefits. Only those services that are provided by a health care professional licensed, certified or registered to practice a profession by the appropriate licensing, certification or registration authority will be covered.

Maximum Benefit

The maximum amount that will be paid for the combination of **Basic Dental Services** and **Major Dental Services** (as outlined in the following sections), is $2,500 per person per calendar year. per person. The total maximum lifetime amount that will be paid for Orthodontic Dental Services for each eligible participant is $2,500.

Alternate Courses of Treatment

When two or more courses of dental treatment are available to correct a dental condition, the OpenCircle dental plan will base reimbursement on the cost of the least expensive treatment that in the opinion of the plan provides a professionally adequate result.

Basic Dental Services

Subject to the Fee Guide and Maximum Benefit provisions outlined earlier, the OpenCircle plan will provide coverage for 80% of the following basic dental services.

Routine examinations and diagnosis

- Complete examinations, once every five calendar years
- Recall examinations, once every calendar year for participants age 19 and over, and once every six months, for participants under age 19
- Emergency examinations
- Sialography
- Radiopaque dyes used to demonstrate lesions
- Interpretation of radiographs or models from another source
- Microbiological, histological, cytological and pulp vitality tests
- Laboratory reports
- Treatment planning
- Consultations with the patient

Dental x-rays and interpretation

- Full mouth or panoramic, once every two calendar years
- Bitewings, once every calendar year for participants age 19 and over, and once every six months, for participants under age 19
- Intra-oral, other than bite-wings, to a maximum of 15 films every two calendar years
- Periapical and extra-oral films

Oral hygiene instruction

- Lifetime limit of one unit per person

Polishing of teeth

- Once every calendar year for participants age 19 and over
- One unit every six months for participants under age 19

Topical fluoride treatment

- Only for participants under age 19, once every six months

Habit breaking appliances

- For the control of harmful dental habits

Pit and fissure sealants

- For participants under age 19, for permanent teeth only

Space maintainers

- For missing primary teeth, for participants under age 19
- Maintenance of space maintainers

Oral surgery

Covered oral surgery includes but is not limited to:

- Removal of teeth
- Surgical exposure of teeth
- The following procedures for remodelling and recontouring oral tissues:
    - Minor alveoloplasty,
    - Gingivoplasty and stomatoplasty, and
    - Reconstruction of the alveolar ridge.
- Surgical incisions
- Surgical excision of tumors, cysts, and granulomas
- Treatment of fractures, including related bone grafts to the jaw
- Treatment of maxillofacial deformities, including related bone grafts to the jaw and cheiloplasty

Palatal obturators, although not listed with oral surgery in the Canadian Dental Association Uniform System of Coding and List of Services, are also covered under this provision. Cleft palate obturators are not covered.

No benefits will be paid for implantology, surgical movement of teeth, services performed to remodel or recontour oral tissues other than those listed above (services for remodeling and recontouring oral tissues are covered under Major Dental Services), or alveoloplasty or gingivoplasty performed in conjunction with extractions.

Fillings

- Composite (tooth-coloured) or amalgam (silver) fillings
- Stainless steel crowns only for participants under age 19
- Replacement fillings are covered only if the existing filling is at least two years old
- Interproximal disking
- Recontouring of teeth
- Caries, trauma and pain control
- Retentive pins and prefabricated post for fillings
- Plastic crowns

Endodontics

Covered endodontic services include but are not limited to:

- Treatment of the pulp chamber

- Root canal therapy for permanent teeth, limited to one course of treatment per tooth (repeat treatment is covered only if the original therapy fails after the first 18 months)
- Apexification
- Periapical services (apicoectomies are covered for permanent teeth only)

No benefits will be paid for root canal therapy for primary teeth, isolation of teeth, enlargement of pulp chambers or endosseous intra coronal implants.

Periodontics

- Limited periodontal examinations, once every calendar year for participants age 19 and over and once every six months for participants under age 19
- Occlusal adjustments to a lifetime maximum of eight units
- Root planing, to a combined maximum of eight units in a calendar year
- Periodontal appliances including maintenance, adjustment and repair to appliances, twice in a calendar year
- Replacement appliances are covered where the existing appliance is at least four years old
- Periodontal surgery
- Desensitization
- Periodontal re-evalutations

Denture services

- Relines and rebasings, limited to once each calendar year
- Denture repairs limited to reasonable and customary frequency
- Resilient liner in relined or rebased dentures after the three-month postinsertion care period has elapsed, once every three calendar years

Adjunctive services

- Minor remedies for relief of dental pain when provided on an emergency basis

Accidental Dental

Coverage for 100% of the charges for the repair, extraction or replacement of natural teeth damaged by a direct accidental external blow to the mouth. The accidental injury and the expense for the repair, extraction or replacement must occur while the individual is eligible for this benefit. The expense for the repair, extraction or replacement must occur within 12 months from the date the dental accident occurred. This 12-month limit should be taken into consideration if choosing a treatment plan that requires multiple procedures with healing time between them. The maximum payable is $10,000 per person per accident. There are limitations to this coverage, contact OpenCircle Benefits for more information.

Major Dental Services

Subject to the Fee Guide and Maximum Benefit provisions outlined earlier, the OpenCircle plan will provide coverage for 50% of the following major dental services.

Examinations

- General prosthodontic exam, once every five calendar years
- Specific prosthodontic exam, once in a calendar year

Crowns, onlays, inlays and veneers

Crowns, onlays, inlays and veneers are covered when a tooth has extensive structural loss that cannot be adequately restored using other procedures, when the existing restoration is at least four years old. The following crowns and related items are covered:

- Metal, plastic, porcelain, and ceramic crowns. Coverage for crowns on molars is limited to the cost of metal crowns. Coverage for complicated crowns is limited to the cost of standard crowns
- Onlays. Coverage for tooth-coloured onlays on teeth other than teeth 1-6 is limited to the cost of metal onlays
- Inlays. Coverage for tooth-coloured inlays on teeth other than teeth 1-6 is limited to the cost of metal onlays
- Veneer applications
- Posts, cores, and pins related to covered crowns
- Copings related to covered crowns
- Repairs to covered tooth-coloured materials
- Rebonding, removal and recementation of crowns, onlays and inlays

Dentures and bridgework

- Standard complete dentures, standard cast or acrylic partial dentures or complete overdentures or bridgework when standard complete or partial dentures are not viable treatment options.
- Coverage for tooth-coloured retainers and pontics on teeth other than teeth 1 through 6 is limited to the cost of metal retainers and pontics.
- Replacement appliances are covered only when the existing appliance is a covered temporary appliance that was placed within the last 12 months, or the existing appliance is at least four years old and cannot be made serviceable. If the existing appliance is less than four years old, a replacement will still be covered if the existing appliance becomes unserviceable 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.
- Replacement dentures that are lost, stolen or broken through misuse are not covered if less than four years old.

Denture Related Surgery

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

Appliance Maintenance

Denture and bridgework maintenance following the three-month postinsertion period including:

- Denture remakes, once every 3 calendar years
- Denture adjustments, once every calendar year
- Tissue conditioning
- Repairs to covered bridgework
- Removal and recementation of bridgework

Orthodontic Dental Services

Subject to the Maximum Benefit provisions outlined earlier, the OpenCircle Benefit Plan will provide coverage for 50% of the following orthodontic dental services. Only participants who are over age 6 and under age 19 are eligible for this benefit. The following services are covered under this benefit: general orthodontic exam, once every five calendar years, cephalometric, hand and wrist, and extra-oral radiographs, diagnostic photographs, orthodontic diagnostic casts, fixed and removable appliances, related charges for observations, adjustments, repairs, alterations, removal and retention.

No benefits will be paid for expenses for replacement of orthodontic applicates which have been lost, stolen, or broken, except where eligible replacement frequency is met. Expenses covered under another group plan's extension of benefits are also not covered. Coverage for services that commenced before age 19 will be covered until treatment is complete. Services rendered for comprehensive orthodontic treatment will not be covered unless a treatment plan and records are submitted for approval in writing. The treatment plan must provide the diagnosis, treatment to be rendered, appliances to be used, length of each phase of treatment, the charges, financial arrangements and commencement date of treatment.

Dental Expenses Outside of Canada

Expenses incurred for dental services outside Canada will be eligible if:

- They represent the usual, customary and reasonable charges for the procedures in the locality where they are performed, and
- Charges for such procedures would have been paid under this plan had the procedures been performed in your province of residence.

Coordination of Benefits

If you are also eligible for benefits under another dental plan, any claim under this plan will be coordinated and limited to the extent that benefits payable from all plans do not exceed 100% of eligible expenses.

Survivor Benefit

If you die while covered for benefits, dental coverage will be continued for your eligible dependents without any further premium payment. This extension will terminate 24 months from the date of your death.

Extension of Benefits

Certain benefits are extended until 31 days after coverage terminates where major dental work is in progress and cannot be safely delayed. No benefits are payable for treatment started after termination of coverage, or for continuation of basic dental services.

Exclusions

No Dental Care Benefits will be paid for or as a result of the following:

- 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 – topical application of antimicrobial agents, subgingival periodontal irrigation, charges for post-surgical treatment and replacement of periodontal appliances that are less than four years old
- 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
- Hypnosis or acupuncture
- Recontouring existing crowns and staining porcelain
- Crowns, onlays or inlays if the tooth could have been restored using other procedures. If crowns, onlays, inlays or veneers are provided, benefits will be based on coverage for fillings
- Expenses covered under another group plan's extension of benefits provision
- Replacement of dentures, devices or appliances that have been lost, stolen or broken, except where the appliance's age makes it eligible for replacement
- 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 or supplies the person is entitled to without charge by law or for which a

charge is made only because the person has coverage

- Orthodontic treatment or devices
- Services or supplies that do not represent reasonable treatment
- Treatment performed for cosmetic purposes only
- Congenital defect or developmental malformation in people 19 years of age or over
- Temporomandibular joint disorders, vertical dimension correction or myofacial pain
- Expenses arising from war, insurrection, or voluntary participation in a riot
- Services provided by a government funded program
- Charges that normally would not be made if the individual were not covered by the plan
- Services provided by any other insurance or benefit plan
- Interest charges
- A service or supply which is experimental or investigative in nature
- Treatment or services provided by a person who is related to, or resides with the individual
- Any services or supplies to which the individual is entitled under any Workers' Compensation statute or any other legislation
- Charges for missed appointments or the completion of claim forms
- Oral appliances, other than required periodontal appliances
- Mouth guards
- Bleaching of teeth
- Recent duplication of services, whether by the same or different dentist
- Hospital charges for dental services
- Spare or duplicate dentures, devices or appliances
- In all cases in which the patient selects a more expensive plan of treatment than is customarily provided for necessary and adequate treatment, payment and coverage will be based on the lesser fee
- Where the charge for a particular service includes a fee for the diagnostic radiograph, no other radiographic charges will be covered for the diagnosis or treatment of that condition
- Fees for polishing and finishing restorations
- Payment in advance of services being rendered (payment for comprehensive cases will be amortized over the length of active treatment)
- Myofunctional therapy
- Motivation of patient
- In all cases in which a fee is charged for a complicated or difficult treatment, payment will be based on the lesser cost of an uncomplicated or standard service

Long Term Disability

If you have any questions regarding the benefits outlined in this section, please contact OpenCircle Benefits.

Eligibility

You are eligible for Long Term Disability (LTD) coverage when the following three conditions are met:

- You are ***under age 65*** following the completion of the ***qualifying period,***
- You are ***in benefit*** under the Hour Bank Benefit Plan, and
- You are ***actively at work*** for an OpenCircle employer who is participating in the OpenCircle LTD program.

The ***qualifying period*** is 120 days of disability.

You are ***in benefit*** if you meet the requirements of being in benefit (as set out earlier in this booklet) for the month during which you became disabled.

You are considered to be ***actively at work*** if you were working for your employer on your last scheduled shift prior to becoming disabled and if your employer reports the hours to OpenCircle and pays the required premiums.

The benefit is payable for as long as you are under age 65 and remain disabled under the Definition of Disability.

Provisions

Benefit

The LTD benefit is $2,500 per month for the first 24 months increasing to $3,000 thereafter.

The LTD benefit is **reduced** by any benefits paid under any Workers' Compensation Act or similar law, and any employer-sponsored short term disability or sick leave benefits.

The benefit is payable only while you remain disabled as provided under the **Definition of Disability**. The benefit is **further reduced** if the total of your income listed under the section **Integration With Other Income** exceeds 85% of your pre-disability income. If it does, your benefit is reduced by the excess amount.

Changes in other government plans and programs could lead to a reduction in the benefits that you receive.

Tax

LTD benefits are taxable if your employer pays any part of the LTD premium and non-taxable if you pay the entire premium.

Payment Period

LTD payments **start** the later of:

- The end of the Qualifying Period, or
- The date you are no longer entitled to receive any wages, short-term disability benefits or severance payments.

LTD payments will **end** the earlier of:

- The date your disability ceases, or
- When you turn age 65.

Pre-Disability Income

Pre-disability income is defined as the current salary paid by your employer, including commission and shift differentials, regular overtime and regular bonuses paid in the last calendar year, at the start of the disability period.

Definition of Disability

To be considered disabled, you must be unable to perform the essential duties of your own occupation during the Qualifying Period and during the first two years immediately following the Qualifying Period. After that, you will be considered to be disabled if you are unable to perform the essential duties of:

- Any occupation for which you are qualified or may reasonably become qualified, by training, education, or experience.
- Any occupation for which you are receiving an income that is equal to or greater than the amount of monthly disability benefit payable under this provision, adjusted annually by the Consumer Price Index.

The availability of work will not be considered by the Insurer in assessing your disability.

If you are required to hold a government permit or license to perform your duties, you will not be considered disabled solely because such permit or license has been withdrawn or not renewed.

Benefits Are Not Payable

You are **not eligible** to receive LTD benefits during any period that you are:

- Not receiving regular, ongoing care and treatment from a physician appropriate to

the disabling condition, as determined by the Insurer,
- Receiving Employment Insurance Maternity or Parental benefits,
- On a lay-off during which you become disabled,
- On a leave of absence during which you become totally disabled, unless your employer is required to pay benefits during this period as required by legislation, regulation or case law,
- Receiving benefits under an employer-sponsored salary continuance or short term wage loss replacement plan,
- Working in any occupation, except as provided under the Rehabilitation Assistance provision, or
- Incarcerated in a prison, correctional facility, or mental institution by order of authority of a criminal court.

Integration With Other Income

The LTD benefit is designed to supplement other benefits that may be available to you during disability. The LTD benefit is **reduced** as outlined below.

All Source Maximum

If your total income from the following sources, when added to the LTD benefit, exceeds an all source maximum limit of 85% of gross pre-disability income (if LTD benefit is taxable) or 85% of net pre-disability income (if LTD benefit is non-taxable), your LTD benefit payment will be reduced:

- Disability benefits under a plan of insurance available through an association.
- Any retirement or pension plan earnings.
- Employment income (including severance/termination payments), disability benefits, or retirement benefits related to any employment. This excludes income from an approved rehabilitation plan, or employer sponsored short term disability or sick leave benefits.
- Earnings from self-employment,
- Any government plan, excluding Employment Insurance Benefits,
- Earnings from Canada or Quebec Pension Plans.
- Benefits another member of your family is entitled to on the basis of your disability under the Canada Pension Plan or Quebec Pension Plan that are paid directly to you.
- Loss of income benefits available through legislation, except for Employment Insurance benefits and automobile insurance benefits, which you or another member of your family is entitled to on the basis of your disability.
- The wage loss portion of any criminal injury award.

Offset Provision

Your LTD benefit is reduced by the following income:

- Benefits under any Workers' Compensation Act or similar law except for:

    - Permanent partial disability awards that were payable for each of the 12 months before a disability period; and
    - Benefits related to employment with another employer.
- Employer-sponsored short term disability or sick leave benefits.
- Loss of income benefits under an automobile insurance plan, to the extent permitted by law.
- 50% of income from an approved rehabilitation plan or program up to 100% of pre-disability income.

Recurrent Disability

If you stop being disabled while satisfying a Qualifying Period, and within 30 days become disabled again from the same or related causes, the Qualifying Period will be extended by the number of days during which the disability ceased.

If you stop being disabled following a disability for which benefits were paid, and within six months become disabled again from the same or related causes, that second disability is considered to be a continuation of the previous disability. If the same disability recurs more than six months after the end of the period for which benefits were paid, such disability will be considered a separate disability.

Two disabilities that are due to unrelated causes are considered separate disabilities if they are separated by a return to work of at least one day.

Medical Coordination and Vocational Rehabilitation

LTD benefits will continue to be paid during a period of approved rehabilitation employment or during participation in a medical coordination program, as recommended by Canada Life. However, your LTD benefits will be reduced by 50% of earnings from approved rehabilitative employment. In addition, your LTD benefit may be further reduced so that your total income from all sources does not exceed 100% of pre-disability gross income (if the LTD benefit is taxable) or 100% of pre-disability net income (if the LTD benefit is non-taxable).

Medical Coordination and Vocational Rehabilitation programs are recommended by Canada Life at the time of claim. In considering whether either of these programs is appropriate, Canada Life will assess individual factors pertaining to your approved disability claim. If either of these programs is appropriate, your Case Manager with Canada Life will discuss these programs with you, along with applicable limitations and participation requirements.

Survivor Benefits

If you die your surviving spouse will be paid, a survivor benefit equal to three times the last monthly disability benefit payment received by you. If you have no surviving spouse, the survivor benefit will be paid to your surviving dependent children. If there are no surviving dependents, the benefit will be paid to your estate.

Waiver of Long Term Disability Premiums

LTD premiums will be waived during any period that you are in receipt of LTD benefits.

Exclusions/Limitations

No LTD benefit is payable for any disability directly or indirectly related to:

- Any period in which you do not participate or cooperate in a reasonable and customary treatment program,
- Any period in which you fail to participate or cooperate in a rehabilitation plan and/or medical coordination program that has been recommended or approved by Canada Life,
- A scheduled duration of leave of absence or lay-off,
- Medical or surgical care which is not medically necessary,
- Self-inflicted injuries or illnesses, whether sane or insane,
- Committing or attempting to commit an assault or a criminal offense,
- Substance abuse, unless you are actively participating in a treatment program that includes a recognized substance withdrawal program,
- War, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion, or
- A pre-existing condition which causes disability within the first 12 months from the date your coverage commences. For more information about pre-existing conditions please contact OpenCircle Benefits.

LTD benefit payments will not commence during any period of Maternity/Parental Leave or Leave of Absence.

Subrogation (Reimbursement for Third Party Liability)

If the Insurer has paid or may be obligated to pay a benefit for an injury or disease for which a third party is or may be liable for damages either in whole or in part, the Insurer will assert their right to reimbursement, where permitted by law. Before benefit payments are made, the Insurer requires that you sign and comply with a reimbursement agreement. You are obligated to reimburse the Insurer when the amount of monthly disability benefit paid, together with the amount you recover from the third party for lost income, exceeds 100% of your lost income. If you recover less than the entire loss, the Insurer is entitled to pro-rate their subrogated recovery.

Termination of LTD Benefit Payments

Your LTD benefit will terminate on the earliest of the following dates:

- You are no longer totally disabled,
- You fail to supply the Insurer with appropriate medical evidence,

- You do not attend a medical, psychiatric, psychological, educational and/or vocational examination or evaluation by an examiner selected by the Insurer,
- You refuse to participate in a vocational or functional capabilities assessment,
- You refuse to participate in a rehabilitation program approved by the Insurer,
- You reach age 65, or
- You die.

Termination of LTD Coverage

Your LTD coverage terminates on the earliest of the following dates:

- You are no longer in benefit under the Hour Bank Benefit Plan,
- You cease to be actively at work,
- Your employer ceases to make any required premium contributions, or
- You reach age 65 less 120 days (the Qualifying Period).

Short Term Disability

If you have any questions regarding the benefits outlined in this section, please contact OpenCircle Benefits.

Eligibility

You are eligible for Short Term Disability (STD) coverage when the following three conditions are met:

- You are ***under age 70*** following the completion of the ***qualifying period***,
- You are ***in benefit*** under the Hour Bank Benefit Plan, and
- You are ***actively at work*** for an OpenCircle employer who is participating in the OpenCircle STD program.

Qualifying Period – you become eligible for STD benefits on the first day of an accident, on the first day of hospitalization, or on the eighth day of illness.

You are ***in benefit*** if you meet the requirements of being in benefit (as set out earlier in this booklet) for the month during which you became disabled.

You are considered to be ***actively at work*** if you were working for your employer on your last scheduled shift prior to becoming disabled and if your employer reports the hours to OpenCircle and pays the required premiums.

The benefit is payable for as long as you are:

- Under age 70,
- Remain disabled under the Definition of Disability, and
- Have not been disabled in excess of 120 days.

Provisions

Benefit

The STD benefit is $800 per week.

The benefit is payable only while you remain disabled as provided under the **Definition of Disability**. The STD benefit is **reduced** by any benefits paid under any Workers' Compensation Act or similar law.

The benefit is **further reduced** if the total of your income listed under the section **Integration With Other Income** exceeds 85% of your pre-disability income. If it does, your benefit is reduced by the excess amount.

Changes in other government plans and programs could lead to a reduction in the benefits that you receive.

Tax

STD benefits are taxable if your employer pays any part of the STD premium and non-taxable if you pay the entire premium.

Payment Period

STD payments start the later of:

- The end of the Qualifying Period, or
- The date you are no longer entitled to receive any wages, short-term disability benefits or severance payments.

STD payments will end the earlier of:

- The date your disability ceases,
- 120 days from the start of payment, or
- When you turn age 70.

Pre-Disability Income

Pre-disability income is defined as the current salary paid by your employer, including commission and shift differentials, regular overtime and regular bonuses paid in the last calendar year, at the start of the disability period.

Definition of Disability

To be considered disabled, you must have a restriction or lack of ability due to an illness or injury that prevents you from performing the essential duties of your own occupation.

The availability of work will not be considered by the Insurer in assessing your disability.

If you are required to hold a government permit or license to perform your duties, you will not be considered disabled solely because such permit or license has been withdrawn or not renewed.

Benefits Are Not Payable

You are **not eligible** to receive STD benefits during any period that you are:

- Not receiving regular, ongoing care and treatment from a physician appropriate to the disabling condition, as determined by the Insurer,
- Receiving Employment Insurance Maternity or Parental benefits,
- On a lay-off during which you become disabled,
- On a leave of absence during which you become totally disabled, unless your employer is required to pay benefits during this period as required by legislation, regulation or case law,

- Receiving benefits under an employer-sponsored salary continuance or short term wage loss replacement plan,
- Working in any occupation, except as provided under the Rehabilitation Assistance provision, or
- Incarcerated in a prison, correctional facility, or mental institution by order of authority of a criminal court.

Integration With Other Income

The STD benefit is designed to supplement other benefits that may be available to you during disability. The STD benefit is **reduced** as outlined below.

All Source Maximum

If your total income from the following sources, when added to the STD benefit, exceeds an all source maximum limit of 85% of gross pre-disability income (if STD benefit is taxable) or 85% of net pre-disability income (if STD benefit is non-taxable), your STD benefit payment will be reduced:

- Any group or association plan,
- Any retirement or pension plan,
- Earnings or payments from any employer, including severance payments and excluding vacation pay,
- Self-employment,
- Any government plan, excluding Employment Insurance Benefits,
- Canada or Quebec Pension Plans, including dependent benefits,
- Any government motor vehicle automobile insurance plan or policy, unless prohibited by law.

Offset Provision

Your STD benefit is reduced by the following income:

- Benefits under any Workers' Compensation Act or similar law except for:
    - Permanent partial disability awards that were payable for each of the 12 months before a disability period; and
    - Benefits related to employment with another employer.
- 50% of income from an approved rehabilitation plan or program up to 100% of pre-disability income.

Recurrent Disability

If you become totally disabled again from the same or related cause as those for which STD benefits have already been paid, and such disability recurs within two weeks from the end of the period for which benefits were paid, the Qualifying Period will be waived. All such recurrences will be considered a continuation of the same disability.

If the same disability recurs more than two weeks after the end of the period for which benefits were paid, such disability will be considered a separate disability.

Two disabilities that are due to unrelated causes are considered separate disabilities if they are separated by a return to work of at least one day.

Medical Coordination and Vocational Rehabilitation

STD benefits will continue to be paid during a period of approved rehabilitation employment or during participation in a medical coordination program, as recommended by Canada Life. However, your STD benefits will be reduced by 50% of earnings from approved rehabilitative employment. In addition, your STD benefit may be further reduced so that your total income from all sources does not exceed 100% of pre-disability gross income (if the STD benefit is taxable) or 100% of pre-disability net income (if the STD benefit is non-taxable).

Medical Coordination and Vocational Rehabilitation programs are recommended by Canada Life at the time of claim. In considering whether either of these programs is appropriate, Canada Life will assess individual factors pertaining to your approved disability claim. If either of these programs is appropriate, your Case Manager with Canada Life will discuss these programs with you, along with applicable limitations and participation requirements.

Exclusions/Limitations

No STD benefit is payable for any disability directly or indirectly related to:

- Any illness or injury which arises out of or in the course of employment, unless the claim has been denied by workers' compensation because the illness or injury is not recognized as resulting from employment,
- Any period in which you do not participate or cooperate in a reasonable and customary treatment program,
- Any period in which the person fails to participate or cooperate in a rehabilitation plan and/or medical coordination program that has been recommended or approved by Canada Life,
- A scheduled duration of leave of absence or lay-off,
- Medical or surgical care which is not medically necessary,
- War, insurrection, the hostile actions of any armed forces or participation in a riot or civil commotion,
- Medical or surgical care which is not medically necessary,
- Substance abuse, unless you are actively participating in a treatment program that includes a recognized substance withdrawal program,
- Committing or attempting to commit an assault or a criminal offense,
- Self-inflicted injuries or illnesses, whether sane or insane.

STD benefit payments will not commence during any period of Maternity/Parental Leave or Leave of Absence.

Subrogation (Reimbursement for Third Party Liability)

If the Insurer has paid or may be obligated to pay a benefit for an injury or disease for which a third party is or may be liable for damages either in whole or in part, the Insurer will assert their right to reimbursement, where permitted by law. Before benefit payments are made, the Insurer requires that you sign and comply with a reimbursement agreement. You are obligated to reimburse the Insurer when the amount of monthly disability benefit paid, together with the amount you recover from the third party for lost income, exceeds 100% of your lost income. If you recover less than the entire loss, the Insurer is entitled to pro-rate their subrogated recovery.

Termination of STD Benefit Payments

Your STD benefit will terminate on the earliest of the following dates:

- You are no longer totally disabled,
- You fail to supply the Insurer with appropriate medical evidence,
- You do not attend a medical, psychiatric, psychological, educational and/or vocational examination or evaluation by an examiner selected by the Insurer,
- You refuse to participate in a vocational or functional capabilities assessment,
- You refuse to participate in a rehabilitation program approved by the Insurer,
- The earlier of the end of the Payment Period or the date you reach age 70,
- You retire, or
- You die.

Termination of STD Coverage

Your STD coverage terminates on the earliest of the following dates:

- You are no longer in benefit under the Hour Bank Benefit Plan,
- You cease to be actively at work,
- Your employer ceases to make any required premium contributions, or
- You reach age 70.

Employee Assistance Program (EAP)

If you have any questions regarding the benefits outlined in this section, please contact OpenCircle Benefits.

Benefit Coverage

The Employee Assistance Program (EAP) is available to you and your eligible dependents to manage work, health, and life issues with complete confidentiality. EAP services include professional counselling, work/life support services, and specialized programs to assist with your everyday issues, complex concerns, and everything in between. EAP provides expert advice, consultation, information, and resources.

The LifeWorks EAP counselling services are available through a network of professionals with a master's degree or doctorate in the fields of psychology, clinical social work, or educational psychology. Many counsellors are also certified in addictions counselling, marriage and family therapy, bereavement issues, anger management and other specialized areas. LifeWorks offices are located in most major centres across Canada. In person, telephonic, online, video counselling and a variety of text-based services are available.

With the innovative LifeWorks app, you can access qualified support for your mental, physical, social, and financial well-being, any time, from anywhere. Search for resources and tools on topics ranging from family and life to health, money and work. The LifeWorks app is available for all smart phones, simply search 'LifeWorks' in the App Store or Google Play.

What's more, the app acts like your digital wallet card. You can call a LifeWorks Employee Assistance Program (EAP) advisor with just one tap – toll-free, 24/7 – for expert advice, resources, and referrals.

Eligibility

You and your eligible dependents can access the EAP when you are in benefit under the OpenCircle Benefit Plan. You are considered in benefit if you meet the requirements of being in benefit as set out earlier in this booklet.

The EAP is available to you and your eligible dependents 24 hours, 7 days a week, 365 days a year by phone at 1.877.916.9116.

Note: When calling LifeWorks, tell them you are under the OpenCircle Benefit Plan. You are not listed under your company name.

Confidentiality

Confidentiality is the cornerstone of the EAP and is taken very seriously. You will be able to discuss your personal problems and concerns in complete confidence, within the limits of the law, in a caring and professional environment, away from your workplace.

LifeWorks has strict guidelines in place to ensure your privacy. When you access EAP services, only you and your counsellor will know. No personal information is ever released to your spouse, your children, your employer, OpenCircle Benefits or OpenCircle.

The commitment to confidentiality ensures you will in no way jeopardize your work situation by using the program. In fact, the program is likely to be of benefit because counselling may help resolve problems that might otherwise affect your job performance.

To further ensure confidentiality, no two employees from the same organization will be seen at the same time at the same office or have appointments back-to-back.

Services Provided

LifeWorks will provide assessment and counselling across a broad spectrum of personal, health and work-related concerns which include but are not limited to:

- Marital/relationship issues
- Bereavement
- Personal and emotional difficulties
- Personal and/or workplace stress
- Family issues including childcare and eldercare
- Interpersonal conflict
- Smoking cessation
- Alcohol/drug misuse and/or abuse
- Gambling addiction
- Work-related concerns
- Financial issues
- Violence
- Single parenting
- Nutritional
- Naturopathic
- Health coaching
- Child care/elder care locators
- Parental Leave Program
- Career counselling
- Legal issues *(information and advice only, no legal activities such as completion of wills, etc.)*

Trauma Response Services

LifeWorks is available to respond immediately to traumatic events providing group and/or individual debriefings. Traumatic events include, but are not limited to:

- Accident resulting in amputation, injury or death
- Violent behavior in the workplace
- Sudden death by suicide or natural causes
- Situations of fraud
- Physical or sexual harassment at work
- Tragedy such as plane, train, or highway crash
- Major organizational restructuring
- Terrorism
- Natural disasters

Cost of Accessing the EAP

There is no cost to you or your eligible dependents to access the services of the EAP. The cost of any service not supplied by LifeWorks or covered by the OpenCircle Benefit Plan is your responsibility.

Counselling Sessions Provided

The EAP provides short-term counselling only. Each individual's needs are different and will thus result in a varying number of counselling sessions for any given problem.

Long-Term Needs

If your situation requires long-term treatment, your counsellor will refer you to a resource in your community. If your situation is recognized as highly specialized and out of the scope of the services normally provided by LifeWorks, you will also be referred to a resource in your community. Any fees for resources outside of the EAP will be at your own expense and you may be able to submit them to Canada Life for reimbursement – please contact OpenCircle Benefits to confirm eligibility.

Survivor Benefit

If you die while covered for benefits, your eligible dependents may continue to access the EAP. This access will terminate 24 months from the date of the employee's death.

Teladoc Medical Experts

If you have any questions regarding the benefits outlined in this section, please contact OpenCircle Benefits.

Expert Medical Services

Teladoc Medical Experts connects individuals and their treating physicians with world-renowned specialists to confirm the correct diagnosis and treatment plan, without having to leave home. It also assists in navigating the health care system through one-on-one coaching and support.

You and your eligible dependents, including parents and parents-in-law, have access to six services:

Expert Medical Opinion

The Expert Medical Opinion service allows you, your dependents, and your attending physician or specialist **access to the expertise** of world-class specialists, resources, information, and clinical guidance.

Whether facing a complex medical condition, questioning an existing diagnosis, or requiring help deciding on the right treatment, the interaction with a clinician and recommendation from a leading expert can make all the difference. The steps for the Expert Medical Opinion service are shown below:

How Expert Medical Opinion works

- You and your dependents can access diagnostic and treatment support services through the Teladoc Medical Experts member portal at Teladoc.ca/canadalife, or phone via the toll-free number 1.877.419.2378.
- You will be connected with a Member Advocate, either a Registered Nurse or a physician, is dedicated to your case throughout the process and will arrange to gather your medical records and discuss any questions or concerns you may have. The information provided is not shared with your employer, OpenCircle or OpenCircle Benefits.
- Teladoc Medical Experts' team of physicians complete an in-depth analysis of your medical records, and any applicable pathology will be retested by our Centre of Excellence.
- The team then identifies and matches the best qualified specialist(s) for you from our global expert panel of over 450 sub-specialties, which is composed of top specialists affiliated with some of the most prestigious medical facilities in the world.
- The specialist will prepare a comprehensive expert report for you summarizing findings, and will confirm, clarify or change your diagnosis and treatment

recommendations. Your Member Advocate will then review the information with you and address any remaining questions.
- You and your treating physician work together to choose the next steps.

Find a Doctor

Teladoc Medical Experts will recommend a doctor from our quality-ranked database of physicians, providing details about each specialist's preferred method of referral and information. Appointments and referrals must be made by your treating physician. **Medical and travel expenses are not covered**.

Care Finder

Teladoc Medical Experts will help members locate specialists or facilities outside of Canada for their treatment or any condition needs. **Medical and travel expenses are not covered**.

Personal Health Navigator

This service empowers members to make informed decisions about their own care by helping them **navigate** the health care system. Personal Health Navigator provides one-on-one support, customized health information and condition-specific content, and access to local resources. It is not only for complex illnesses but can also help all members and their dependents with any health care questions.

Ask the Expert

This service enables members to **ask questions** about their health concerns and treatment options. Individuals calling Teladoc Medical Experts are connected with a Member Advocate to discuss their health concerns. An expert will be selected from Teladoc Medical Experts' global network of top-rated specialists to address questions. Answers and suggestions for treatment plans or further testing will be provided in a written report.

Mental Health Navigator

Members will get a review of their diagnosis, treatment plan, and mental health conditions by our carefully selected expert clinicians. The expert will recommend modifications with their findings if necessary. A personalized action plan is then created for the member and ongoing support will be provided to assist members.